Harrogate and District NHS Foundation Trust

The meeting of the Board of Directors held in public will take place at 9.00am on Wednesday 31 July 2019 in the Boardroom, Trust HQ, Harrogate District Hospital, HG2 7SX

AGENDA			
Item No.	**Item**	**Lead**	**Paper No.**
	9.00am – 9.20am		
Patient Story – Mr Ben Goode, Patient Experience Team, will attend with the patient.			
	9.20am – 10.30am		
1.0	**Welcome and Apologies for Absence** *There are no known apologies for absence.*	Mrs A Schofield, Chairman	-
2.0	**Declarations of Interest and Register of Interests** *To declare any interests relevant to the agenda and to receive any changes to the Register of Interests*	Mrs A Schofield, Chairman	2.0
3.0	**Minutes of the Board of Directors meetings held on 24 and 29 May 2019 and 26 June 2019** *To review and approve the Minutes of the meetings*	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** **5.1 Integrated Board Report**	Mr S Russell, Chief Executive	5.0 5.1
	To deliver high quality health care		
6.0	**6.0 Chief Nurse Report** **6.1 Summary from Quality Committee meeting of 3 July 2019** *To be considered and discussed* **6.2 Annual Efficiency Programme Quality Impact Assessment** *To be considered and approved* **6.3 Infection Prevention and Control report** *For discussion and comment* **6.4 Medical Director Report**	Mrs J Foster, Chief Nurse Ms L Robson, Chairman Mrs J Foster, Chief Nurse Mrs J Foster, Chief Nurse Dr D Scullion, Medical Director	Verbal 6.1 6.2 6.3 Verbal

You matter most

	6.5 Operational Performance Report	Mr R Harrison, Chief Operating Officer	6.5
	6.6 NHS Resolution Maternity Incentive scheme – year 2 report	Mr R Harrison, Chief Operating Officer	6.6
	To work with partners to deliver integrated care		
	10.45am – 11.00am		
	Break		
	11.00am – 12.30pm		
	To ensure clinical and financial sustainability		
7.0	**7.0 Finance Report**	Mr J Coulter, Director of Finance	7.0
	7.1 Summary from Resources Committee meeting of 29 July 2019 (to follow**)** *To be considered and discussed*	Mrs M Taylor, Chairman of Resources Committee	7.1
	7.2 Capital Investment Programme Update *To consider and approve the revised programme*	Mr J Coulter, Director of Finance	7.2
	7.3 Summary of meeting of Pensions Committee on 26 June 2019 *To be considered and discussed*	Mrs A Schofield, Chairman	7.3
	7.4 Workforce and Organisational Development Report *To be considered and discussed*	Ms A Wilkinson, Director of Workforce and Organisational Development	7.4
	7.5 Workforce Race Equality Standard draft Report *To be discussed and approved*	Ms A Wilkinson, Director of Workforce and Organisational Development	7.5
	7.6 Workforce Disability Equality Standard draft Report *To be discussed and approved*	Ms A Wilkinson, Director of Workforce and Organisational Development	7.6
	Governance		
8.0	**8.0 Board of Directors Terms of Reference review** *For review and approval*	Mrs A Schofield, Chairman	8.0
	8.1 UCI World Cycling Championships – July 2019 update *To be considered and discussed*	Mr R Harrison, Chief Operating Officer	8.1
9.0	**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 July 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	1. Member of North Yorkshire Local Safeguarding Children's Board and sub-committees. 2. Chair of the Safeguarding Practice Review Group. 3. Chair of the North Yorkshire and York Looked After Children Health Professionals Network. 4. Member of the North Yorkshire and York Safeguarding Health Professionals Network. 5. Member of the national network of Designated Health Professionals. 6. Member of the Royal College of Paediatrics and Child Health Certificate of Eligibility of Specialist Registration (CESR) Committee and assessor of applications for CESR.

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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
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

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Report Status: Open

BOARD OF DIRECTORS MEETING

Minutes of the Board of Directors' meeting held in public on
Wednesday 29 May 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 Paul Nicholas, Deputy Director of Performance and Informatics Ms Laura Robson, Non-Executive Director Mr Steve Russell, Chief Executive 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 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 David Britton, Head of Nursing, Planned and Surgical Care (Patient story only) Mr Andrew Forsyth, Interim Company Secretary 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

Patient Story

Mrs Schofield welcomed Mrs Jackson and Mr Britton to the meeting. She said that the patient story would be in the form of an audio recording.

Mrs Jackson said that the audio recording had been edited from a meeting with a family following the report on a Serious Incident. She noted that the experience described by the family had not formed part of the original concerns but had been felt to be an important learning opportunity for the Trust when they described their experience of support in an end of life scenario.

The Board meeting listened to the recording, which recounted the experience of the family when called in by telephone to the ward after the death of their father, who had been an in-patient. They had arrived unaware that their father had died and had been met on arrival by a student nurse who did not know the situation; and they had then not been treated appropriately once in the ward. The family had been left alone and received no assistance in packing up personal belongings. Once they were ready to leave they were told that the staff in the General Office would contact them the following morning, but they

said they were able to 'wander around' the ward without being challenged. No telephone call was received and when the family telephoned the hospital they were told that the Coroner was involved, something of which they had been unaware.

Mr Britton said that this situation should not have arisen. The ward staff were also upset at the way the family's visit had been handle. There had been reflection both from the staff on that shift and the remainder of the ward staff. There had not been sufficient prioritisation of the family by the staff; he would have expected all the staff on shift to have been briefed that the family would be visiting and how they should be supported. There should have been a conversation with the Nurse-in-Charge, in a private area, assistance with personal belongings and information on next steps.

Mrs Schofield had been involved with the investigation and even after more than six months the family's emotions were very raw. Dr Scullion said that, despite this story, the family had been complimentary about the investigation, and especially its thoroughness, but - as he had been heard saying in the recording – the basic courtesies and dignities had been lacking.

Mrs Foster said that the way they had been treated had possibly not been at the forefront of their minds at the time given the very sad situation they were dealing with but did so with hindsight. Family members in such situations often remembered those who had made the experience easier. She was aware of a similar situation in another ward. She considered that the administration of last offices and what followed were a standard known by all trained nurses – and was disappointed that they had not been used. Mrs Foster said that in general the processes after death were handled well – as evidenced by the large number of complimentary cards which were received – and there was a good support package in place, as long as it was used.

Mrs Schofield asked whether there was a theme and Mrs Jackson said sometimes the follow-up call the next day was not always happening. Dr Scullion said that sometimes the certification of death needed to be discussed with the consultant of care and with HM Coroner, both of which could take time, but it was usually completed quickly and the family was kept involved. He said that the appointment of a Medical Examiner, who would take responsibility for most aspects of the process after the death of a patient, could significantly improve the process.

In Mr Alldred's view the audio recording had been very powerful; it was important the staff made the end of life process the best it could be made. He intended to play the audio to the Long-Term and Unscheduled Care directorate board and ward teams. There was a discussion about whether relatives could or should be informed of the death of a patient over the telephone. Mr Britton said that it was always a delicate balance, dependent on a number of factors, and Dr Scullion noted that the Trust's duty of care extended to supporting the family after the death of a relative.

Mrs Armstrong suggested that relatives in this situation would probably take in little of the information imparted to them at the time and information in a 'takeaway' form was therefore vital. It also needed to be jargon-free and as 'natural-sounding' as possible. Whilst Mrs Schofield was concerned about the impact on the student nurse, Ms Robson commended the practices of the maternity and paediatrics teams and suggested that they could provide lessons on these situations for other wards. Mr Russell agreed that the audio had been distressing and noted three points: managing interactions kindly was important in situations which were not normal to people using our services, there had

been no intent from the night shift for this to happen and what part did human factors play in the situation. Dr Scullion said that the family had been extraordinarily gracious and dignified throughout, despite the evident shortcomings, and their reactions measured and reasoned.

In summary, Mrs Schofield thanked Mrs Jackson and Mr Britton for presenting the story. She wondered what had prevented the staff from practising the Trust values, and said that the story presented a salutary lesson for the Trust and that we should continue to reflect on what prevents colleagues from living the Trust's values as they would always intend to. She said that she would write to the daughter of the deceased and explain how their story had been discussed at the Board.

Action: Mrs Schofield to write to family featured in the Patient story.

1.0 Welcome and Apologies for Absence

1.1 Mrs Schofield noted there were apologies for absence from Mr Robert Harrison, Chief Operating Officer and welcomed Mr Paul Nicholas, Deputy Director of Performance and Informatics, in his stead.

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

1.3 Mrs Schofield welcomed two Governors, Mr Cowans and Ms Heaney, two members of the public and two members of Trust staff. She also welcomed Mr Steve Russell to his first meeting as Chief Executive of the Trust.

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. There were no declarations of interest additional to those in the paper.

3.0 Minutes of the meeting of the Board of Directors on 27 March 2019

The draft minutes of the meeting held on 27 March 2019 were approved subject to the following amendments:

Minute 4.3
Line 10 – **Delete**: 'Joint' **Insert:** 'Judgement'

Some minor typographical errors required correction.

APPROVED:
The Board of Directors approved the minutes of the meeting held on 27 March 2019 as an accurate record of proceedings, subject to the agreed amendments.

4.0 Review of Action Log and Matters Arising

4.1 Action 81: Mr Nicholas said that progress was being made but it was proving to be challenging to collect the right information. Mr Alldred said that the Harrogate and Rural

Alliance (HARA) had moved on and this also needed to be reflected. Mrs Schofield agreed to a further update at the July meeting.

4.2 Action 131: Ms Robson confirmed that she would report back to the Board in September on the action taken by the Quality Committee.

4.3 Action 132: Mr Alldred said that the caseload for this team had always been significantly higher, largely because of the high number of residential homes in that area. This would change when the boundaries are adjusted under HARA. Partner organisations were being used to move patients off the caseload and manage them differently. Board action complete.

4.4 Actions 133: A report will be prepared. Mrs Schofield suggested that the Freedom to Speak Up Guardian should have regular meetings with the Chairman and Managing Director of HIF. Board action complete.

4.5 Action 134: Board action complete.

4.6 There were no other matters arising.

APPROVED:
The Board of Directors noted completed actions and updates on outstanding actions.

Overview by the Chairman

Mrs Schofield noted a number of items:

- She welcomed Mr Russell and said that his arrival had been long anticipated.
- Mrs Schofield noted that this was the first meeting since the year-end. 2018/19 had been a good year both financially and in terms of Trust performance. She thanked the staff for their hard work. The Trust had significantly improved its position in terms of NHS performance ratings.
- She reported that the contract with Harrogate and Rural District Clinical Commissioning Group (HaRD CCG) had been signed after numerous discussions and significant efforts, which she believed had been worth the investment of time.
- A contract had been signed with Leeds Institute for Medical Education for the continued support of medical students at Harrogate. Dr Scullion noted the significant contribution made by Dr Gareth Davies, who would be retiring in the next few weeks. He had led the work over a number of years and his contribution has been welcomed by the University. Mrs Schofield would write to Dr Davies to thank him
- The Board had discussed strategic planning and pensions taxation at the April workshop, and then undertaken excellent visits in Darlington and Stockton which had emphasised the value of moving Board workshops around the Trust footprint. She commented that similar visits to services in Knaresborough and Harrogate should be programmed in future, especially to the Knaresborough team, which had recently been recognised as 'Team of the Month' in the Trust's Making a Difference awards.

ACTION:
Mrs Schofield to write to Dr Gareth Davies

5.0 Report by the Chief Executive

5.1 The report and Integrated Board Report (IBR) had been circulated in advance of the meeting and were taken as read.

5.2 Mr Russell said that as this was his first report he welcomed feedback on what would be helpful to fellow Board members. He conveyed his personal thanks for the warm welcome and support he had received. He had been spending time on work aligned to key risks to the Trust and learning about priorities. The Trust had grown in scope and scale and it was very important to reflect the Boards focus in a balanced way across all the Trust's services and geographical areas.

5.3 Moving to the operational plan, he was pleased that the contract and Memorandum of Understanding (MOU) with HaRD CCG had been signed. There was a positive relationship with the CCG. Delivery of the plan would be incredibly difficult but there was a clear understanding of the risks and an intention to jointly share and address them. Jonny Hammond was working on a transformation programme for planned care and Mike Forster and Andy Alldred on urgent and emergency care.

5.4 Mr Russell said that pensions taxation was a significant issue for medical staff and for the Trust, both around morale and delivery of services, and would be discussed at greater length in the private session.

5.5 Turning to current highlights, Mr Russell noted that community and hospital teams had been under pressure: activity was higher than planned and higher than for the same month last year. The Emergency Department had achieved 93.6% against the 95% target for April, a stronger performance, and the Referral to Treatment (RTT) had improved to 88.5%, which meant that the 92nd percentile was at 21 week wait as against the 18 week threshold. The focus for the wider NHS, however, was total waiting list numbers. The Trust was very challenged in 2-week waiting lists for breast cancer, following a rise in referrals (reflected across West Yorkshire and Harrogate (WY&H)) and the withdrawal of evening clinics due to the pensions issue. There was a plan to close at least half the gap but recovery would take some time.

5.6 Financially the Trust was ahead of plan for April but it was still a deficit performance and the Trust needs to reduce run rate spend in order to live within its budget. Mr Russell was pleased to note the huge achievement of having no falls with harm for the month, which is significant progress but we are working hard to understand the themes underlying the rising trend in pressure ulcers in both acute and community settings. He drew the Board's attention to the Trust's ability to invest in capital and manage cash which was on the Corporate Risk Register. This remained a material risk which was not sufficiently mitigated. The lack of cash had also been putting significant pressure on the Accounts Payable team. The key action to reduce this risk is the receipt of the PSF which is expected in July/August from NHS Improvement.

5.7 Turning to more positive news, Mr Russell was encouraged that there were 14 female and 9 male recipients of Clinical Excellence Awards, which would start to reduce the gender pay gap in HDFT. Making a Difference Awards, internally, and external recognition of some staff initiatives showed both the kindness of teams and their contribution to charitable causes. He and the Chairman had sealed the contract extension for Children's 0-19 services in Darlington until 2022, which showed how effectively they were being delivered.

5.8 Mrs Schofield thanked Mr Russell for his report and invited questions and comments. Mrs Armstrong was concerned about the surge in breast cancer referrals and consequent pressure in the system and asked whether it was anticipated that this growth would continue and whether there a plan to create greater capacity. In response Mr Russell said this did not appear to be a spike but the new normal, and there was no clear solution to the capacity issue. Mr Alldred added that the spread was between 16 and 21 days and the team was monitoring the delays in diagnosis; GPs were counselling patients on the delays. Dr Scullion said that the referral guidelines had changed but the incidence had not, whilst Mr Russell confirmed that surgical capacity was available and there was a focus on ensuring that those diagnosed were being treated within the 62-day target. Dr Johnson said that the pensions taxation issue was causing a vulnerability and Mr Coulter confirmed that the risk around this in the Corporate Risk Register would be reviewed at the Risk Review Group meeting on 14 June.

5.9 Moving to the Integrated Board Report, Ms Robson noted the rising trend in readmissions and asked whether these were the result of unsafe discharges or failed procedures. Mr Russell confirmed that the Trust was an outlier on readmissions with a rate that was 7% higher than the national position. Mr Coulter added that figures would need correlating with those for Length of Stay. Ms Robson noted that Delayed Transfers of Care (DTOCs) had fallen. Mr Coulter said this had been reviewed last year and it was agreed that a further review of emergency readmissions would be appropriate.

5.10 In response to Mrs Schofield's question, Mr Russell said that the measure of occupied bed days was about inpatient efficiency – rising figures would be of concern but it would be more helpful to express it as a a standardised figure related to the size of the population to show the extent to which we were reliant on hospital bed based care.

5.11 Mrs Taylor asked about implications of the merger of the three Clinical Commissioning Groups (CCGs). Mr Russell said that the proposal to merge was now in the 'merger pipeline'; there would be an impact but that it was too early to assess it. The combined CCG would also need to work with the Vale of York CCG, an issue which would need to be work through. Mr Coulter considered there would be economies of scale and a more strategic view of commissioning. It was agreed that the Board should discuss the merger at an appropriate Board workshop.

5.12 Mr Thompson said that it was good to see more about community teams in the IBR but asked about the OPEL system. Mr Alldred said it was a daily measure to assess pressure in the system, including caseload, activity and Emergency Department activity data, on a scale of 1 (normal) to 4 (highest pressure).

5.13 Mrs Webster was concerned about the waiting times for patients between 18 and 38 weeks. Mr Nicholas said that the total number of those on the waiting list for any condition stood at 14,469. Mrs Webster asked which specialities had the longest waiting lists – these were ophthalmology and orthopaedics. Mrs Schofield said that the IBR should reflect the waiting list for each speciality and the maximum waiting time for each.

ACTION: Board workshop to discuss implications of merger of the CCGs;
ACTION: IBR to reflect waiting list numbers and maximum waiting time for each specialty
ACTION: Executive team to commence a programme of work on readmissions.

To deliver high quality healthcare

6.0 Quality Committee Report – 1 May 2019

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

6.2 Ms Robson asked for clarification around the position on staple guns; she had understood previously that the Trust did not use them. Dr Johnson said that the safety alert had been about elective colorectal surgery staple guns, which the Trust did use. She said there had been no complications and concerns about holding an insufficient number for Trust requirements had now been resolved. Ms Robson noted that the Resus lead would be attending the Quality Committee meeting on 5 June to discuss the ResPECT programme. She said that the presentation by the National Maternity and Neonatal Safety Collaborative had been fantastic and that there were lessons to be learned by the Trust; Mrs Foster said that there would be a similar presentation at the forthcoming Quality Conference.

6.3 Mrs Schofield asked about the ResPECT programme and the Trust process; it would be helpful to understand the reasons why the Trust chooses not to use it, if that is the outcome. Dr Scullion replied that there were different groups in the Trust invested in different approaches to End of Life care and progress in resolving the differing views was slow. The Trust continues to use Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) in the Emergency Department and he noted that ResPECT is not yet available electronically. Mr Alldred said that changes needed to be made systematically and sensitively – the HaRD CCG view was that Trust practice was better than ResPECT and to move to the latter would be a backward step. Mrs Webster pointed out that the last audit gave limited assurance to the DNACPR approach; the important thing was to have a standardised approach across the Trust which was used by everyone.

7.0 Annual Efficiency Quality Impact Assessment

7.1 Mrs Foster said that her paper would now be presented in July, as it had been placed into an annual cycle which including scrutiny by the Quality Committee in early July before presentation at the Board meeting later that month. She was pleased to report that following a re-audit, the process had received Significant Assurance.

8.0 Guardian of Safe Working Hours Report

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

8.2 Dr Scullion said that the Trust was generally supporting doctors in training well with fewer exception reports than the national average. Following discussion it was agreed that Dr Gray would continue to compile quarterly reports, which would be presented to the Board as appropriate, rather than changing their periodicity to match the Board cycle.

8.3 Ms Robson asked about issues with rota co-ordination for doctors in training. Dr Johnson said that in Planned and Surgical Care they provided cross-cover for medicine. The rota co-ordinators were aware of the issue and were working to improve the situation, which was currently causing stress in doctors in training. Doctors in anaesthesia were trialling a new model, which might offer some solutions. Dr Scullion said that he had viewed the Allocate electronic rostering system and he thought it was very positive, but would require funding. Mr

Coulter said that a business case had been prepared and would be presented to the Senior Management Team (SMT) in the near future.

8.4 Mr Alldred said that whilst the rota co-ordinator in the Long Term and Unscheduled Care Directorate was working to improve matters, the underlying issue was gaps in the rotas caused by vacancies.

8.5 Dr Lyth, as tutor for Specialist and Associate Specialist (SAS)-grade doctors, noted the success of the Certificate of Eligibility for Specialist Registration (CESR) programmes in Emergency Medicine and Paediatrics but highlighted that similar issues to those for doctors in training existed in the middle tier rotas. After discussion it was agreed that the areas covered by the Guardian of Safe Working Hours should be extended to all SAS doctors.

Actions:

- **Mr Coulter to facilitate presentation of business case for Allocate rostering system to the Senior Management Team**
- **Dr Scullion to discuss with the Guardian of Safe Working Hours how his services are to be extended to all SAS doctors.**

The Board of Directors noted the report.

9.0 Annual Patient Experience and Complaints Report 2018-19

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

9.2 Mrs Foster reminded the Board that it was intended to run a Rapid Improvement Workshop (RPIW) on the complaints process in an effort to improve Trust performance. In the meantime improvements were being sought in understanding the questions to be answered and the timeliness of responses – in the case of the latter, the majority of responses were at least 10 days late.

9.3 Mr Alldred agreed that more work was needed at Directorate-level. He assured Board colleagues that it was not for want of commitment to improving the process and he now had weekly oversight of complaints in Long-Term and Unscheduled Care, working jointly with the Patient Experience Team. His staff were engaged and experienced angst when deadlines were missed, but he believed the position was improving. Dr Johnson noted that her Directorate's performance had deteriorated in Q4 because of sickness absence and the process was fragile. She gave an example where the quality assurance (QA) of the complaint process was clearly in the wrong place and as a consequence she was changing it, with the Lead Investigator agreeing the key issues with the QA lead at the outset.

9.4 Mrs Foster noted that improvement of the complaints process was one of the Trust's Quality Priorities for 2019/20. Mr Stiff said that the Quality Committee was focused on this work.

9.5 Mr Thompson was disappointed that only four reviews had been posted on NHS Choices in the last quarter and wondered how patients could be encouraged to record their views. Mrs Foster said that it was largely dependent on how patients and carers were asked about the quality of their care and most needed to be encouraged to contribute their views. Mrs Armstrong said that this was not an easy process and it needed to be simplified. Dr Lyth said that in a learning organisation she was disappointed that of 320 stories only one had changed a process. Mr Coulter connected this with the previous discussion, noting that whilst it was right to increase focus on the complaints process, the Trust scored very highly across the board when it came to recommendation as a place to be treated.

ACTION:
Mrs Foster to update the Board in September on progress with improving the complaints process

10.0 Learning from Deaths Quarterly Update

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

10.2 Dr Scullion said that the national report on the deaths of patients with learning disabilities would be made available to Board members when it was published – there had been one such death in the Trust in the previous year; Dr Johnson pointed out that maternity and paediatric deaths were not included in the figures in the report. Board members should be confident that these were always investigated robustly and reported elsewhere; Mrs Webster wondered how any learning from these deaths could be spread more widely in the Trust and Dr Johnson said that it would be shared at the Quality Committee. Mrs Schofield reminded the Board that serious incidents would be subject to formal investigation, with learning shared throughout the Trust. However, she considered that it would be helpful to add some details about maternity and paediatrics deaths to the Learning from Deaths reports.

Action: Dr Scullion to add details about maternity and paediatrics deaths to the Learning from Deaths reports.

To work with partners to deliver integrated care

11.0 West Yorkshire Association of Acute Trusts report

11.1 Mr Russell gave a verbal report. He noted that the Chief Executives had agreed that urgent and emergency care should be prioritised when the transformation funding was allocated. The 62-day cancer performance was under pressure across the region and the current urology pathway was being reviewed in a joint improvement event.. There had also been agreement at WYAAT that some of the funding for the Academic Health Science Network should be used to support collaborative work on outpatients across the WYAAT Trusts.

11.2 Mrs Webster wondered how the change of Hyper-Acute Stroke Services (HASU) had progressed; Ms Robson said that the Quality Committee would be receiving an evaluation after a reasonable period of operation of the new arrangements.

To ensure clinical and financial sustainability

12.0 Report of the Resources Committee

12.1 The summary reports of the April and May meetings 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 April report as matters had moved on significantly. She noted that in the May meeting (the day previous to the Board meeting) the Committee had been updated on the outturn for April which, although less

than the planned deficit (£2.111m) had still been a deficit of £1.677m. Pressures in the Cost Improvement Programme (CIP), commissioner income and property services were offset by underspends in medical staffing, other nursing, administrative and clerical services and drugs

12.3 The papers on workforce planning and position had been well-received and the comparison of planned against actual figures were a real step forward. Cash remained an issue for the Trust, particularly in the absence of the earned Provider Sustainability Fund monies from 2018/19. The Committee had also discussed the national costs collection programme for last year.

12.4 Mrs Taylor said that in discussion it had become clear that it would be beneficial for there to be committee oversight of the digital transformation strategy. The proposal was that this oversight be added to the Terms of Reference of the Committee; this was agreed.

12.5 Ms Robson asked about the governance of the ICT programme. Mr Coulter said this was managed through the ICT Steering Group, with Dr Matt Shepherd as the Clinical Lead for ICT, which in turn reports to the Operational Delivery Group and thence to the Senior Management Team. Ms Robson remained concerned about the focus on quality issues in ICT developments and Mr Harrison was tasked with providing information on this to the Board. Mr Coulter agreed that there were questions around how to improve quality of care and any risks to quality of care posed by the development of ICT.

12.6 Moving on to the year-end position for 2018/19, Mrs Taylor said that Harrogate Harlow was progressing well and had achieved 66% of its planned activity by year end. Mrs Barron would be presenting a report to the Committee at its June meeting.

12.7 Mr Coulter noted the reference costs performance of the Trust in the data published in December 2018, which showed the Trust at 94 as against the 'ideal' of 100 ie the Trust was performing better than the expected standard. He said that, as reported at the Board meeting on 24 May, KPMG had not yet completed the audit of the draft accounts. These, however, would be submitted unaudited – as agreed with NHSI – by midday that day and resubmitted when the audit opinion was available. There had been no changes since 24 May and he did not envisage any being required, as sample testing had revealed no issues. He anticipated resubmitting the financial statements on 31 May or 3 June. Mrs Schofield paid tribute to the work which had been put in to the Quality Report and financial accounts.

12.8 Turning to the new financial year, Mr Coulter noted that delivery of the plan would require constant attention. In month one (April) the Trust had paid the consolidated Agenda for Change pay award for those at the top of their pay band (c£800k) and the Clinical Excellence Awards. The Directorates had delivered a positive performance. There were unresolved issues around NHS Property Services rental payments and the number of properties occupied by the Trust. Looking forward to months two and three, it was important not to repeat the pressures in month one. Delivery of the CIP was key and it was important not to commit resource until the run rate was properly managed and CIP was being delivered. It was likely that funding would be made available centrally, for this year at least, to cover some rather than all of the costs of the pay awards to local authority staff working for the Trust. Mr Coulter acknowledged that no date for receipt of the PSF for 2018-19 had yet been confirmed. In terms of capital funding, all providers had been required to review their submitted capital spending plans, following affordability concerns in NHSI; any delay in approving them would be a significant issue for the Trust. Finally he

confirmed that the Trust was reporting a Use of Resources rating of 3, the maximum possible under a deficit budget regime.

12.9 Mr Stiff asked about the route for the funding of local authority pay awards and Mr Coulter confirmed that this would be direct to providers, rather than via commissioners. In the case of NHS Property Services, Mrs Taylor said that the Trust was also examining the use of other properties and the Resources Committee would receive a report in August. Mr Alldred was concerned about the impact of the delay in PSF payments on the capital programme – Mr Coulter responded that the payment was currently expected in August and NHSI would continue to be pressed to understand the impact of any delay.

12.10 Mrs Schofield asked about the delay in payment of suppliers due to the cash situation. Mr Coulter said that if £2m of the PSF was dedicated to payments this would significantly improve the position – the ideal would be 90% paid within 30 days and the funding would improve the position to 66% between 42 and 49 days. He estimated that the Trust was c£4.5m behind the 90% standard. Mr Alldred said suppliers to pathology and medicines were reflecting the cash pressures and pushing to be paid, whilst Mrs Taylor noted that the Trust itself needed to receive payment from debtors. Dr Scullion asked whether suppliers were prioritised for payment and Mr Coulter said that local suppliers and those with penalty charges were indeed prioritised. Mr Coulter said that a mini-RPIW would be examining the payments process, including cash income, in the next few months.

Actions:

- **Oversight of the digital transformation strategy to be added to the Terms of Reference of the Resources Committee**
- **Mr Harrison to clarify governance around IT programme including quality issues**

13.0 Business Planning Update – Operational Plan 2019-20

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

13.2 Mr Coulter said that the plan had been submitted as required in early April and then resubmitted, in particular as the result of revised capital spending plans linked to excess planned spend of between £1.5bn and £2.0bn at national level. This required all Provider organisations to revise downwards their capital spending plans. The Trust had achieved this by rephasing and deferring some capital planning. He invited the Board to endorse and approve the amendments to the Operational Plan.

APPROVED:
The Board of Directors approved the revised Operational Plan 2019-20

14.0 WY&H Integrated Care System Financial Framework 2019-20

14.1 The paper had been circulated in advance and was taken as read. Mr Coulter reminded the Board that the subject had been considered in detail by the Resources Committee and at the Board workshop on 24 April. It had been endorsed at the latter, due to a pressing deadline for agreement, subject to confirmation at this formal Board meeting.

14.2 He reminded Board members that the framework would establish a shared control total across the ICS and that PSF would be dependent on the financial performance of the ICS as a whole. The framework would put 15% of the PSF dependent on the delivery of the system financial performance. Agreement would also unlock transformation funding.

14.3 Mrs Schofield reminded the Board that the proposal had been discussed in detail in Darlington on 24 April and said that it was a further demonstration of the strength and benefits of working in partnership.

APPROVED:
The Board of Directors approved the adoption of the WY&H ICS Financial Framework 2019-20

15.0 Consideration of IBR and other metrics related to workforce and other HR issues

15.1 Ms Wilkinson drew attention to the sickness absence rate, at 4.64%, which remained above the Trust target of 3.9% as it had done since September 2018. Long-term sickness accounted for c80% of this, particularly in the Children's and Countywide Community Care directorate. There had been around 6,000 episodes of sickness absence, each averaging 12.5 days during 2018-19. Ms Wilkinson said there were a number of underlying issues and she was seeking different ways of presenting information to gain a better understanding of the reasons behind them.

15.2 Whilst the Trust Wellbeing programme was satisfactory, it was not necessarily having a positive impact on sickness absence levels. Ms Wilkinson said she was focusing on the Occupational Health service; the Trust was two months into a joint agreement with Airedale NHS Foundation Trust and the clinical and administrative support were working well, with a positive impact on lead times. There was, as yet, no Employee Assistance programme and she was exploring options to develop this type of support. A review of the Sickness Absence policy was underway, including a Kaizen/RPIW, and insight and engagement from staff would be essential – the Policy must reflect the fair and just culture and be staff-centred.

15.3 Mr Alldred agreed that reducing sickness absence was a high priority and said that support from the Human Resources team was excellent. He believed, however, that managing sickness absence for medical staff needed attention and Dr Johnson agreed, saying that it had always been an issue; she suggested that it was reported to clinicians rather than managers. Deep dives, for example in maternity, had been helpful in her Directorate. Dr Lyth said that she had a strong focus on sickness absence and looked regularly at hotspots; she wondered whether the high long-term sickness absence rate in her Directorate was linked to the age profile of the staff, particularly in the new contracts in Gateshead and Sunderland..

15.4 Turning to the move towards developing a fairer and more just culture, Mr Russell noted that some of the Trust policies (including health and wellbeing) do not necessarily reflect that intent. There was a need to connect the narrative with action in a single strategy, and support first line leaders as a priority. It was agreed that this should be explored at the Board workshop in August.

15.5 Ms Robson said that deep dives on sickness absence were useful and the Trust should be learning more widely from those Trusts which had been rated as Outstanding

as well as those areas in the Trust with a good record. Mrs Webster suggested using high-performing Trusts as a benchmark in this regard and wondered about the position of temporary staff. Mrs Schofield suggested that the mental health of staff should also be included in the discussion.

Action:
Mr Forsyth to schedule the Board to explore connection between policies and fair and just culture at the August workshop.

Governance

16.0 Summary from Audit Committee meetings – 8 and 21 May 2019

16.1 Mr Thompson's reports had been circulated in advance of the Board meeting and were taken as read.

16.2 Mr Thompson said that the Board had considered both reports at the meeting on 24 May. He considered that the Board should be assured that the Audit Committee was maintaining focus on the Internal Audit process and on evening security, both of which had improved under increased scrutiny.

The Board of Directors noted the Actions in the approved the Summary of the Audit Committee meetings – 8 and 21 May 2019

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

17.1 The Board of Directors noted the Minutes of the Council of Governors' Meeting held on 26 January 2019.

The Board of Directors noted the Minutes of the Council of Governors' Meeting held on 26 January 2019.

18.0 Resources Committee Annual Report 2018-19

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

18.2 Mrs Taylor asked the Board to note the change of name and amendments to the Terms of Reference which had taken place during the year. She considered that the Committee was working effectively under its new remit. Mrs Schofield said that it was a good report and the move to monthly rather than bi-monthly meetings, as well as the widening of the Terms of Reference, had been the right move and had improved the effectiveness of the Committee; she thanked Mrs Taylor for her chairmanship. Mr Coulter agreed and said that Mrs Taylor managed the Committee well whilst Ms Wilkinson welcomed the inclusion and discussion of workforce issues.

18.3 Mr Schofield reminded Board members that there was an open invitation for anyone to attend Board Committee meetings and said that the change in focus of the Resources Committee, in particular, had improved Board assurance.

The Board of Directors received and noted the Annual Report of the Resources Committee

19.0 Quality Committee Annual Report 2018-19

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

19.2 Ms Robson thanked the Executive Directors and Clinical Directors who provided excellent support to the Committee. She said that the review in mid-year had changed some of the content of Committee meetings and improved their focus. Mrs Webster added that there was now more insight from staff and in her view the Committee was building momentum. Ms Robson added that the content of annual Quality Report had been discussed and agreed at the Quality Committee and she said that it was an excellent reflection of the work of the Trust over the year.

19.3 Mrs Schofield endorsed that view and reminded Board members about the Quality Conference on 12 June at The Pavilions

The Board of Directors received and noted the Annual Report of the Resources Committee 2018-19

20.0 Audit Committee Annual Report 2018-19

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

20.2 Mr Thompson reminded Board colleagues that the report had been received and considered at the meeting on 24 May and he had nothing to add to what had been said at that meeting. The report was incorporated into the Trust Annual Report.

The Board of Directors received and noted the Annual Report of the Audit Committee 2018-19

21.0 Any other relevant business not included on the Agenda

There was no other business not included on the Agenda.

22.0 Board Evaluation

Board members agreed that the pace of the meeting had been good and, despite full discussion of issues, had been less rushed. The patient story had been particularly strong.

Mrs Webster suggested that the report by the Director of Finance should have been considered under Section 8 of the agenda and Mr Coulter said he would discuss how triangulation of issues could best be reflected.

Mr Russell noted that the content and presentation of the IBR could be improved, with a way found to reflect the development of the Harrogate and Rural Alliance as well as deciding where WYAAT business and Children's 0-19 should be positioned. He emphasised the value of the different perspectives taken by Board members and, in particular, the opportunity for challenge by the Non-Executive Directors, which he hoped would increase. In his view the Board should consider hearing a staff story to complement

the Boards focus on patient stories.
23.0 Confidential Motion
The Chairman moved 'that members of the public and representatives of the press be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest'. The Board agreed the motion unanimously. The meeting closed at 12.03pm.

Report Status: Closed

BOARD OF DIRECTORS MEETING

Minutes of the Board of Directors' meeting held in private on
Friday 24 May 2019 at 10.30am in the Boardroom at Harrogate District Hospital

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

In attendance:
Mr Andrew Forsyth, Interim Company Secretary (minutes)

A.1 Welcome and Apologies for Absence

A.1.1 Mrs Schofield noted that apologies had been received from Mr Richard Stiff, Non-Executive Director.

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

A.1.3 Mrs Schofield expressed her thanks to the Audit Committee and Quality Committee, and noted that the Board could take assurance from their scrutiny of the Annual Report, Financial Statements and Quality Accounts.

A.1.4 Mr Coulter said that the audit of the accounts this year had been a more challenging process than in previous years. There were a number of reasons for this – including the volume of work being undertaken and other Trusts across WYAAT had reported some similar challenges. The ISA 260 which the Board would consider was still a draft version and KPMG had warned that there was a risk that they would not complete their work in time for the Trust to submit the accounts by the deadline on 29 May. This was being flagged as a risk at this stage and the Trust would raise this with NHSI. Mr Coulter assured the Board that there was a very low risk of any change to the bottom line. The delay was disappointing, and it had been agreed to hold a debrief session to review learning for future years once the whole process was completed.

A.1.5 Mr Coulter recommended that the Board should proceed to consider the documents as if the audit had been completed and approve them on a 'subject to' basis, delegating authority to the Chairman and Chief Executive to sign them off once they were finalised.

He was not anticipating changes to any of the documents other than the completion of the ISA 260.

A.1.6 Mr Thompson, as Chairman of the Audit Committee, agreed. He noted that KPMG had rightly confirmed the risk and that the work was moving forward – pragmatically the Board should adopt the approach outlined by Mr Coulter. Mr Harrison asked whether it had been KPMG's process which had caused the delay and Mr Coulter replied that there were a number of contributory factors, including transfer to a new ledger, a different audit approach, and the impact of only receiving a Type 1 audit from our ledger supplier.

A.1.7 Mrs Schofield asked whether all the documents were affected and Mr Coulter assured the Board that it was only the financial accounts – all the rest of the Annual Report and Quality Report were unaffected.

A.2 Declarations of Interest

A.2.1 No declarations of interest were received.

A.2.2 It was noted Mr Coulter and Mr Thompson were directors of Harrogate Healthcare Facilities Management. No agenda items were planned which would present a conflict of interest. It was however agreed that Mr Coulter and Mr Thompson could participate fully in any items which included reference to Harrogate Healthcare Facilities Management.

A.3 Annual Governance Statement 2018-19

A.3.1 Mr Russell noted the importance of the Annual Governance Statement in providing the Board with assurance on the internal controls in place and the risk being managed through a proper process. It was underpinned, he said, by the culture of the Trust and the Freedom to Speak Up Guardian. The Statement set out how risks were identified and the process for managing them. The Quality Impact Assessment process, in which shortcomings had been noted last year, had been improved. There had been changes to the Committee structure of the Trust, further to the advisory visit from NHS Improvement (NHSI) and in the recent Care Quality Commission (CQC) no material issues had been identified. The Head of Audit Opinion had been supportive. The governance of the Trust was sound and there were no significant risks to the system of internal control. Mr Coulter noted the introduction of the new version of the ORACLE ledger system and the compensating controls were referenced in the statement.

A.3.2 Mr Russell had presented the Annual Governance Statement for 2018/19 at the Audit Committee on 21 May and Mr Thompson confirmed that the Audit Committee had supported and accepted the Annual Governance Statement 2018/19.

APPROVAL:
The Board of Directors approved the Annual Governance Statement 2018/19 for submission to NHS Improvement.

A.4 Audit Committee Annual Report 2018/19

A.4.1 The report had been circulated in advance of the meeting and was taken as read.

A.4.2 Mr Thompson noted that the report was along standard lines and relatively short. It would also be considered at the Board meeting on 29 May. The report recorded the membership and attendance at the Committee and noted his position at Audit Yorkshire, which had been declared to the Committee. Early in the year there had been meetings

about the 2017/18 Accounts and financial statements, and work on the 2018/19 Accounts had been taking place into 2019/20.

A.4.3 Amongst issues considered by the Committee during the year, Mr Thompson noted that evening security inspections had shown shortcomings which were being addressed by the Senior Management Team; whilst there had been improvements the advice of the Local Security Management Specialist had been sought across the Trust. Progress had also been made with the quality and timeliness of Post Project Evaluation reports and management responses and actions flowing from Internal Audits were significantly better. The Annual Effectiveness survey had provided reasonable assurance that the Committee was working effectively in accordance with its Terms of Reference.

A.4.4 Mrs Schofield thanked Mr Thompson for his report and for the work of Committee over the year. She said that the Board should draw considerable assurance from their work.

APPROVAL:
The Board of Directors received and noted the Audit Committee Annual Report 2018/19.

A.5 Report from the Audit Committee meetings of 8 and 21 May 2019

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

A.5.2 Mr Thompson confirmed that the reports were self-explanatory. The meeting on 8 May had been a routine meeting and had also considered the draft Financial Statements. It had reviewed the Corporate Risk Register and noted a couple of changes. The Committee was pleased to note progress with Internal Audits and noted in particular the Significant Assurance assessment for IV cannula care.

A.5.3 The Committee had considered the draft ISA 260 from KPMG and noted three items highlighted in it. The business rates legal action was not considered 'virtually certain' by KPMG, whilst the Committee believed that there would be a positive action and the £2.6m receipt should be included. In respect of the income from Yorkshire Cancer Network, KPMG considered that not all of the £3.5m of income should be recognised in 2018/19, with in their view £1.2m not yet appropriated expended. The Audit Committee recommended that the £3.5m should be included. Mr Coulter added that KPMG's view had changed from a previous transaction two years ago. Mrs Webster thought that the expenditure was on infrastructure and there would be evidence that the work had been done. Mr Coulter said that HIF had produced a schedule.

A5.4 Ms Robson said that treatment of the business rates item had been consistent with last year but asked what would happen if the case failed – Mr Coulter said that the sum would be written off and Mr Thompson noted that if it succeeded then there would be a cash benefit to the Trust but if it failed there would be no cash penalty as no cash had yet been received.

A.5.5 Mr Thompson invited the Board to note the extra work which KPMG had undertaken but importantly to note the impact for the Trust finance staff. It had been a big task for them and there was likely to be more work to be completed.

A5.6 The Audit Committee had recommended that the Board of Directors should approve the Financial Accounts and the Letters of Representation.

APPROVED:
The Board of Directors received and noted the reports from the Audit Committee meetings on 8 and 21 May 2019

A6 Harrogate and District NHS Foundation Trust Consolidated Accounts 2018/19

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

A.6.2 Mr Coulter advised that his briefing paper covered the highlights in the financial statements and the other documents. Mrs Taylor noted the content and said that it gave a good summary. The Board agreed that paper 5.1 was very helpful and noted that paragraph 17 of the Letter of Representation was bespoke around the ISA 260 report from KPMG; Mrs Schofield noted a typographical error. The Board approved papers 5.1 and 5.2 (subject to the change). Turning to the ISA 260 Mr Coulter said that the issues raised would be picked up, as they had already been discussed and the outcomes would be reflected in a final version. Mrs Taylor asked about the issues raised around Payroll and HR; Mr Coulter said they would be explored and the recommendations followed up, with a report to the Audit Committee in due course, to provide assurance.

A.6.3 Ms Robson was surprised at the statement about lack of materiality of the Payroll issues and Mr Coulter said this was a standard set by KPMG rather than the Trust. He said that the note about pay progression was incorrect and confirmed to Mr Russell that it would be corrected but was not relevant to the Letter of Representation. Mrs Webster asked about the valuation of land and buildings – was it regarded as a Trust valuation even though it had been carried out by the District Valuer. Mr Coulter replied that this would need to be addressed – the Trust had used the impartial District Valuer whilst other Trusts had used companies, and had recently had their valuations questioned. Paper 5.3 was approved by the Board.

A.6.4 Mrs Schofield said that if the final accounts were ready by then the Board could approve final versions of the financial statements and ISA 260 at its meeting on 29 May, in advance of the NHSI deadline. Mr Coulter agreed but requested that the Board approve the available version 'subject to' final changes and delegate to Mr Russell and himself to agree the final versions when they were available. Mrs Schofield said that Mr Russell could report to the Board on 29 May. The Board of Directors approved the financial accounts for 2018/19 as presented, subject to finalisation, and that the final sign-off would be delegated to Mr Russell and Mrs Schofield once agreed by Mr Coulter. The Board also thanked all staff involved in the preparation of the financial accounts.

A.6.5 Mrs Schofield asked whether there was a discrepancy between the details of the MARS payments in paragraph 4.3.13 of the Annual Report and the figures in the financial statements. Mr Forsyth confirmed that this would be investigated and reconciled before submission to NHSI.

A.6.5 The Board approved the statement that the Accounts has been prepared and audited on the basis of going concern.

APPROVED:
The Board of Directors:
- **approved the statement that the Accounts has been prepared and audited on the basis of going concern;**
- **approved the Letter of Representation for submission to KPMG LLP;**
- **received the draft External Auditor's Opinion on the Financial Statements and the ISA 260 Highlights Memorandum;**

- **approved the consolidated accounts for Harrogate and District NHS Foundation Trust for 2018/19, subject to investigation of the discrepancy noted and finalisation and**
- **delegated authority to Mr Russell and Mrs Schofield to sign-off the finalised accounts.**

A.6 Approval of the Quality Report 2018/19

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

A.6.2 Mrs Schofield said that both the Audit and Quality Committees had considered the Quality Report in detail. Mrs Foster said that it had been prepared in accordance with the detailed guidance issued by NHSI. She thanked Dr Wood for what she described as a magnificent job of compiling the Report. Mrs Schofield echoed those thanks and said it told a fascinating story, with brilliant content. Mr Coulter said that KPMG had given assurance in the draft ISA 260.

A.6.3 The Board approved the Letter of Representation for the Quality Report 2018/19 and approved the Quality Report 2018/19.

APPROVED:
The Board of Directors:
- **approved the Letter of Representation for the Quality Report 2018/19; and**
- **approved the Quality Report 2018/19.**

A.7 Annual Report 2018/19

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

A.7.2 Mr Coulter explained the Trust was required to work to prescriptive guidance in preparing the Annual Report, that elements of the Annual Report had been subject to audit by KPMG, that it was consistent with the other documents and there had been nothing to highlight.

A.7.3 Mr Forsyth noted that Mr Russell had provided a second part to the Introduction by the Chief Executive and agreed to circulate it to Board members.

A.7.4 The Board approved the Annual Report 2018/19.

APPROVED:
The Board of Directors approved the Annual Report 2018/19.
ACTION:
Mr Forsyth to circulate additional paragraph to Board members.

A.8 Other matters relating to compliance with the Trust's Licence or other exceptional items to report, including issues reported to the Regulators

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

A.8.2 Mr Coulter outlined the requirements which lay behind the self-certifications, which had been considered by the Audit Committee. The Trust had also been subject to external inspection and guidance from CQC and NHSI during the year, which had provided evidence to support the self-certification. The Board noted there were two self-certification declarations; the first was the declaration required by general condition 6 and continuity of

service condition 7 of the NHS provider licence and the second was the corporate governance statement (FTs and NHS trusts) – including certification on training of Governors - in accordance with s151(5) of the Health and Social Care Act.

A.8.3 The Board confirmed approval for both annual self-certifications.

APPROVED:
The Board of Directors:

- **Noted the self-certification process was considered by the Audit Committee on 21 May 2019.**
- **Approved the annual self-certification for:**
  a) **the Declarations required by General condition 6 and Continuity of Service condition 7 of the NHS provider licence**
  b) **Corporate Governance Statement (FTs and NHS trusts) – including Certification on training of Governors - in accordance with s151 (5) of the Health and Social Care Act.**

A.9 Any other relevant business not included on the agenda

A.9.1 There being no other business, Mrs Schofield declared the meeting closed at 11.40am.

Harrogate and District NHS Foundation Trust

Report Status: Open

BOARD OF DIRECTORS MEETING

Minutes of the Board of Directors' meeting held on
Wednesday 26 June 2019 at 9.20am in the Blaydon Room, Gateshead Civic Centre, Regent Street, Gateshead NE8 1HH

Present:
Ms Sarah Armstrong, Non-Executive Director
Mr Jonathan Coulter, Deputy Chief Executive/Finance Director
Mr Robert Harrison, Chief Operating Officer
Ms Laura Robson, Non-Executive Director
Mr Steve Russell, Chief Executive
Mrs Angela Schofield, Chairman
Dr David Scullion, Medical Director,
Mrs Maureen Taylor, Non-Executive Director
Mr Chris Thompson, Non-Executive Director/Vice Chairman
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 Kat Johnson, Clinical Director, Planned and Surgical Care
Dr Natalie Lyth, Clinical Director for Children's and County Wide Community Services

1.0 Welcome and Apologies for Absence

1.1 Mrs Schofield noted there were apologies for absence from Mrs Jill Foster, Chief Nurse and Mr Richard Stiff, Non-Executive Director

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

1.3 Mrs Schofield explained that the meeting had been convened to consider the recommendation to establish of a Committee of the Board of Directors, in accordance with the Trust Constitution.

2.0 Declarations of Interest and Board Register of Interests

2.1 There were no declarations of interest pertinent to the establishment of the Committee.

3.0 Resolution to establish a Pensions Committee of the Board of Directors

3.1 Mrs Schofield outlined the rationale for the establishment of the Committee. An issue had arisen in which all the executive members of the Board had a current or potential conflict of interest. The Trust Board needed to confirm Trust policy on the issue.

Under the terms of Article 16.9.1 the Board is able to establish Committees and the proposed Terms of Reference for the Pensions Committee limited it to discussion and decision on a limited scope of issues on pensions which were within the authority of the Trust to decide.

3.2 The Board discussed the requirement for the establishment of the Committee. It was noted that the Minutes of this Board meeting would be received at the July meeting of the Board of Directors in public, on 31 July 2019.

3.3 The draft Terms of Reference of the Pensions Committee were considered by the Board and agreed.

3.4 Following the discussion, Mrs Schofield invited Board members to confirm the recommendation to establish the Pensions Committee.

APPROVED:

- **The Board of Directors resolved unanimously to establish the Pensions Committee of the Board.**
- **The Board of Directors approved the draft Terms of Reference of the Pensions Committee.**

Mrs Schofield closed the meeting at 9.35am

4

HDFT Board of Directors Actions Schedule
Action Log
July 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	**July** 2019	*From January and May 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	**September** 2019	*From May 2019*
135	May 2019 (Patient Story)	Write to family featured in Patient Story	Mrs Schofield, Chairman	July 2019	
136	May 2019 (minute 5.11)	Programme discussion of implications of CCG merger at future Board workshop	Mr Forsyth, Interim Company Secretary	July 2019	
137	May 2019 (minute 5.13)	Integrated Board Report to reflect waiting list numbers and maximum waiting times for individual specialties	Mr Harrison, Chief Operating Officer	July 2019	
138	May 2019 (minute 8.3)	Facilitate presentation of business case for e-rostering system to Senior Management Team	Mr Coulter, Director of Finance	July 2019	
139	May 2019 (minute 8.5)	Discuss with Guardian of Safe Working Hours how to extend his services to SAS doctors	Dr Scullion, Medical Director	July 2019	
140	May 2019 (minute 9.4)	Update Board on progress to improve Trust complaints process	Mrs Foster, Chief Nurse	September 2019	
141	May 2019 (minute 10.2)	Details about maternity and paediatric deaths to be added to quarterly Learning from Deaths report	Dr Scullion, Medical Director	September 2019	
142	May 2019 (minute 12.4)	Oversight of the digital transformation strategy to be added to the Terms of Reference of the	Mrs Taylor, Non-Executive Director, Chair of	July 2019	

		Resources Committee	Quality Committee		
143	May 2019 (minute 12.6)	Provide clarification around governance of IT programme including quality issues	Mr Harrison, Chief Operating Officer	July 2019	
144	May 2019 (minute 15.4)	Programme discussion to explore connection between Trust policies and fair and just culture	Mr Forsyth, Interim Company Secretary	August 2019	

Chief Executive's Report – July 2019

Introduction

1. The first quarter of the 2019/20 year has now passed, and this report seeks to set out a summary of our progress during that time as well as some of the key issues that we have been working on since the last Board meeting.

2019/20 Operating Plan and Transformation Plan

2. NHS England and NHS Improvement agreed to provide our local commissioners with £6m of non-recurrent funding to support this year's contract. The Trust and Harrogate and Rural District (HaRD) CCG took on an additional £4m of savings, of which £2m is planned to be achieved through improvements to pathways for both emergency care and planned care as well as the cost of drugs.

3. This programme of work is underway, with positive working relationships, and a 'one team' approach. The aggregate savings required across HDFT and HaRD CCG is £18.4m in 2019/20. The Resources Committee will oversee the development and delivery of the transformation programme, and a summary of progress will be included in the Director of Finance's report to the Board in future.

4. The local system met with NHS England and NHS Improvement to enable them to review progress. Whilst they were encouraged, they have only released £2m of the £6m and have asked for further assurance about other risks before the remaining £4m is released. We are naturally disappointed about this, and will continue to work with NHS England and NHS Improvement to address their queries. As Board colleagues will be aware it is not unusual to have a level of risk within such a programme, especially in the earlier phases of its development.

5. The key risks to the programme are non-elective demand and the balance of activity between HaRD CCG and Leeds CCG, which has become an issue as a result of changes made in the referral arrangements for the Leeds system. Colleagues are working to mitigate this risk and further detail is provided in the Chief Operating Officer and Director of Finance's reports.

6. The NHS Long Term Plan Implementation Framework has now been issued. As part of this we have received a letter from the West Yorkshire and Harrogate Integrated Care System (the ICS) with templates for Activity, Finance and Workforce which need to be completed in draft by 23 August but as a final submission on 1 November 2019. We are in discussions with the ICS and overarching system regarding completing this information. This process will be discussed further through Resources Committee in August. Work is underway to determine how this will link with the clinical strategy which is due to start soon. Further updates will be given as this work progresses.

Medium Term Financial Sustainability

7. One of the conditions of the £6m financial support was an externally supported piece of work to consider why the Harrogate system has a financial challenge and what the

underlying causes are, to what extent these can be addressed and over what period of time. This is a piece of work we and HaRD CCG would have wanted to undertake anyway, and the SRO's for the work will be myself and Amanda Bloor, as the two Accountable Officers. Oversight of the work will be provided by the ICS.

8. We have agreed a scope for this work, and are aiming to commence it as soon as possible.

Capital

9. Aggregate provider plans for 2019/20 exceeded the limit on capital spending set by the Department of Health. NHS England and NHS Improvement asked Trusts to reduce planned capital spend, and we originally revised our plan downwards by £150k.

10. The first round of reviews still resulted in the limit be breached and NHS England and NHS Improvement then set each ICS a 'capital control limit' and asked each ICS to review planned spend and to live within this limit. HDFT was asked to reduce planned spend by a further £633k.

11. This is of significant concern given the need for us to invest our retained depreciation in renewing equipment and facilities. We have reviewed our capital programme and have agreed with the ICS (subject to Board approval) that we will aim to slip some schemes into 2020/21 on the basis that this 'headroom' will be made available next year, in addition to routine capital spend.

12. This is the subject of a paper later in the agenda from the Director of Finance, but I would draw the Boards attention to the fact that the revised spend we have been asked to live within is below our retained depreciation.

Pathology Joint Venture

13. NHS Improvement have now completed their review of our business case to join the Bradford and Airedale Joint Venture and have confirmed to us that they consider the transaction to be 'material' which means the Trust can now progress this. We are currently planning to join on 1 October 2019. This will allow us to achieve better value from our pathology services, and also will enable us to improve our pathology equipment.

NHS Pension Scheme

14. The Trust established a Pension Committee as a committee of the Board to consider the current pensions restructuring payment policy. This Committee did not include any Board member who had a potential conflict of interest. A decision was taken to remove the current policy, and not to extend the policy to cover those affected by an Annual Allowance tax charge. This removes the inequality that existed between colleagues who were breaching the Lifetime Allowance cap and those breaching the Annual Allowance cap.

15. Whilst colleagues affected by this issue are disappointed, there is general recognition that the Trust has sought to act in a way that reflects fairness and equity. A working group has been set up with a range of medical staff representatives to consider alternative and practical ways in which the Trust can support colleagues to manage this issue.

16. We are clear that we agree with many colleagues that the existing pension scheme rules and the tax regime is punitive in many cases, but we are also committed to protecting the NHS pension scheme and to treating all colleagues at HDFT fairly.

17. The Department of Health and Social Care has begun a consultation on possible changes to the pension scheme for senior medical staff only and we will review our position in light of the result of the consultation and any changes that are made to the scheme.

Focusing on colleagues in HDFT

18. Having spent some time listening to colleagues across the Trust's geography and services, we have put a significant amount of work in to the development of an overall 'teamHDFT' plan which focuses on the health, wellbeing and resilience of all colleagues in HDFT, support to first line leaders, access to coaching and mentoring and bringing a bigger voice from colleagues into decision making. Feedback on the components of the plan have been positively received to date and we now intended to test it more widely with colleagues as we continue to iterate and finalise how we will deliver our objectives. The first part of this is due to launch in late September and we will bring the plan to the Board following the helpful Board workshop which took place in June.

19. As part of the development of a fair and just culture we are developing an over-arching strategy to bring all the strands of work together. This is to reflect our desire to see this as a consistent approach and a set of behaviours resulting in better and fairer lived experience for all our colleagues across everything that we do. We will bring this to the Board in September.

20. As part of this work, we have already started to review some of our key employment policies such as sickness, disciplinary and grievance.

21. The work we have commissioned from Deloitte in respect of a 'neutral assessment' has commenced with good engagement from colleagues. We will keep the Board updated with emerging themes when the first phase is completed.

Senior Management Team

22. We have broadened the membership of SMT to include all Heads of Nursing, and a Senior AHP lead will also join. We are giving consideration to how we engage with and benefit from the voices and experience of our clinical leads and it is likely we will further develop how SMT operates.

23. We are starting to join up our quality improvement (QI) work to ensure SMT is sighted on the improvements being planned and delivered but also to ensure that we are providing

support to unblock barriers our colleagues face. We have agreed an approach that we wish to take to develop our current QI approach into the core of how we work on a day to day basis. A refreshed QI strategy will come to the Board in due course.

Summary of Month three and Quarter one.

24. The adverse variances in the Integrated Board Report (IBR) relate to Falls, reporting of low/no harm incidents (Safe), SIRIs, waiting times for A&E, elective care, first outpatient appointment for suspected cancer referrals and 62 day waiting times for screening services (Responsive), sickness (Workforce), and a deficit run rate (Finance).

25. Operational performance was in line with plan with the exception of cancer, we met our financial plan but have a risk of £3.8m which after mitigations reduces to a forecast in line with plan, and we have seen a net loss of substantive staff which highlights a risk in our workforce plan.

26. The key risks are covered in the papers from the lead Directors later in the agenda.

Making Experiences Count

27. Improving how we learn from the experiences of patients remains a priority and we have increased our focus on providing a timely response which addresses concerns raised by patients. The response rate for Q1 is currently running at 32% and the longest response time for Q1 was 60 days with an average of 36, which is a slight improvement from the last period.

28. There were 11 overdue complaints at the end of the quarter, which is a reduction of 2 from the beginning and it will take some time to improve reported performance.

29. 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 planned to take place in the week commencing 9 September. We will continue to report this to the Quality Committee for scrutiny and challenge.

Flu planning

30. Flu is a serious and communicable disease. There is considerable concern about the experience in Australia, and we will need to reflect on the uptake of flu vaccination in that context. It is clear there is considerable work to do in order to encourage better uptake, particularly amongst medical staff, which is disappointing.

31. SMT has discussed the approach to flu for 2019/20 and also agreed to review our arrangements in the event of a significant number of cases. This is being led by the Chief Nurse and Chief Operating Officer and we will bring the flu plan to the August Board workshop.

EU Exit preparations

32. The UK is currently scheduled to leave the European Union (EU) on 31 October 2019. A number of contingency arrangements had been put in place in the event of the UK leaving without a transition period for the previous planned exit date of 29 March 2019. This is potentially a significant risk to the NHS and Social Care and the contingency planning work is now being refreshed; we expect there to be significant activity re-starting to ensure the NHS is as prepared as it can be for the possible implications of exiting the EU.

33. The Department of Health and Social Care is the lead body for these preparations, which have included a focus on the supply of medicines and medical equipment. Trusts were directed that they should not seek to stockpile supplies and that contingency arrangements such as additional freight capacity, additional storage and buffer stocks, air capacity for products with a short shelf life and changes to regulatory frameworks would all be managed at a national level.

34. The Chief Operating Officer leads our local planning, and we will ensure the Board continues to be updated on the contingency arrangements and risks.

35. The Trust has circa 170 colleagues who are nationals of other EU countries, with a further circa 70 colleagues in Harrogate Integrated Facilities (HIF). They are, and remain valued colleagues who are an important part of the HDFT family. We will continue to do our best to support them as the EU exit date approaches and have previously supported those colleagues who wished to do so to apply for the settlement scheme.

Celebrating success

36. Our Gateshead and Sunderland 0-19 teams had their first 'birthday' as part of the HDFT family. Colleagues have worked incredibly hard and we were delighted to be able to celebrate their achievements in their first year.

37. Our Gateshead and Sunderland parenting programmes – the only ones of their kind in the north of England – have won a national award for the work they do to support young and disadvantaged first-time mums.

38. Our Growing Healthy services in County Durham and Darlington were re-accredited for the UNICEF baby friendly initiative and received a Gold Award which recognises excellent and sustained practice in the support of infant feeding and parent-infant relationships.

39. One of our North Yorkshire 0-19 team developed and ran a programme at a local school to help educate and support young people about risky behaviours and to provide signposting and advice to help them lead healthy and safe lives. It was very well received and the service is considering the learning from the event.

40. We celebrated over 170 colleagues who had given 25, 30, 35 or 40 years to the NHS. Between them they had over 5,200 years of service to the NHS. More than 30

colleagues started in HDFT on the day they joined the NHS and 26 have worked their entire NHS career at HDFT.

41. Monica Sharpe, an Emergency Department Nurse, retired after spending 50 years of caring for patients across four of the Harrogate District's hospitals. She was our longest serving colleague and worked all 50 years of her NHS service at Harrogate.

42. We are one of 30 Trusts involved in involved in QIST (Quality Improvement for Surgical Teams) QIST, which is scaling up interventions such as screening and the use of bodywash and nasal gel treatments to reduce infection rates for patients having joint replacement surgery. The work of the programme has seen more than 16,000 patients receiving this treatment and it was recognised as the 'Infection Prevention and Control Initiative of the Year' at the 2019 HSJ Patient Safety Awards.

43. Following an outbreak of Hepatitis A in Ripon, our immunisation team, supported by colleagues from the North Yorkshire 0-19 service and with outstanding support from pharmacy delivered a very significant and rapid immunisation programme to over 500 children representing uptake of circa 75%. The team has received praise from NHS England and Public Health England.

44. Rebecca Preece one of our Specialist Practitioner District Nurses has been awarded the 'Philip Goodeve-Docker Memorial Prize' by the Queen's Nursing Institute (QNI) for 'outstanding achievement as a District Nursing student'.

45. Following on from the Nidderdale walk, Harrogate Hospital and Community Charity ran two key events in June – "It's a Knockout" and the Yorkshire Three Peaks challenge. Fourteen teams participated in It's a Knockout (although sadly the winning team was from P&G, one of our corporate sponsors), and nine colleagues took on the Three Peaks. Significant sums were raised across the two events although final figures are still being compiled.

46. Active against Cancer, which is an incredibly exciting service supported by Yorkshire Cancer Research launched on 15 July and has already had over 50 referrals.

47. Our Emergency Department ran our first ever Wellbeing week, and one of our midwives ran a Health and Wellbeing conference. In addition to providing great support to those who participated, we are reflecting on the learning and considering how we can build some of the elements into the overall health and wellbeing programme.

48. We received our organ donation report for last year and there were six donations which led to 10 patients receiving organs. We would like to thank colleagues who lead this work through the organ donation committee.

49. One of our podiatrists has developed an apprenticeship and degree programme with Hull University to help address the workforce challenges in Scarborough. This is a really exciting development and we are looking forward to welcoming applicants to HDFT.

Licences signed

50. I am pleased to report that since the May meeting of the Board of Directors the following Licences have been signed:

- Two Licences with North Yorkshire County Council in respect of School Nurse offices at Tadcaster and Rural Selby Prevention Hub and Selby Cabin. Both Licences run until 31 March 2020, which ties in with the contract end date for North Yorkshire 0-19 Children's Services;
- A Licence for a fortnightly sessional clinic room at Wetherby Health Centre for use by a second consultant and
- The Residential Tenancy Agreement for 21 Elmwood Street, renewed for a further 12 months from 6 July for the Global Learners Programme.

Risks

Corporate Risk Register Summary

Corporate risk register summary of changes: Updated June 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*	
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*	
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*	
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	↔	*2*	*Oct-19*	*Progress score improved from 4 to 2.*
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*	*NB Target date to be reviewed and updated next meeting*
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*	
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	↔	*5*	*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	8	↔	*TBC*	*TBC*	*To be removed from corporate risk register*
CR39	Risk to the quality of service delivery due to the clinic capacity of the one-stop service - breaching 2WW times; risk of complaint; non-compliance with national standards; critical report; low performance rating due to significant daily breaches of the breast 2WW times	12	New	*TBC*	*TBC*	*Risk to be reviewed and updated by LTUC*

Progress key

1 = fully on plan across all actions

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

3 = actions defined - work started but behind plan

4 = actions defined but largely behind plan
5 = actions not yet fully defined

Risks added to the corporate risk register

- CR40 Breast- Risk to the quality of service delivery due to the clinic capacity of the one-stop service - breaching 2WW times; risk of complaint; non-compliance with national standards; critical report; low performance rating due to significant daily breaches of the breast 2WW times

Risks removed from corporate risk register

- CR38 Access to historical Outlook files. Risk of failure to meet regulations for claims, complaints and incidents if historical outlook emails cannot be accessed following move to NHS net

Board Assurance Framework Summary

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*	

There were no changes following the Board consideration of the BAF in May.

Steve Russell **25 July 2019**
Chief Executive

Harrogate and District NHS Foundation Trust

Integrated board report - June 2019

Key points this month

1. The IBR has been updated to transition to the use of the new run chart tool. Further work will be done with the tool in the next month to update reset control limits to reassess the variation (see key on p20 below).

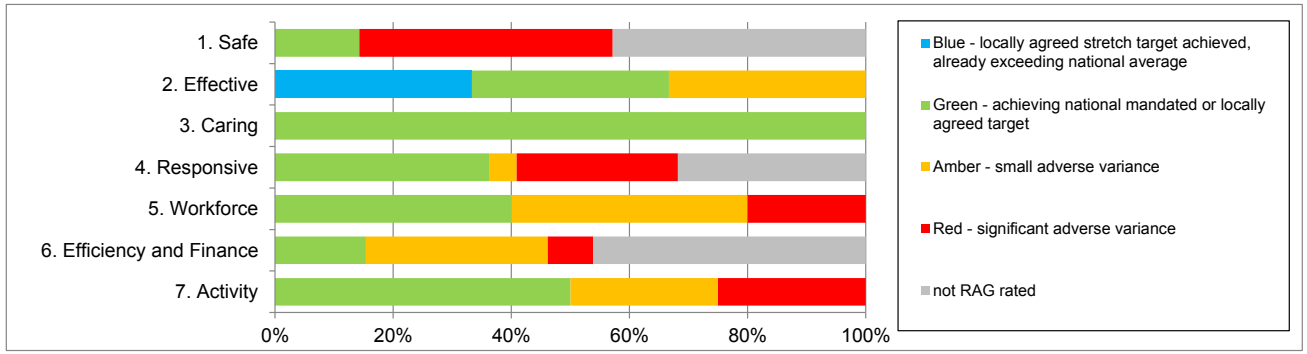
1. The Trust reported a deficit in June taking the year to date deficit to £2m.

2. HDFT's performance against the A&E 4-hour standard was below 95% reported at 94.5%.

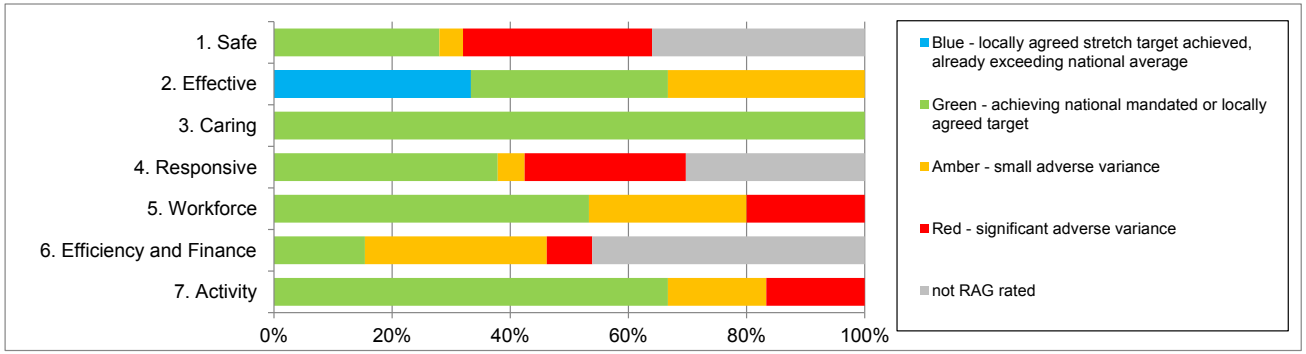
3. The Trust's 18 weeks performance remained below the 92% standard in June with performance at 88.3%.

4. Provisional data indicates that 5 of the 8 cancer waiting times standards were achieved in June and Q1, with the standards for both 14 day standards and the 62 day Screening not delivered - 14 day breast symptomatic standard (6.5%), the 14 day suspected cancer standard (87.9%), and the 62 day Screening (66.7%).

Summary of indicators - current month



Summary of indicators - year to date



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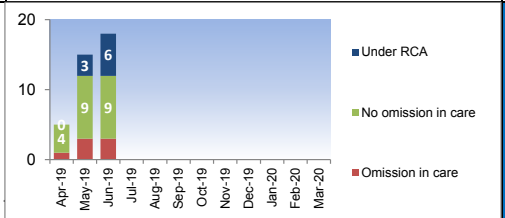
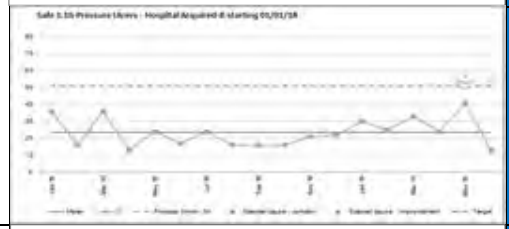
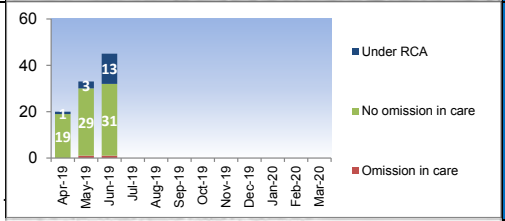
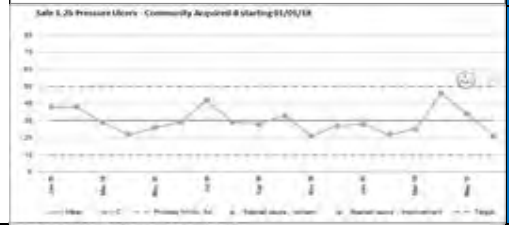
Indicator number	Indicator name / data quality assessment	Trend chart	Interpretation
1.1a	DQ Pressure ulcers hospital acquired		There were 2 hospital acquired category 3 and above pressure ulcers reported in June (including device related and device related mucosal). This is lower than last year with an average of 6 per month reported in 2018/19. Of the 3 reported there were 0 omission in care, 0 no omission in care and 3 under RCA.
1.1b	DQ		The number of hospital acquired category 2 and above pressure ulcers reported in June was 13. The reported number is inclusive of device related and device related mucosal pressure ulcers.
1.2a	DQ Pressure ulcers community acquired		There were 12 community acquired category 3 and above pressure ulcers reported in June (including device related and device related mucosal). The average per month reported in 2018/19 was 11. Of the 12 reported there were 2 no omission in care and 10 under RCA.
1.2b	DQ		The number of community acquired category 2 and above pressure ulcers reported in June was 21. The number reported is inclusive of device related and device related mucolsal pressure ulcers.

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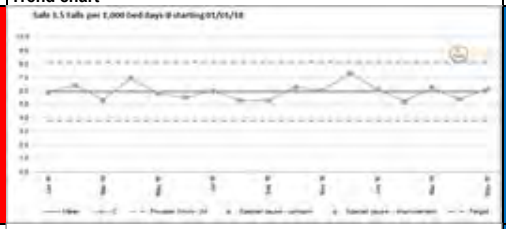
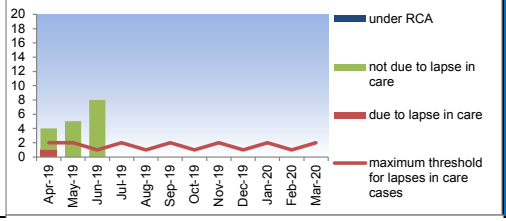
Indicator number	Indicator name / data quality assessment	Trend chart	Interpretation
1.5	Falls DQ		The rate of inpatient falls was 6.09 per 1,000 bed days in May. This is slightly higher than the average HDFT rate for 2018/19 (6.01)
1.6	Infection control DQ		There were 3 cases of hospital apportioned C. difficile reported in June, none of which were due to a lapse in care. No MRSA cases have been reported in 19/20. The annual maximum threshold for lapses in care cases for 2019/20 is 19.

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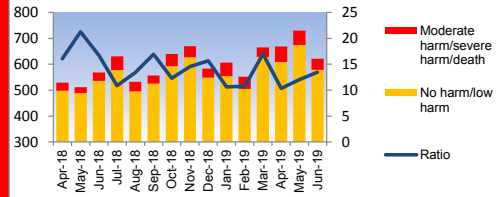
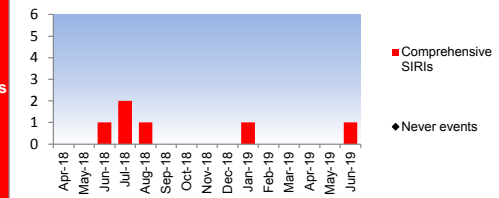
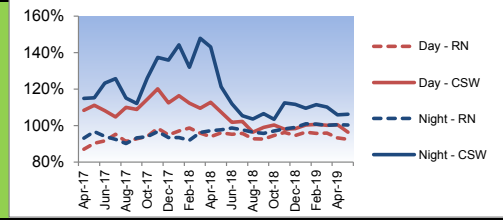
Indicator number	Indicator name / data quality assessment	Trend chart	Interpretation
1.7	Incidents - all DQ		The latest published national data (for the period Apr 18 - Sept 18) shows that Acute Trusts reported an average ratio of 46 no harm/low harm incidents for each incident classified as moderate 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 May gives a ratio of 11, a slight improvement on the April position of 10. CCCC is continuing to focus on its reporting culture. There are now 4 DATIX super-users and a focus on reporting and learning. CCCC is showing improvements in its reporting culture and there is a focus on response rates.
1.8	Incidents - SIRIs and never events DQ		There was one comprehensive SIRI in June but no Never Events were reported for the quarter. No Never Events were reported in 2017/18 or 2018/19.
1.9	Safer staffing levels DQ		In June staff fill rates were reported as follows: Registered Nurses Day 92.2% and Night 96.6%, Care Staff Day 95.3% and Night 103.5%. Reported care hours per day per patient was 8.55 hours per day.

Narrative

Safer staffing

The table below summarises the average fill rate on each ward during June 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 June was 8.55 care hours per patient per day.

Harrogate and District NHS Foundation Trust

Section 1 - Safe - June 2019

Indicator number	Indicator name / data quality assessment	Trend chart	Interpretation

	Jun-2019						
	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
Byland	92.9%	94.2%	95.3%	120.0%	2.93	3.54	6.47
Farndale	95.8%	82.8%	100.0%	101.7%	3.39	3.76	7.14
Granby	95.3%	106.7%	100.0%	93.3%	3.79	3.39	7.18
Harlow	106.7%	96.7%	100.0%	-	7.11	1.91	9.01
ITU/HDU	93.4%	-	95.3%	-	24.59	3.09	27.68
Jervaulx	94.7%	91.9%	93.3%	115.6%	3.02	3.52	6.54
Lascelles	100.6%	92.7%	98.3%	100.0%	5.04	4.36	9.39
Littondale	95.4%	91.1%	96.7%	140.0%	4.35	2.66	7.02
Maternity	88.8%	87.9%	93.9%	87.5%	14.36	4.16	18.52
Medical Assessment Unit	89.1%	105.6%	101.7%	100.0%	5.98	3.70	9.68
Medical Short Stay	98.5%	94.8%	97.9%	101.1%	4.58	2.75	7.33
Nidderdale	87.9%	93.9%	97.8%	103.3%	3.82	2.33	6.16
Oakdale	88.9%	82.9%	98.9%	103.3%	4.04	3.90	7.94
Special Care Baby Unit	88.3%	61.4%	93.3%	-	46.88	8.55	55.43
Trinity	97.4%	106.0%	100.0%	100.0%	3.81	4.51	8.32
Wensleydale	91.8%	102.5%	100.0%	98.3%	3.89	2.55	6.44
Woodlands	78.7%	71.7%	85.6%	66.7%	12.06	2.95	15.01
Trust Total	**92.2%**	**95.3%**	**96.6%**	**103.5%**	**5.23**	**3.32**	**8.55**

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Section 1 - Safe - June 2019

Indicator number	Indicator name / data quality assessment	Trend chart	Interpretation

Further information to support the June safer staffing data

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

The ITU /HDU day and night staffing levels which appear as less than planned are flexed when not all beds are occupied and staff assist in other areas. National standards for RN's to patient ratios are maintained.

The planned staffing levels on Farndale ward were adjusted in June to reflect the closure of beds in this area in response to activity levels.
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 and care staff gaps were due to sickness in June; however a professional assessment was made on a shift by shift basis to ensure that nurse staffing numbers matched the activity.

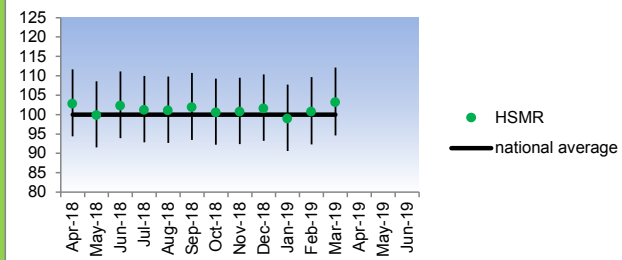
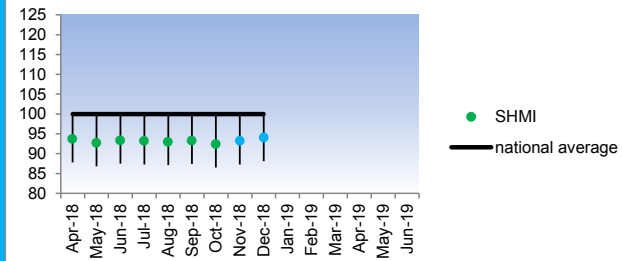
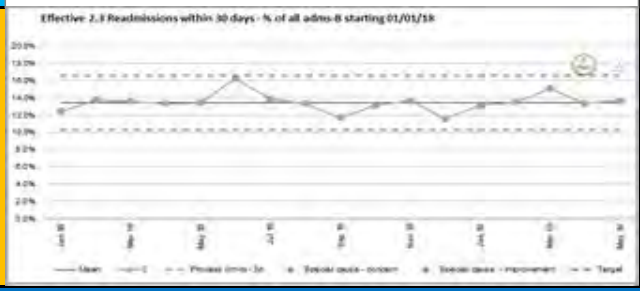
On Nidderdale ward although the daytime RN and care staff hours were less than planned in June, the occupancy levels varied in this area throughout the month which enabled staff to assist in other areas.

In some wards the actual care staff hours show additional hours used for enhanced care for those patients who require intensive support. In June this is reflected on the wards; Byland, Jervaulx, Littondale, MAU, Trinity and Oakdale.

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

On Woodlands ward the day and night time RN and care staff hours are less than 100% in June, 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.

Section 2 - Effective - June 2019

Indicator number	Indicator name / data quality assessment	Trend chart	Interpretation
2.1	**Mortality - HSMR** DQ		Our HSMR has increased to 103.1 for the last 12 months up to March 2019 (1000.68 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 99.2.
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 slightly in May to 13.6%. This is at the samel level as the 2018/19 average. The increase in March was largely due to an increase in the number of patients readmitted following admissions under Urology, General Surgery, and General Medicine.

Narrative

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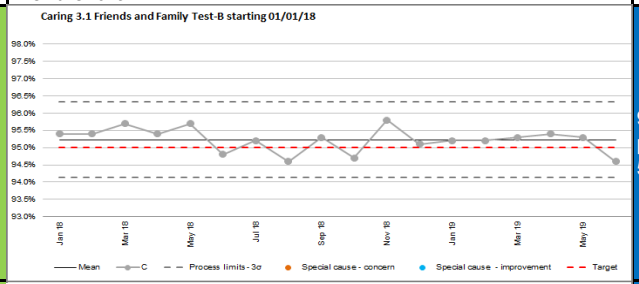
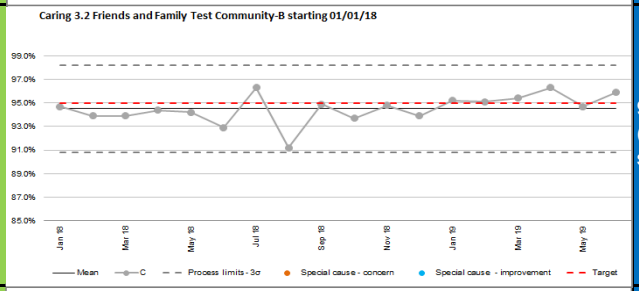
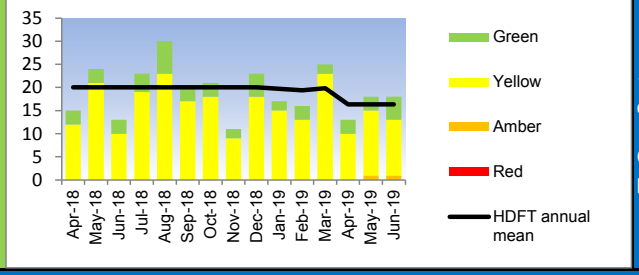
Section 3 - Caring - May 2019

Indicator number	Indicator name / data quality assessment	Trend chart	Interpretation
3.1	Friends & Family Test (FFT) - Patients DQ		94.6% of patients surveyed in June would recommend our services remaining above the latest published national average (93.6%). 5,037 patients responded to the survey this month of which 4,765 would recommend our services.
3.2	Friends & Family Test (FFT) - Adult community services DQ		95.9% of patients surveyed in June would recommend our services, an increase on last month (94.6%). Current national data (March) shows 94% of patients surveyed would recommend the services. 416 patients from our community services responded to the survey this month.
3.3	Complaints DQ		18 complaints were received in June, the same as May, and above the average for 2018/19. No complaints were classified as amber or red this month. CCCC has now introduced a weekly tracker to monitor timeliness and stage of the complaints process.

Narrative

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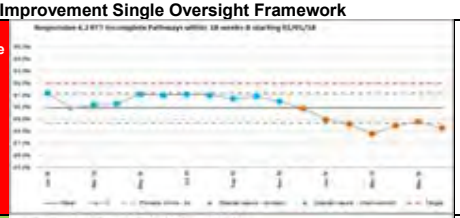
Section 4 - Responsive - June 2019

NHS Improvement Single Oversight Framework

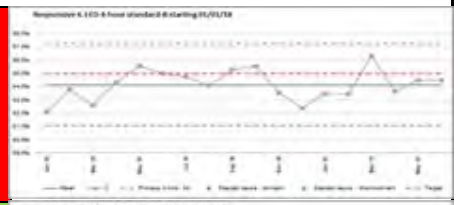
Standard	Q1	Q2	Q3	Q4	YTD
RTT incomplete pathways	88.5%				88.5%
A&E 4-hour standard	94.2%				94.2%
Cancer - 62 days	85.3%				85.3%
Diagnostic waits	99.4%				99.4%
Dementia screening - Step 1	93.4%				93.4%
Dementia screening - Step 2	96.6%				96.6%
Dementia screening - Step 3	100.0%				100.0%

4.1 NHS Improvement Single Oversight Framework — DQ

4.2 RTT Incomplete pathways performance — DQ

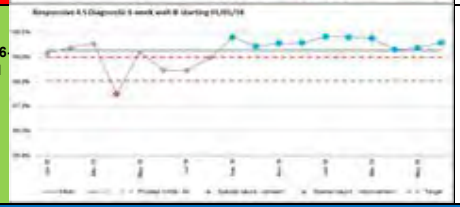


4.3 A&E 4 hour standard — DQ

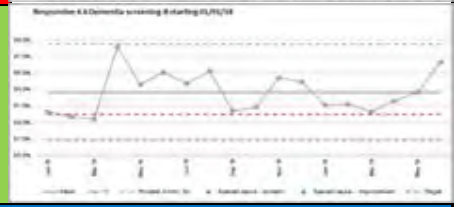


4.4 Cancer - 62 day wait for first treatment from urgent GP referral to treatment — DQ

4.5 Diagnostic waiting times - 6 week standard — DQ



4.6 Dementia screening — DQ



Narrative

Performance against the 62 day cancer standard was delivered for June and Q1 with provisional performance at 89.1% and 85.3% respectively (see a more detailed summary below). 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.

Following further meetings between the COO and the teams delivering the Breast Clinics an agreement has been reached to change a number of job plans to increase the clinic capacity available by the equivalent of approximately one additional clinic per week. In addition, a scheme is now being taken forward to convert an office in Radiology to an additional Ultrasound room, this will enable the addition of at least five additional patients to existing clinics each week. These measures should stabilise the performance and then a further plan to reduce the backlog of appointments (approximately 14 to 16 days of referrals) over the coming months to bring performance back to plan.

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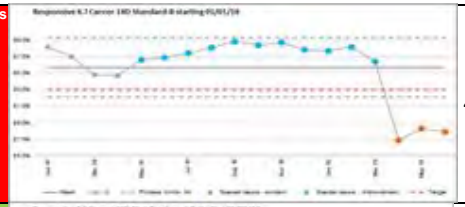
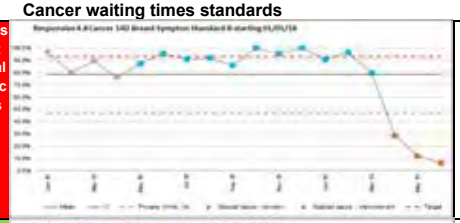
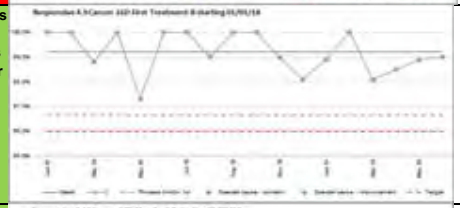
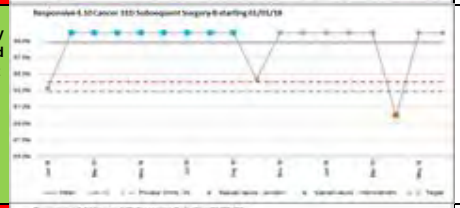
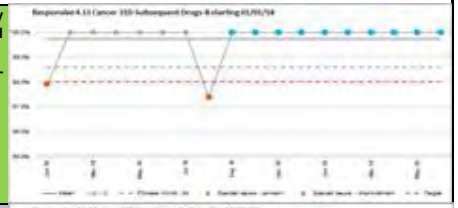
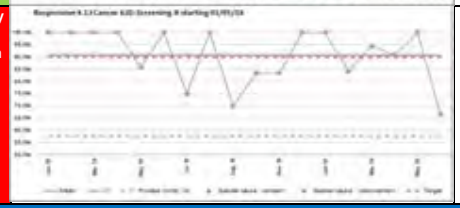
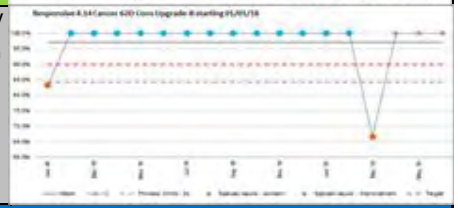
Section 4 - Responsive - June 2019

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 

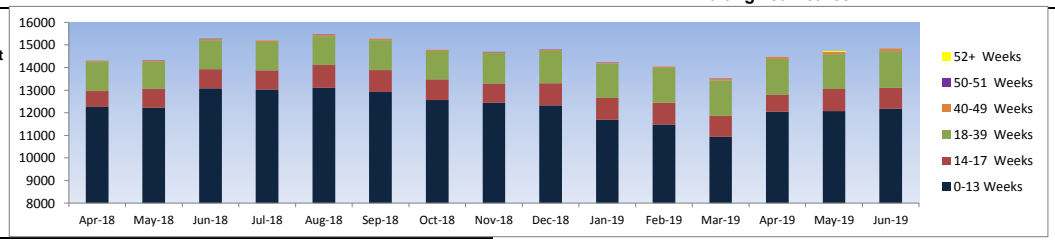
Narrative

Provisional data indicates that 5 of the 8 cancer waiting times standards were achieved in June and Q1, with the standards for both 14 day standards and the 62 day Screening not delivered.

The were 59.5 accountable 62 day standard treatments in the month with 6.5 breaches, meaning performance was above the standard at 89.1%. Of the 11 tumour sites, 3 had performance below 85% in June - Haematology (1.0 breach), Lung (0.5 breach), and Urological (3.5 breaches). 5 patients waited over 104 days for treatment in June - three were due to complex diagnostic pathways, one due to outpatient capacity in oncology, and one was due to a delay to diagnostics.

There were 46 non-cancer related breast symptomatic attendances in June, with 43 patients seen after day 14 (6.5%). The denominator for the 14 day suspected cancer standard was 752 in June with 91 patients first seen outside 14 days (87.9%), which was a slight deterioration on the previous month (88.3%). Of these 91 patients, 85% (77) were breast referrals.

RTT waiting list metrics

4.15	RTT waiting list split by weeks	DQ	

Harrogate and District NHS Foundation Trust

Section 4 - Responsive - June 2019

Narrative

Of the 14,841 patients on the waiting list at the end of June, 12,175 have been waiting 0-13 weeks, 929 for 14-17 weeks, 1,613 for 18-39 weeks, and 124 between 40-50 weeks. The 92nd percentile for June was 21-22 weeks.

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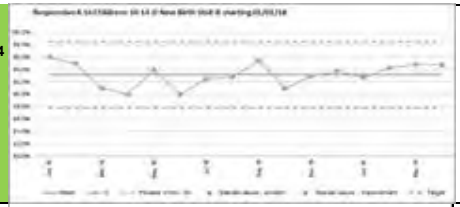
Section 4 - Responsive - June 2019

Children's Services metrics

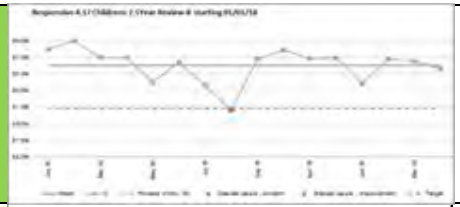
4.16 Children's Services - 10-14 day new birth visit

DQ



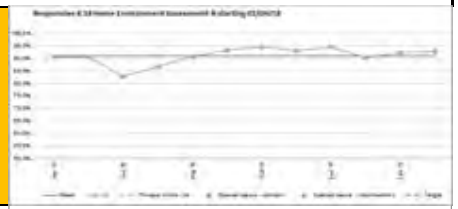
4.17 Children's Services - 2.5 year review

DQ



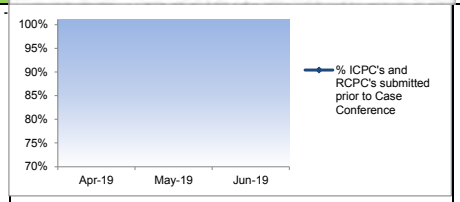
4.18 Children's Services - Use of the Home Environment Assessment Tool

DQ



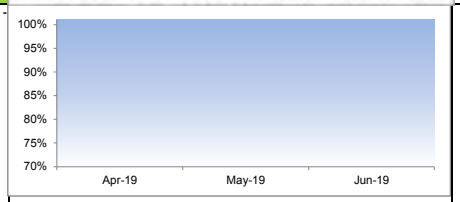
4.19 Children's Services - Reports for Initial and Review Child Protection Case Conferences

DQ



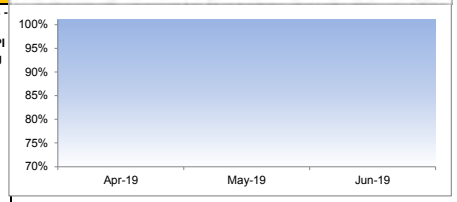
4.20 Children's Services - Staff compliance with Safeguarding Supervision.

DQ



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

DQ

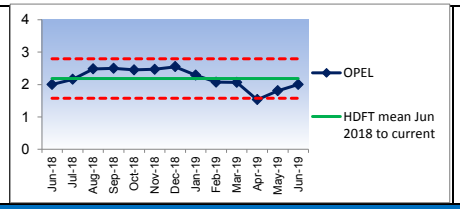


Narrative

Adult Community Services metrics

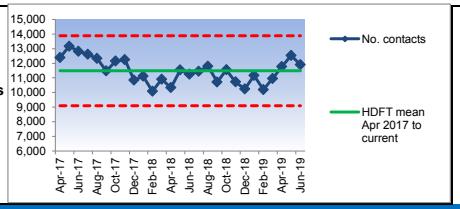
4.22 OPEL level - Community Care Teams

DQ



4.23 Community Care Teams - patient contacts

DQ

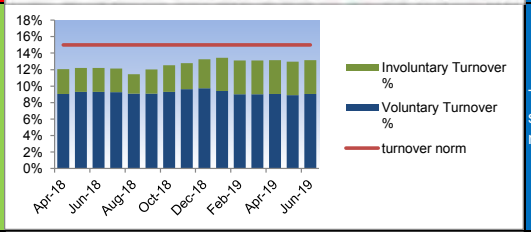


Narrative

The Community Care Teams have now commenced mobilisation to form the new Harrogate and Rural Alliance community teams with partners in the Local Authority. The current metrics will therefore be reviewed to reflect the new ways of working and the integrated model of delivery.

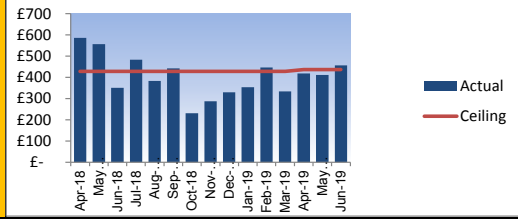
Harrogate and District NHS Foundation Trust

Section 5 - Workforce - June 2019

Indicator number	Indicator name / data quality assessment	Trend chart	Interpretation
5.1	Staff appraisal rates DQ		There has been a reduction in appraisal rates to 76.9% in June from 79.2% in May 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. So far 25% of appraisals have been completed during the appraisal period which is behind our trajectory of 50% to meet our 90% compliance rate. Therefore Directorates are being asked to provide assurance that appraisals are planned in the diary during this period.
5.2	Mandatory training rates DQ		Mandatory % Report – Trust exc HIF 01.07.19 The data shown is for the end of June 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 95% and has increased by 1% since the last reporting cycle.
5.3	Sickness rates DQ		The Trust sickness absence rate for June is 4.2% which is a decrease from May's rate of 4.8%. This remains above the Trust target of 3.9%. The HR team are about to commence a review of the Managing Attendance and Promoting Health and Wellbeing policy as part of improving our people practices work. Stakeholder groups will be established to coproduce our Trust approach.
5.4	Staff turnover rate DQ		Turnover for June shows a slight increase to 13.1% from 13.0% in May. This has remained fairly static and the recruitment and retention group continue to meet on a monthly basis to discuss a number of initiatives.

Harrogate and District NHS Foundation Trust

Section 5 - Workforce - June 2019

Indicator number	Indicator name / data quality assessment	Trend chart	Interpretation
5.5	Agency spend in relation to pay spend DQ		While agency expenditure remains within the ceiling to date, in month performance was adverse by £19k which is a concern.

Narrative

Sickness Absence

The Trust sickness absence rate in June was 4.17% which is a reduction from May's rate of 4.76%. This remains above the Trust target of 3.9%. The HR team are about to commence a review of the Managing Attendance and Promoting Health and Wellbeing policy as part of improving our people practices work. Stakeholder groups are being established this month to coproduce our Trust approach.

Turnover

Turnover for June shows a slight increase to 13.14% from 12.98% in May. 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 further reduction in appraisal rates to 76.89% in June from 79.17% in May and from 83.48% in April 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. So far 25% of appraisals have been completed during the appraisal period which is behind our trajectory of 50% to meet our 90% compliance rate. Therefore Directorates are being asked to provide assurance that appraisals are planned in the diary during this period.

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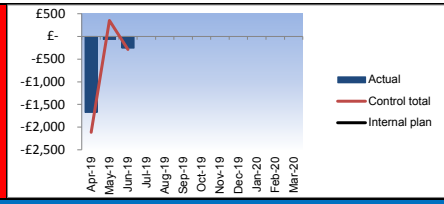
Section 6 - Efficiency and Finance - June 2019

Finance

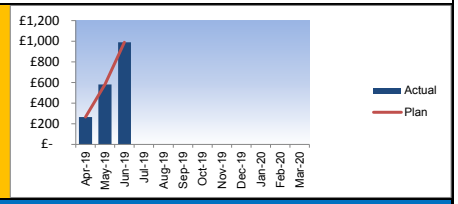
6.1 Surplus / deficit and variance to plan — DQ



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		2
Agency	1	1
Financial Sustainability Risk Rating	3	3

6.3 Capital spend — DQ



Narrative

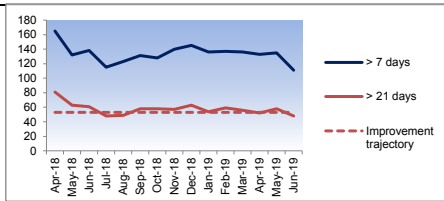
Surplus/deficit and variance to plan - The Trust reported a deficit in June taking the year to date deficit to £2m. This is in line with the control total expectation from NHSI, meaning the Trust will receive Q1 PSF funding. The rating remains red as a result of the level of deficit, signifying the required improvement in run rate.

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

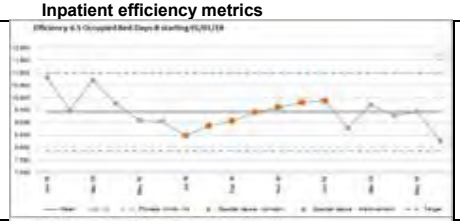
Capital Spend - Discussions continue at a national level regarding the availability of capital resource, with a expectation of a 20% reduction needed nationally. The Trust will look to manage pressures through the year and the position is currently balanced to plan.

Inpatient efficiency metrics

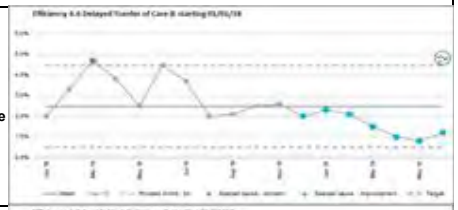
6.4 Long stay patients



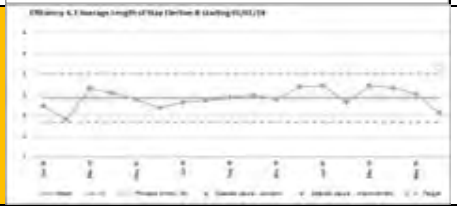
6.5 Occupied bed days



6.6 Delayed transfers of care — DQ

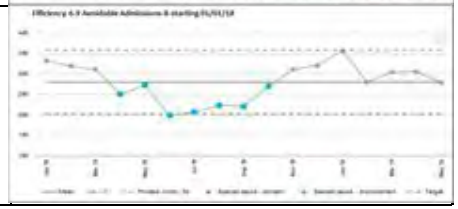


6.7 Length of stay - elective



6.8 Length of stay - non-elective

6.9 Avoidable admissions — DQ



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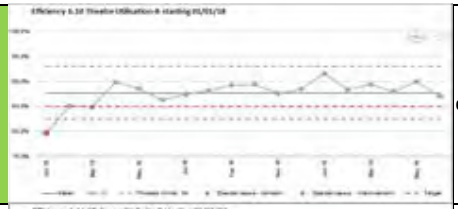
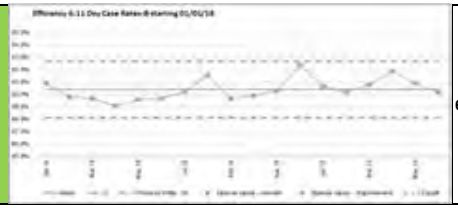
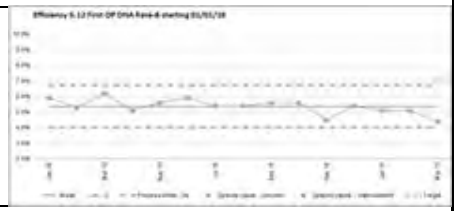
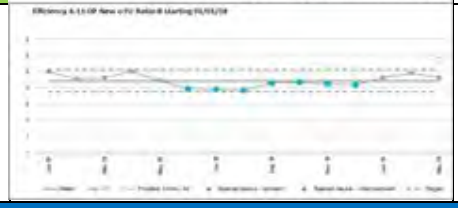
Section 6 - Efficiency and Finance - June 2019

Narrative

Non Elective Length of stay was below the national and benchmark group average in June at 4.1 days.

NHSI/E have written to the Trust setting a 42% improvement target for the number of patients in a hospital bed over 21 days. In order to monitor our progress against this target NHSI/E will require that each Trust establish a team, headed up by a senior manager, to undertake a weekly review of every patient in hospital more than 21 days. These will need to take place on the wards with the outcomes captured and coded and then submitted nationally. For HDFT this process needs to be in place by Sept 19 and we will need to adjust the board report to reflect the trajectory submitted.

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 fell slightly in March but is at a similar level to the HDFT mean from April 2016 to current and is lower than the benchmark group and national average. 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.

During April and May there has been a lower level of % theatre session utilisation due to school holidays. Further work is ongoing to include annualised PAs for flexible operating sessions to support increased use of sessions vacated due to annual leave and a reduced reliance on premium rate lists.

Section 7 - Activity - June 2019

Narrative

The HaRD CCG AIC contract is over-performing in nearly all areas, this remains a concern. Whilst New Outpatient attendances are slightly lower than the same period last year, they remain significantly above this year's plan. Similarly Follow Up attendances are in line with last year, however, they also are above this year's plan. Overall Elective admissions are above plan, with elective inpatient below plan and last year being cancelled out by elective day-case over-performance.

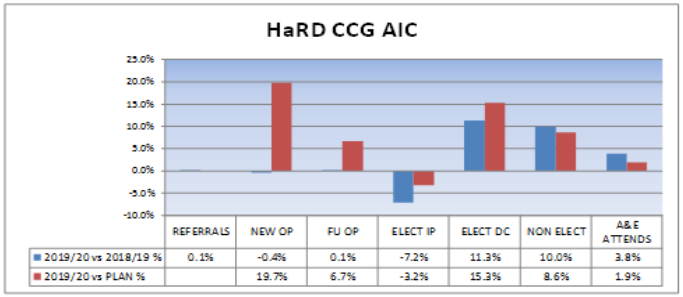
Other CCG contracts are under plan for outpatient and overall elective admissions. This is partly owing to the circa £2m activity removed from the HaRD plan being transferred to 'other' CCGs. The position is also exacerbated by the situation in Leeds whereby the introduction of a Referral
Assessment Service has resulted in all GP referrals going into LTHT, including patients from the North of Leeds who would usually choose Harrogate as their provider. April to June 2019 shows 687 fewer referrals than the same period last year, this will result in a richer mix of HaRD CCG patients being seen in clinic and electively admitted for treatment.

Non elective activity is above both plan and the same period last year against all CCG contracts.

Activity Summary

HaRD CCG AIC

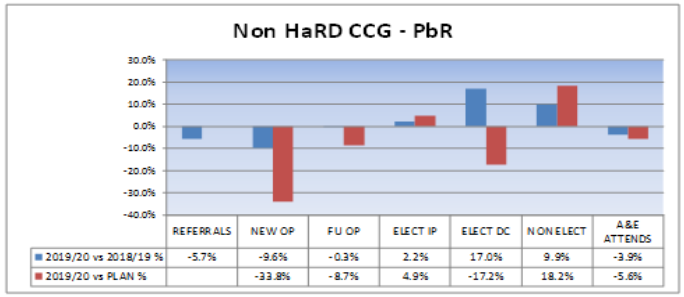
GROUP	2018/19 JUN	2019/20 JUN PLAN	2019/20 JUN ACTUAL	2018/19 YTD	2019/20 PLAN	2019/20 ACTUAL	2019/20 vs 2018/19	2019/20 vs PLAN	2019/20 vs 2018/19 %	2019/20 vs PLAN %
REFERRALS	3,173		3,119	9,543		9,556	13		0.1%	
NEW OP	5,464	4,681	5,524	16,486	13,708	16,414	-72	2,706	-0.4%	19.7%
FU OP	10,596	10,557	10,627	32,914	30,892	32,952	38	2,060	0.1%	6.7%
ELECT IP	194	171	187	558	535	518	-40	-17	-7.2%	-3.2%
ELECT DC	1,584	1,523	1,738	4,914	4,743	5,468	554	725	11.3%	15.3%
NON ELECT	1,297	1,342	1,456	4,048	4,097	4,451	403	354	10.0%	8.6%
A&E ATTENDS	3,246	3,229	3,284	9,433	9,616	9,796	363	180	3.8%	1.9%



Non-HaRD CCG - PbR*

GROUP	2018/19 JUN	2019/20 JUN PLAN	2019/20 JUN ACTUAL	2018/19 YTD	2019/20 PLAN	2019/20 ACTUAL	2019/20 vs 2018/19	2019/20 vs PLAN	2019/20 vs 2018/19 %	2019/20 vs PLAN %
REFERRALS	1,749		1,477	5,146		4,853	-293		-5.7%	
NEW OP	2,500	3,361	2,221	7,261	9,917	6,564	-697	-3,353	-9.6%	-33.8%
FU OP	3,851	4,506	3,941	12,106	13,219	12,069	-37	-1,150	-0.3%	-8.7%
ELECT IP	87	98	105	315	307	322	7	15	2.2%	4.9%
ELECT DC	647	869	768	1,924	2,720	2,252	328	-468	17.0%	-17.2%
NON ELECT	448	381	425	1,252	1,164	1,376	124	212	9.9%	18.2%
A&E ATTENDS	1,265	1,253	1,114	3,661	3,730	3,520	-141	-210	-3.9%	-5.6%

*Non-HaRD CCGs: Hambleton and Richmondshire CCG, Leeds CCG, Vale of York CCG, All Other CCGs



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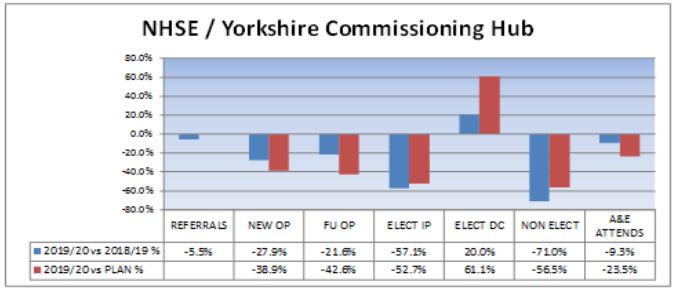
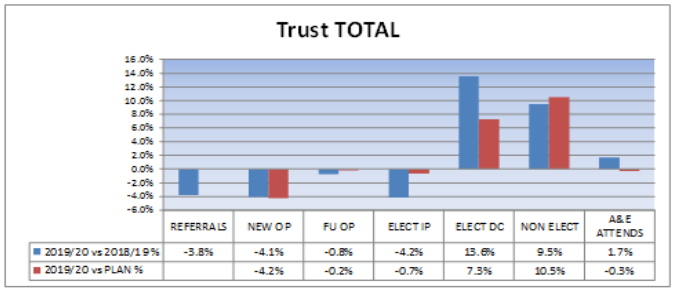
GROUP	2018/19 JUN	2019/20 JUN PLAN	2019/20 JUN ACTUAL	2018/19 YTD	2019/20 PLAN	2019/20 ACTUAL	2019/20 vs 2018/19	2019/20 vs PLAN	2019/20 vs 2018/19 %	2019/20 vs PLAN %
REFERRALS	200		203	676		639	-37		-5.5%	
NEW OP	283	346	224	856	1,010	617	-239	-393	-27.9%	-38.9%
FU OP	467	798	451	1,706	2,333	1,338	-368	-995	-21.6%	-42.6%
ELECT IP	2	2	1	7	6	3	-4	-3	-57.1%	-52.7%
ELECT DC	255	75	202	715	533	858	143	325	20.0%	61.1%
NON ELECT	12	7	7	31	21	9	-22	-12	-71.0%	-56.5%
A&E ATTENDS	23	22	24	54	64	49	-5	-15	-9.3%	-23.5%



Trust Total

GROUP	2018/19 JUN	2019/20 JUN PLAN	2019/20 JUN ACTUAL	2018/19 YTD	2019/20 PLAN	2019/20 ACTUAL	2019/20 vs 2018/19	2019/20 vs PLAN	2019/20 vs 2018/19 %	2019/20 vs PLAN %
REFERRALS	5,122		4,799	15,365		14,778	-587		-3.8%	
NEW OP	8,247	8,387	7,969	24,603	24,635	23,595	-1,008	-1,040	-4.1%	-4.2%
FU OP	14,914	15,861	15,019	46,726	46,444	46,359	-367	-85	-0.8%	-0.2%
ELECT IP	283	271	293	880	849	843	-37	-6	-4.2%	-0.7%
ELECT DC	2,486	2,567	2,708	7,553	7,995	8,578	1,025	583	13.6%	7.3%
NON ELECT	1,757	1,730	1,888	5,331	5,282	5,836	505	554	9.5%	10.5%
A&E ATTENDS	4,534	4,504	4,422	13,148	13,410	13,365	217	-45	1.7%	-0.3%

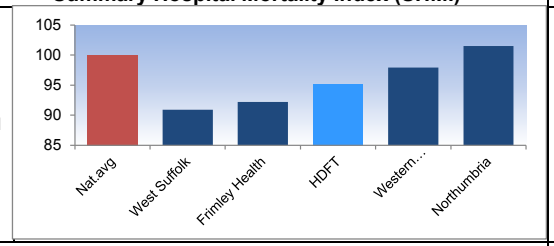


Harrogate and District NHS Foundation Trust

Section 8 - Benchmarking - June 2019

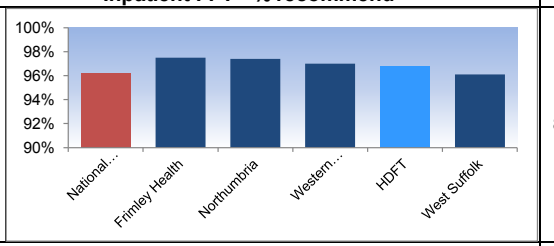
Summary Hospital Mortality Index (SHMI)

8.1



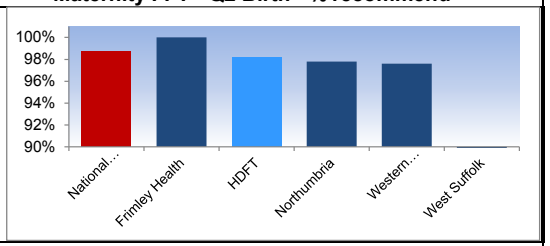
Inpatient FFT - % recommend

8.2



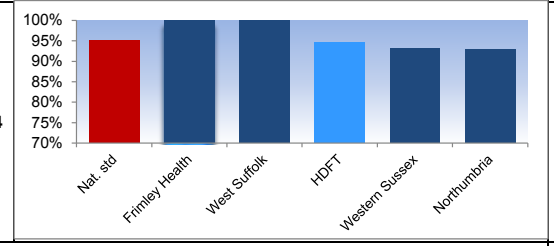
Maternity FFT - Q2 Birth - % recommend

8.3



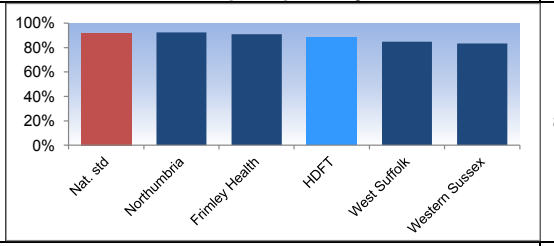
Emergency Department 4 hour standard

8.4



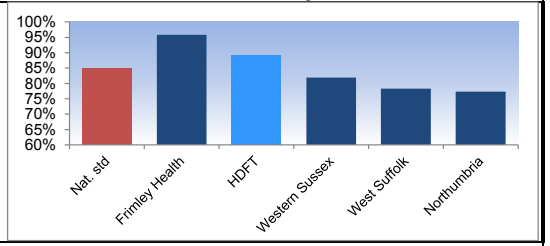
RTT incomplete pathways

8.5



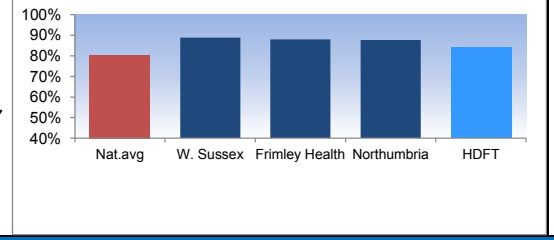
Cancer 62 days

8.6



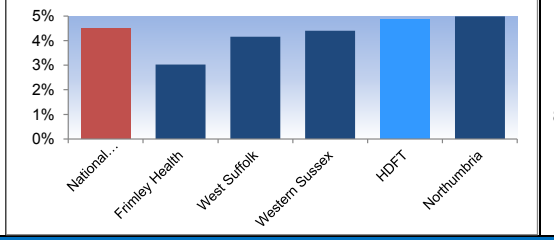
Staff FFT - % recommend (place to work)

8.7



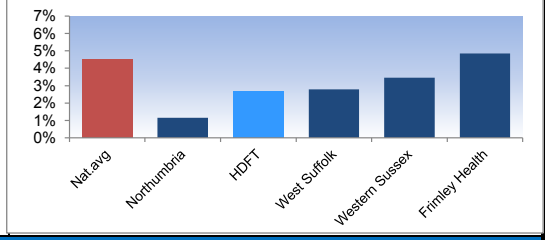
Sickness absence

8.8



Proportion of temporary staff

8.9



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.

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Integrated board report - June 2019

Key for SPC charts

Icon	Description
	Special cause variation - cause for concern (indicator where high is a concern)
	Special cause variation - cause for concern (indicator where low is a concern)
	Common cause variation
	Special cause variation - improvement (indicator where high is good)

Icon	Description
	Special cause variation - improvement (indicator where low is good)
	The system is expected to consistently fail the target
	The system is expected to consistently pass the target
	The system may achieve or fail the target subject to random variation

Data Quality - Exception Report

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

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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

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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

6.1

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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:	3 July 2019
Date of Board meeting for which this report is prepared	31 July 2019

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

Hot Spots:
Non Executives from the Quality Committee and Dr Sylvia Wood had a meeting with the respiratory team. This was the result of concerns expressed by committee members that we received little assurance from the team regarding the range of national audits that applied to respiratory medicine. The team had been unable to free the time to attend the committee and provide verbal assurance. The meeting was positive and the team are obviously skilled, innovative and hugely committed to delivering high quality care. A number of issues were highlighted which are being looked at by the directorate team. These included:

Capacity to undertake the volume of work with only 2 consultants.

Data entry into the national audit database which had given poor results, highlighting higher than expected mortality rates. On further review errors in data entry were identified. The team have a number of audits to complete and believe they require a dedicated data entry clerk to ensure accurate results.

Accommodation. The whole team are based in two offices. The offices are used for clinical investigation as well as staff bases and secretarial support.

The committee will seek further assurance from the directorate as these issues are addressed. Recruitment of another consultant is in progress.

Complaints response times remain a priority for the committee.

There were no additional hotspots raised at the meeting.

Board Request for QC to seek assurance:
Issues raised at the board in May had been considered at the June meeting and become part of the Quality Committee agenda. Family and Friends test is being

looked at with the quality priorities. Readmissions were explained but had fallen in the latest BAF. The Chief Operating Officer is reviewing the way in which the data is presented. The evaluation of changes to the Stroke service will be presented in October 2019. Implementation of ReSPECT will be reviewed again in September, resolution to this issue is very complex. A presentation was delivered to the committee and there is clearly significant work to do within the local health economy as well as the Trust.

Reports Received:
Quality improvement project.
A presentation was received from Charlotte Gill who described changes she had made to the skill mix in her team introducing a new role. She described significant benefits to the team and to patients in the community. The project was undertaken as part of the RCN leadership programme. Since completing the project and the course Charlotte had been promoted. An excellent example of the benefits of this programme to staff and quality of care to patients.

Quality Impact Assessments
The committee received a report providing assurance regarding the quality impact assessment process.

Annual reports received
- Adult Safeguarding
- Learning disability
- Pressure Ulcer Prevention
- Inpatient Falls
- TEWV report of the work undertaken to support the Trust managing patients with significant mental health needs.

Quality priorities
The committee received a report on progress implementing the quality priority to increase patient and public participation in the development of services.

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

Pressures in respiratory medicine.
Delay implementing an agreed alternative to ReSPECT

Matters for decision

No decisions required

Action Required by Board of Directors:
To note.

6.1

6.1

Date of Meeting:	31 July 2019	**Agenda item:**	6.2
Report to:	Trust Board		
Title:	Impact assessment processes – update report		
Sponsoring Director:	Jill Foster, Chief Nurse		
Author(s):	Sylvia Wood, Deputy Director of Governance		
Report Purpose:	**Decision**		**Discussion/ Consultation** ✓ **Assurance** ✓ **Information** ✓
Executive Summary:	This report is the first report of progress with implementation of the new processes in relation to impact assessments for 2019/20 CIPs.		

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 having a robust process that can be evidenced, for assessing and monitoring the potential impact on quality and equality of CIPs. This report is to provide assurance that the organisation is effectively addressing this risk.
Legal / regulatory:	The Clinical Commissioning Group and the CQC request evidence of effective quality impact assessments. The Equality Duty was created under the Equality Act 2010. There is an obligation on public authorities to positively promote equality, not merely to avoid discrimination. Public sector organisations are required to demonstrate that they are giving 'due regard' to the needs of protected groups. This means that equality issues must be considered and evidenced in the decision making process.
Resource:	There is resource associated with the robust completion of impact assessments because staff need time to complete and consult, and there may be financial resource implications within individual schemes to mitigate impact.
Impact Assessment:	Not applicable
Conflicts of Interest:	None identified.
Reference documents:	None required
Assurance:	Directorate Boards and Impact Assessment Panel.
CQC key line of enquiry:	Associated with the CQC trust wide well-led key line of enquiries.

Action required by the Trust Board:

It is recommended that the Trust Board:

- **Notes** the progress included within the report;
- **Considers** whether this provides sufficient assurance at this stage of implementation;
- **Considers** whether or not the date for the next report in March 2020 is appropriate.

Harrogate and District NHS Foundation Trust

Report to: Trust Board

Report title: Impact assessment processes – update report

Report by: Sylvia Wood, Deputy Director of Governance / Jill Foster, Chief Nurse

Date: 31 July 2019

Introduction

The Trust has developed a new Impact Assessment Policy, processes, templates and supporting documentation during 2018/19 to ensure appropriate governance around the potential impact on quality and equality when projects, savings schemes and service change is planned and implemented. The policy supports quality governance by defining the expectations in relation to assessment, quality assurance and monitoring of impact on quality and equality, to inform and enable appropriate decision-making regarding proposed service changes.

The National Quality Board guidance: How to – Quality Impact Assess Provider Cost Improvement Plans (2012) outlines an approach to the appreciation of impact on patients and staff of any planned workforce reductions, service changes or other efficiency gains. The role of clinicians was noted to be central to the process.

The current HDFT policy has been developed to ensure robust processes for savings schemes or cost improvement programmes or plans (CIPs). The processes for other triggers including service development or change, transformational change, new strategies or policies and significant policy changes, and business development and business cases will be clarified later.

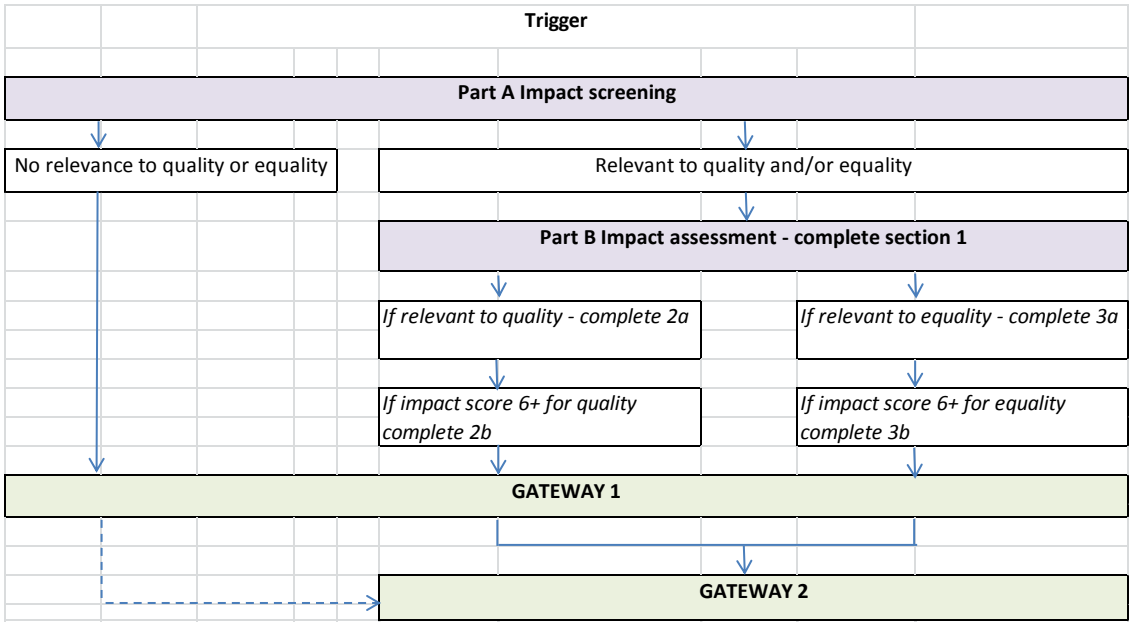
The policy and processes require an initial assessment of relevance to quality and equality, and then a more detailed assessment if required. There is a 2 stage gateway process to provide rigour to impact assessments of projects.

Gateway 1:

All impact assessments require directorate approval by either Clinical Director or Corporate Deputy Director, prior to Directorate Board approval. This must be logged or minuted at the relevant board meeting and confirmed on the Impact Assessment Screening template. Triggers that are rated as having no relevance to quality or equality do not require any further level of approval for implementation. However a sample of the impact screening will be reviewed by the Trust Impact Assessment Panel.

Gateway 2:

Triggers that are screened as having relevance to quality and/or equality and therefore a potential impact require the approval of the Trust Impact Assessment Panel. The panel will comprise the Chief Nurse and Medical Director, with others including Project Leads, Clinical Leads, Clinical Directors, Operational Directors, Deputy Corporate Directors and Executive Directors co-opted to attend as required.



The policy was reviewed at Senior Management Team in October 2018 but required some further work to agree processes and responsibilities. This has been completed and the final policy is going to SMT in July for ratification.

Internal Audit completed a follow up audit of quality impact assessments in May 2019 (Quality Impact Assessments Follow Up: HDFT2018/39) and provided significant assurance. Outstanding recommendations are being addressed as part of this work.

This report is the first report of progress with implementation of the new processes in relation to impact assessments for 2019/20 CIPs.

2019/20 CIP progress report

Children and County-wide Community Services Directorate

The directorate have completed their impact screening for 2019/20 CIPs although the detail of this was completed in an old template and is yet to be presented in the current template in the shared drive set up by the PMO to ensure evidence can be accessed.

The 2 schemes that required a detailed assessment (CCCC04 and CCCC37) however have been completed and the evidence provided.

These were reviewed and discussed at a Gateway 2 – Impact Assessment Panel meeting on 30 May 2019. The assessed impact, monitoring required and potential for cumulative impact was reviewed and both schemes approved to progress. See review notes in appendix 1.

The date for the next review meeting was agreed to be arranged for the end January / early February 2020 to review the development of 2020/21 schemes, and evaluation of 2019/20 schemes and impact.

Long Term and Unscheduled Care Directorate

The directorate have completed their impact screening for 2019/20 CIPs and this was reviewed and discussed at a Gateway 2 – Impact Assessment Panel meeting on 31 May 2019.

There were 3 schemes that were identified with impact on quality / equality. For two of these there was only an anticipated positive impact on quality and it was agreed that the screening template would be modified to record this so a detailed impact assessment is not required.

One scheme related to bed modelling was reviewed and discussed in detail. There were risks around flow and patients being managed on appropriate wards, but there were escalations processes and plans in place and monitoring identified. Cumulative impact was possible due to impact on surgical beds and elective capacity. This needed to be considered further and metrics identified to monitor impact. See review notes in appendix 2.

The next planned meeting was agreed to be end July / early August to follow up the detailed impact assessment, potential cumulative impact, mitigations and monitoring in relation to bed modelling, and further development of 2019/20 schemes. A meeting was also to be arranged for end January / early February 2020 to review the development of 2020/21 schemes, and evaluation of 2019/20 schemes and impact.

Planned and Surgical Care Directorate

The first meeting arranged had to be postponed due to work pressures and availability of key staff. This has been re-arranged for 12 July 2019.

Corporate Directorate

The summary screening and impact assessments for the corporate directorate need to be reviewed at the next Corporate Directorate meeting on 18 July 2019 and then an Impact Assessment Panel arranged if required.

Summary

There has been considerable work undertaken to establish realistic but robust processes and documentation for quality and equality impact assessments. These have now been implemented with evidence of screening and detailed impact assessments within some directorates, with directorate review and some initial Impact Assessment Panels for 2019/20 CIPs completed. There are plans in place to follow up outstanding assessments and reviews.

The process will continue to be embedded during the year and the policy, processes, templates and supporting documentation adapted and revised as required.

When this was previously discussed at Quality Committee in April 2019 it was suggested a follow up assurance report in March 2020 to cover the evidence for the process completed for 2019/20 CIPs, and progress with impact assessments for 2020/21 CIPs.

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Appendix 1: Directorate Impact Assessment Gateway 2 Review Meeting CCCC

Date: 30 May 2019
Attendees: Jill Foster, David Scullion, Richard Chillery, Natalie Lyth, Sylvia Wood

Scheme ref and name	Screening or detailed impact assessment reviewed	Approved or not approved	Notes	Monitoring indicated
CCCC04 0-19 Children's Services Remote Systems Access (VPN)	Detailed impact assessment and directorate quarterly update April 2019	Approved	Risk is of staff sickness, vacancies etc on top of planned reduction in posts to fund VPN	Risk register re sickness / vacancies etc IBR indictors Staff feedback Quarterly update review through CCCC Board – reported to SMT To save quarterly update in shared folder
CCCC37 Specialist Children's Service Review	Detailed impact assessment and directorate quarterly update April 2019	Approved	Organisational reputation in relation to defining what is commissioned and potential impact on some services	Risk register re sickness / vacancies etc IBR indictors Staff feedback Quarterly update review through CCCC Board – reported to SMT To save quarterly update in shared folder

Any anticipated cumulative impact:

- Learning from VPN might have positive impact on other community services;
- Staff concerns about impact on some services

Recorded by: Sylvia Wood

Next planned meeting: End January / February 2020 – development of 2020/21 schemes, and evaluation of 2019/20 schemes and impact

Appendix 2: Directorate Impact Assessment Gateway 2 Review Meeting LTUC

Date: 31 May 2019
Attendees: Mike Forster, Jill Foster, David Scullion, Sylvia Wood

Scheme ref and name	Screening or detailed impact assessment reviewed	Approved or not approved	Notes	Monitoring indicated
LTUC19-20 – 03 – 04b Pathology JV	Screening reviewed Business case developed and approved by Board Positive impact anticipated	Approved		
LTUC19-20 – 05-15 Cancer – Macmillan posts	Screening reviewed Only positive impact anticipated NB amend the QIA/EIA screening template to distinguish positive impact – don't require full impact assessment	Approved		
LTUC19-20 – 24 Bed modelling – beds closed in summer	Screening reviewed	Approved	Risks around flow / patients been managed on appropriate wards Escalations processes and plans in place	Opel levels Pressure indicators e.g. ED attendances, ED admissions, outliers Elective surgery cancellations ED 4 hour waits

Any anticipated cumulative impact: Bed modelling may impact on surgical beds and elective capacity. Need to consider and identify metrics to monitor

Recorded by: Sylvia Wood

Next planned meeting: End July / Early August 2019, then end January / early February 2020 to review the development of 2020/21 schemes, and evaluation of 2019/20 schemes and impact.

INFECTION PREVENTION AND CONTROL REPORT for Trust Board July 2019

Dashboard 2018/2019

Month	*C. difficile*		MSSA BSI		MRSA BSI		*E.* coli BSI		Klebsiella BSI		*Pseudomonas aeruginosa* BSI	
	HAI	CAI*	HAI	CAI	HAI	CAI	HAI	CAI	HAI	CAI	HAI	CAI
April	1	0	1	6	0	0	1	12	0	2	0	0
May	1	3	0	2	0	0	1	14	0	1	0	0
June	1	0	1	2	0	0	1	12	1	1	0	2
July	4	0	0	3	0	0	1	9	0	0	1	0
August	2	2	0	2	0	1	1	15	1	4	0	1
September	3	0	0	0	0	1	1	10	2	2	1	0
October	0	2	0	5	0	0	1	9	1	6	0	1
November	0	3	1	0	0	0	1	4	0	1	0	1
December	0	1	1	1	0	0	1	7	0	1	0	0
January	1	3	0	3	0	0	1	13	0	2	0	1
February	4**	3	1	3	0	0	2	9	0	1	0	0
March	2	4	0	4	0	0	1	16	0	2	0	2
Running total	**19**	**21**	**5**	**31**	**0**	**2**	**12**	**130**	**5**	**23**	**2**	**8**

** includes one case of pseudomembranous colitis diagnosed on MRI; this is also a reportable case.

- There were 19 cases of hospital acquired C.*difficile* against a target of 12.
- Analysis (RCA) of each case determined there were 2 cases where there were lapses in care

- No fines were imposed by the Commissioners

C.*difficile* Ribotyping

	RIBOTYPE																
Ward where identified	**no result available**	**002**	**005**	**011**	**014**	**015**	**018**	**020**	**026**	**029**	**054**	**056**	**078**	**103**	**174**	**No growth**	**Total**
AMU		1	1					1			1				1		5
Byland																1	1
CATT	1	1												1			3
Farndale										1			1				2
Granby																	
Harlow	1																1
ITU/HDU						1			1								2
Jervaulx													2*				2
Lascelles			1														1
Littondale	3				1								1				5
MAU	1			1			1										3
Nidderdale	1							1									2
Oakdale			1														1
SROMC	1																1
Trinity			1									1					2
Grand Total	8	2	4	1	1	1	1	2	1	1	1	1	4	1	1	1	31

Ribotype 078 is quinolone resistant, and more virulent than some of the other types.
The two cases on Jervaulx occurred two months apart.

C.*difficile* 2019/2020 - Changes to Reporting Rules

NHSI announced changes to the categorisation of *C difficile* cases to be implemented from 1st April 2019. This was to bring the UK data into line with European (ECDC) and North American (CDC) definitions.

The changes to reporting onto the Data Capture System for 2019/20 are:

- adding a prior healthcare exposure element for community onset cases
- reducing the number of days after admission to identify hospital onset healthcare associated cases from ≥3 to ≥2.

From April 2019 cases reported to the HCAI DCS will be assigned by DCS as follows:

a) **HOHA** Healthcare onset healthcare associated: cases detected in the hospital **≥2** days after admission,
b) **COHA** Community onset healthcare associated: cases that occur in the community (or ≥2 days of admission) when the patient has been an inpatient in the trust reporting the case in the previous 4 weeks,
c) **COIA** Community onset indeterminate association: cases that occur in the community (or ≥2 days of admission) when the patient has been an inpatient in the trust reporting the case in the previous 12 weeks but not the most recent four weeks,
d) **COCA** Community onset community associated: cases that occur in the community (or ≥2 days of admission) when the patient has not been an inpatient in the trust reporting the case in the previous 12 weeks.

We completed an exercise to consider if the 34 cases diagnosed by the HDFT laboratory April 1st 2018 to March 2019, including six which were in the community at the time, had been categorised this way, what would our numbers look like:

HOHA – 19 (the change from >3 days post admission to >days would have made a difference in two cases)
COHA-3
COIA-1
COCA-11

The number of Trust-apportioned cases would therefore have been 24 (the combined totals of COHA and HOHA)

2019/2020 CDI Objectives

The 2019/2020 CDI objective for HDFT has been set at **19** cases, based on the new categories.

The following is cut and pasted directly from the NHSI report, although there seems to be a typo on the second line; the rest of the document clearly states that cases detected two or more days will count as hospital cases, not three.

> Acute provider objectives for 2019/20 will be set using these two categories:
>
> - hospital onset healthcare associated: cases that are detected in the hospital three or more days after admission
> - community onset healthcare associated: cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the trust reporting the case in the previous four weeks.
>
> CCG objectives will be set on the total number of CDI cases assigned to the CCG (hospital onset healthcare associated, community onset healthcare associated, community onset indeterminate association and community onset community associated).

PHE estimate that in most areas, 67% cases will be Trust apportioned.
In this area 70% cases would become Trust apportioned.

Don't forget that at HDFT, we still encourage wards to test patients with loose stool regardless of whether they have another plausible explanation for having loose stool. Patients are tested in this hospital who would possibly not be tested at all in some other Trusts.

Sanctions
The Commissioners are able to fine the Trust £10,000 for each case over the new objective, although this is discretionary, and it is up to the Commissioners to decide which ones, if any, will incur a financial penalty. This doesn't seem to have changed.

Dashboard 2019/2020

Month	*C difficile*					MSSA BSI		MRSA BSI		*E.* coli BSI		Klebsiella BSI		*P. aeruginosa* BSI	
	Trust	HOHA	COHA	COIA	COCA	HAI	CAI	HAI	CAI	HAI	CAI	HAI	CAI	HAI	CAI
April	4	2	2	0	4	0	3	0	0	0	11	1	4	0	0
May	2	0	2	0	1	1	1	0	0	1	5	1	4	0	0
June	3	3	0	0	0	0	3	0	0	0	6	1	0	0	1
July	(0)	(0)	(0)	(0)	(0)	(0)	(1)	(0)	(0)	(1)	(1)	(0)	(0)	(0)	(1)
August															
September															
October															
November															
December															
January															
February															
March															
Running total	9	5	4	0	5	1	8	0	0	2	23	3	8	0	2

- There are 9 cases of hospital acquired C.*difficile* against a target of 19.
- There are 2 cases where there has been possible lapses in care

C difficile cases 2019/2020

Case	Category	Hospital ID	Type	Date	Location	DOA	Last admission date	Last discharge date	Speciality	Team	Directorate	RCA?	Lapses in care	Notes
	COCA	77526	New infection	02/04/2019	Jervaulx	01/04/2019	14/08/2018	21/08/2018	Elderly Care	MacCreanor	LTUC			
1	COHA	84016	Relapse	03/04/2019	A&E	03/04/2019	18/03/2019	19/03/2019	Acute Medicine	Smith	LTUC		None	Prev post Feb 19
2	HOHA	228764	New infection	07/04/2019	Oakdale	29/03/2019	26/03/2019	26/03/2019	Haematology	Haematology Team	LTUC	16/05/2019	None	N
3	HOHA	O15483	Relapse	15/04/2019	Nidderdale	07/04/2019	29/01/2019	14/02/2019	General Surgery	Farooq	P&SC	11/06/2019	Yes	NB was case 14 in 2018/2019; should have taken previous CDI into account
4	COHA	641958	New infection	18/04/2019	Woodlands	18/04/2019	09/04/2019	11/04/2019	General Surgery	Farooq	P&SC	11/06/2019	None	Post appendicetomy, transferred to Leeds
A	COCA	282781	New infection	20/04/2019	MSS	19/04/2019	None	None	Acute Medicine	Acute Medicine	LTUC			
B	COCA	706005	New infection	24/04/2019	Harlow	23/04/2019	23/10/2013	25/10/2013	Endocrinology	Maguire	LTUC			
C	COCA	O48143	New infection	29/04/2019	Kingswood Surgery	Community	14/03/2018	14/03/2018	General Practice		HaRD			
D	COCA	304507	New infection	14/05/2019	Boston Spa Surgery	Community	23/01/2017	24/01/2017	General Practice		Leeds North CCG			
5	COHA	171410	New infection	24/09/1934	Ripon Spa Surgery	Community	09/05/2019	17/05/2019	T&O	Farndon	P&SC	No	None	Previous clindamicin, but appropriate Rx
6	COHA	142767	New infection	29/05/2019	Park Parade Surgery	Community	08/05/2019	10/05/2019	O&G	Altanis	P&SC	No	None	Previous cephalexin and metz- appropriate
7	HOHA	O43156	New infection	03/06/2019	Wensleydale	29/05/2019	11/02/2019	19/02/2019	T&O	Conroy	P&SC	No	None	Laxatives. Incidental finding, not treated
8	HOHA	246068	New infection	10/06/2019	Littondale	07/06/2019	19/05/2019	30/05/2019	General Surgery	Farooq	P&SC	No	Appropriate use of cephalosporins	
9	HOHA	17140	Relapse	26/6/19	Farndale	03/06/2019	3/6/19	1/7/19	Orthogeriatrics	Fardon	P&SC	No	None.	NB was case 5 as well Treated with fidaxomycin

Respiratory Viruses

The season kicked off properly in December 2018. All the influenza strains were influenza A, either A H3, or the H1N1 2009 strain. This caused an outbreak on Jervaulx. RSV was responsible for many admissions of elderly people with respiratory problems. The last confirmed case of 'flu was on the 19th March 2019.

Table 2, respiratory viruses as of 14/03/2019

Location when spec taken	Influenza			RSV			Parainfluenza		
	CAI	HAI	Indeterminate	CAI	HAI	Indeterminate	CAI	HAI	Indeterminate
AMU/MSS	13			2	1				
Byland	1	1	1		1				
CATT/MAU	47	1		19		1	1		
CAT clinic	11						1	1	
ED	17								
Farndale	2				1		1		
Granby	2	4	2			1			
Harlow				1					
ITU	5			2			1		
Jervaulx		11*			7				
Lascelles		1							
Littondale	1	2							
Nidderdale	1	1							
Maternity AC	1								

Oakdale	3	1			2	1	1		
Pannal	1	1							
SROMC	2			7					
Woodlands	7			3			2		
Rowan	3								
OPD	4								
Histology	1								
Total cases:	**121**	**23**	**3**	**34**	**12**	**3**	**7**	**1**	**0**
Virus count:	**147**			**49**			**8**		

*NB were additional 5 staff members with confirmed ‘flu, and one with confirmed RSV

Planning for this year’s Flu Campaign is underway.

Hepatitis A Outbreak in Ripon.

Following 30 confirmed cases of Hepatitis A in the Ripon community, index case and transmission through a local secondary school, Public Health England requested an outbreak response of mass vaccination in 1 secondary school and 3 primary schools to interrupt the transmission of this infectious disease.

The initial primary school mass vaccination programme was requested on Wednesday the 3rd July and HDFT responded with a small number of childhood immunisation nurses and vaccinated the school children and staff on Monday the 8th July. This was a small rural school and 95% of the children were vaccinated.

The request to mass vaccinate a secondary school was requested on Friday the 12th July and HDFT responded with the childhood immunisation team and support from the local healthy child team (school nurses and health visitors) a total of 42 vaccinators were sent and 73% of the school community were vaccinated on the 16th July. A total of 552 vaccines where given during this session by HDFT nurses.

The final primary school mass vaccination programme was requested on the evening of the 16th July, and HDFT responded with the childhood immunisation team and local HCT on the 19th July and vaccinated 95% of the children and staff at the primary school.

A catch up session has been offered since at a local venue for children or staff that were missed at school.

As well as vaccinating children and adults, HDFT have also ordered and managed all of the vaccine through pharmacy services, and notified GP's, advertised health promotion through trust social media platforms, and have continued to work with Public health throughout the outbreak period. We have had no new confirmed cases since the 18th July 2019.

Jill Foster, Chief Nurse and Director for Infection, Prevention and Control
Dr Jenny Childs, Microbiologist

Harrogate and District NHS Foundation Trust

6.5

vDate of Meeting:	31 July 2019	**Agenda item:**	6.5
Report to:	Board of Directors		
Title:	Operational Performance Report		
Sponsoring Director:	Mr Robert Harrison, Chief Operating Officer		
Author(s):	Mr Jonathan Green, Information Analyst Specialist		
Report Purpose:	**Decision** ✓ **Discussion/ Consultation** ✓ **Assurance** ✓ **Information** ✓		
Executive Summary:	• All cancer waiting times standards were achieved for Quarter 1, with the exception of both 2 week wait standards and 62 day Screening (monitored on a monthly basis). • HDFT's performance against A&E 4-hour standard was below 95% in June and for Quarter 1 overall. • The RTT standard was below the expected 92% for June and Q1 but in line with the NHSI trajectory.		

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

Key implications	
Risk Assessment:	Risks associated with the content of the report are reflected in the Board Assurance Framework via: BAF 9: risk of a failure to deliver the operational plan; BAF 10: risk of a breach of the terms of the NHS Provider licence;
Legal / regulatory:	Risk to segmentation based on the Single Oversight Framework
Resource:	None identified.
Impact Assessment:	Not applicable.
Conflicts of Interest:	None
Reference documents:	
Assurance:	

Action Required by the Board of Directors:

It is recommended that the Board:

- **Notes** items included in the report.

You matter most

OPERATIONAL PERFORMANCE REPORT

1.0 SERVICE ACTIVITY

Following changes to the referral booking process in Leeds, there has been a significant impact on the referrals from Leeds GPs to Harrogate services. The new process appears to have impacted on choice of provider and as a result referrals are down 17% compared to the same period last year. This has been raised formally with Leeds commissioners and work is continuing to support the transfer of patients to Harrogate from Leeds Teaching Hospitals, this is currently focussing on Gynaecology, General Surgery and Urology Referrals, however the impact has been across all specialities and a solution to resolve this without the current resource intensive transfer system is still required. Overall this is impacting on the proportion of activity being carried out for HaRD CCG compared to other CCGs.

At the end of Quarter 1 Non Elective Activity is 9.5% above the same time period last year, across all commissioners. This has meant that the hospital site has had to maintain escalation capacity beyond the plan for this year, however, extensive work on improving length of stay, implementation of long stay patient multiagency reviews and the use of the new Combined Assessment Team has mitigated this to an extent, with bed occupancy generally lower than the same period last year.

2.0 RTT PERFORMANCE

At the end of June there were 14,841 patients on the waiting list, of which 88.3% were waiting under 18 weeks. The Trust trajectory, agreed with NHSI for 2019/20, was a total waiting list of 15,852 and RTT position of 88.4% by the end of June. There were 1,737 patients waiting over 18 weeks and of these 124 were above 40 weeks. There were no over 52 week waiting patients at the end of June, however at the end of May the Trust had one over 52 week wait patient, which had been missed from the waiting list at the point of listing for surgery. A review of this case was completed and actions put in place to minimise the potential for recurrence. The review has been shared with NHSI.

In addition, the Trust will report one cancellation not rebooked and completed within 28 days in July. The patient was cancelled the second time due to a Trauma list overrun on the day, with their surgery then being completed two days later.

3.0 Elective Clinical Review of Standards

The Trust has been selected to be a field testing site for the review of elective care clinical standards. This will run from 01 August 2019 for an initial 4 month period. During this period the Trust will continue to submit data nationally and monitor 52 week waiters and total waiting list. We will be working closely with NHSI and E during this period to assist in the evaluation of these standards for use in future years.

4.0 EMERGENCY DEPARTMENT PERFORMANCE

HDFT's Trust level performance against the 4-hour standard was 94.5% (Trajectory 94.6%) in June, below the constitutional 95% standard. This includes data for the Emergency Department at Harrogate and Ripon MIU. The Trust is therefore below the required standard for Quarter 1 overall with a Trust level performance of 94.2% (Trajectory 94.6%).

In support of our continued focus on improvement we have invited in a team to work with us to review our Acute flows, they have agreed to do this in collaboration with us as they also

want to identify the characteristics of a high performing organisation. It is anticipated the learning from this work will be mutually beneficial to both of organisations.

5.0 CANCER WAITING TIMES

Provisional data indicates that 5 of the 8 cancer waiting times standards were achieved in Quarter 1, with the standards for both 14 day standards and the 62 day Screening not delivered.

There were 59.5 accountable 62 day standard treatments in the month with 6.5 breaches, meaning performance was above the standard at 89.1%. Of the 11 tumour sites, 3 had performance below 85% in June - Haematology (1.0 breach), Lung (0.5 breach), and Urological (3.5 breaches). 5 patients waited over 104 days for treatment in June - three were due to complex diagnostic pathways, one due to outpatient capacity in oncology, and one was due to a delay to diagnostics.

There were 46 non-cancer related breast symptomatic attendances in June, with 43 patients seen after day 14 (6.5%). The denominator for the 14 day suspected cancer standard was 752 in June with 91 patients first seen outside 14 days (87.9%), which was a slight deterioration on the previous month (88.3%). Of these 91 patients, 85% (77) were breast referrals. It is anticipated that the additional Ultrasound room will be completed on 3rd August and revised job plans for the Radiologists and Breast Surgeons commence at the end of July, these changes enable an increase in weekly available capacity and it is therefore planned to recover to the required performance standard by October. Early indications show a recovery to 17% for July and nearer 30% predicted for August.

NHS Resolution

Maternity incentive scheme - Board declaration Form

Trust name Harrogate & District NHS Foundation Trust
Trust code T339

An electronic signature must also be uploaded. Documents which have not been signed will not be accepted.

	Safety actions	Action plan	Funds requested	Validations
Q1 NPMRT	Yes		-	
Q2 MSDS	Yes		-	
Q3 Transitional care	Yes		-	
Q4 Medical workforce planning	Yes		-	
Q5 Midwifery workforce planning	Yes		-	
Q6 SBL care bundle	Yes		-	
Q7 Patient feedback	Yes		-	
Q8 In-house training	Yes		-	
Q9 Safety Champions	Yes		-	
Q10 EN scheme	Yes		-	
Total safety actions	**10**	**-**		
Total sum requested			**-**	

Sign-off process:

Electronic signature

For and on behalf of the board of Harrogate & District NHS Foundation Trust

Confirming that:

The Board are satisfied that the evidence provided to demonstrate compliance with/achievement of the maternity safety actions meets standards as set out in the safety actions and technical guidance document and that the self-certification is accurate.

The content of this form has been discussed with the commissioner(s) of the trust's maternity services

If applicable, the Board agrees that any reimbursement of maternity incentive scheme funds will be used to deliver the action(s) referred to in Section B (Action plan entry sheet)

We expect trust Boards to self-certify the trust's declarations following consideration of the evidence provided. Where subsequent verification checks demonstrate an incorrect declaration has been made, this may indicate a failure of board governance which the Steering group will escalate to the appropriate arm's length body/NHS System leader.

Name:
Position:
Date:

Harrogate and District NHS Foundation Trust

6.6

Date of Meeting:	31 July 2019	**Agenda item:**	6.6
Report to:	Board of Directors		
Title:	Maternity Incentive scheme – year 2 (maternity safety action 1) NHS Resolution		
Sponsoring Director:	Rob Harrison, Chief Operating Officer		
Author(s):	Dr Kat Johnson Clinical Director Planned and Surgical Care		
Report Purpose:	**Decision** ✓ **Discussion/ Consultation** **Assurance** ✓ **Information** ✓		
Executive Summary:	The Trust has met the requirements of this standard with: • 100% review using PNMRT commenced within 4 months of death • 67% completed to draft report stage within 4 months of death • In 100% of cases parents were informed a review was taking place and their perspectives/ views sought • Learning from Deaths is detailed including actions taken Note - the most significant challenge to timely report writing is a delay in post-mortem reporting which is essential to complete the review. The maternity service is in the process of changing provider for this service.		

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

Key implications	
Risk Assessment:	None identified
Legal / regulatory:	None identified
Resource:	None identified
Impact Assessment:	Not applicable
Conflicts of Interest:	None identified
Reference documents:	https://www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf
Assurance:	Report reviewed at Maternity Services Forum and Maternity Safety Champions meeting in July 2019.

Action Required by the Board of Directors:

It is recommended that the Board:

- **Agrees** that the evidence provided in the perinatal mortality review report demonstrates achievement of this safety action to the required standard as set out in the technical guidance document by NHS Resolution.

Harrogate and District NHS Foundation Trust

Safety Action 1 - Are you using the NationalPerinatal Mortality Review Tool to review perinatal deaths to the required standard?

Standard

- A review of 95% of all deaths of babies suitable for review using the Perinatal Mortality Review Tool (PMRT) occurring from Wednesday 12 December 2018 have been started within four months of each death'.
- At least 50% of all deaths of babies who were born and died in your trust (including any home births where the baby died) from Wednesday 12 December 2018 will have been reviewed, by a multidisciplinary review team, with each review completed to the point that a draft report has been generated, within four months of each death.
- In 95% of all deaths of babies who were born and died in your trust (including any home births where the baby died) from Wednesday 12 December 2018, the parents were told that a review of their baby's death will take place and that their perspective and any concerns about their care and that of their baby have been sought.
- Quarterly reports have been submitted to the trust Board that include details of all deaths reviewed and consequent action plans

Evidence

First quarterly report reviewed at Quality Committee April 2019.

Second quarterly report provided below.

Note although standards met biggest challenge to writing draft report within 4 months remains delay in obtaining post mortem results.

Harrogate and District NHS Foundation Trust

Appendix 1: Report for Quality Committee

Report to Quality Committee: NHS Resolution - Maternity Incentive Scheme

Safety Action 1: Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths to the required standard?

Eligible cases - Period 12 December 2018 to Current (updated 22/7/19)

Case ID	Details	Live birth	Date of birth/death	PMRT Review deadline	Review status	Report completed	Actions/comments
51079	T^{+12} IUD and shoulder dystocia.	No	25/12/2018	25/04/2019	Review completed	Yes (outside 4 month timescale)	• Parents felt intrapartum care excellent. • Felt lack of continuity of doctors in clinic. • Previous LLETZ procedure did not receive cervical length scan. • Growth scans 6 weekly • Placenta not sent with baby for post-mortem • Shoulder dystocia managed as emergency • Report completed outside of timescale due to delay in receipt of post-mortem findings. Findings indicate episode of acute hypoxia associated with excessively long cord and nuchal cord entanglement.
51387 60577	Intrapartum stillbirth	No	10/01/2019	10/05/2019	Review completed	Yes	• **Excluded from figures in accordance with NHS Resolution guidance, as HSIB investigation**. Review completed 19/7/19 • No recommendations and all care appropriate. • PM cause of death intrapartum hypoxia which was not detected during labour despite observations in accordance with national guidance; placental distal villous malformation
51393	Admitted 24^{+2}. No fetal movements for 2 days. Awaiting PM results.	No	18/01/2019	18/05/2019	Review completed	Yes	• Previous LLETZ procedure received cervical length scanning. • Not asked at booking about domestic abuse as partner present. Not asked again. • Non-smoker and CO 1. Lived with family members who were smokers. They were not offered referral to smoking cessation services.
51746	23 weeks admitted in labour. Declined resuscitative measures. Neonatal	Yes	07/02/2019	07/06/2019	Review completed	Yes (outside 4 month timescale)	• Raised BMI. Did not have early GTT and did not commence early aspirin • Declined resuscitative measures and supported to have quality time with baby prior to neonatal death

NHS
Harrogate and District
NHS Foundation Trust

61778	Neonatal death anaemia	Yes	10/04/2019	10/08/2019	Review completed	Draft	• Several questions by parents • Delay in acting upon sinusoidal CTG trace though considered to be chronic anaemia and outcome would have been unchanged. • Human factors about subsequent case reviews • Lack of communication to paediatric team about suspected anaemia • Awaiting PM report before finalising.
63056	32+6 IUD. Fibroid.	No	21/05/2019	21/10/2019	Review started	No	• Antenatal care at Leeds • Being followed up through Leeds • Joint review ongoing and awaiting antenatal assessment of care from Leeds prior to completion. Still within 4 month timescale for completion.
62781	TRAP twins (Twin reversed arterial perfusion sequence) – incomplete twin development	No	25/05/2019	25/09/2019	Review completed	Draft	• Rare condition of TRAP sequence • Delay in recognition of abnormality on scan (did not contribute to outcome but caused some distress to parents). • Action to ensure sonography staff aware of this rare condition. • Was followed up appropriately after diagnosis • Awaiting details of any parental perspectives on care before finalising report
63036	38+6 week IUD. Reduced fetal movements	No	10/06/2019	10/10/2019	Review completed	Draft	• Appropriate information provided about monitoring fetal movements. However, used own handheld Doppler for reassurance prior to the fetal demise. • Abnormal placental insertion. • Parents unable to carry baby 'in arms' to mortuary; delay in transfer of baby for post-mortem and lack of communication to parents • Awaiting PM at Leeds. PM report being finalised.
	death.						• Received anaesthetic referral letter after death of baby

Harrogate and District NHS Foundation Trust

Requirement:

	Current compliance
Review of 95% of all eligible deaths using PMRT, started within 4 months of each death.	100% (7/7)
At least 50% of eligible deaths where babies who were born and died in your Trust reviewed to point of draft report within 4 months of each death	67% (4/6) *2 completed outside of the timescale: one due to delay in receipt of post-mortem report (3 current in draft report stage awaiting PM report, 1 still to be completed but within timescale)
In 95% of eligible deaths where babies who were born and died in your Trust, the parents were informed of the review taking place and perspectives/concerns sought	100%

Date of Meeting:	31 July 2019	**Agenda item:**	6.6
Report to:	Trust Board		
Title:	Maternity Incentive scheme – year 2 (maternity safety action 4) NHS Resolution		
Sponsoring Director:	Rob Harrison, Chief Operating Officer		
Author(s):	Dr Kat Johnson Clinical Director Planned and Surgical Care		
Report Purpose:	**Decision** ✓ **Discussion/ Consultation** **Assurance** ✓ **Information** ✓		
Executive Summary:	**This action is comprised of two elements – obstetric staffing and anaesthetic staffing.** **The obstetric staffing element** requires that we note the proportion of obstetrics and gynaecology trainees in the trust who 'disagreed/strongly disagreed' with the 2018 General Medical Council National Training Survey question: 'In my current post, educational/training opportunities are rarely lost due to gaps in the rota.' There were three eligible trainees; one agreed, one disagreed and one strongly disagreed. We were not a negative outlier nationally in this respect. The obstetric staffing element also requires a plan to ensure that trainees do not lose training opportunities due to rota gaps. The Trust is compliant with this element. **The anaesthetic staffing element** requires elective caesarean sections to be undertaken by dedicated teams on dedicated lists, separate to the on call team. The service is compliant with this unless demand outstrips capacity. This paper provides evidence of the mitigations to ensure that this occurs safely and that this has been considered and agreed by SMT and board has had sight of this through the confidential board minutes. The service is fully compliant with the other two parts of the anaesthetic element which require dedicated resident anaesthetic cover for obstetrics and participation of the obstetric anaesthetist in the delivery suite ward round.		
Related Trust Objectives			
To deliver high quality care ✓	**To work with partners to deliver integrated care:** ✓	**To ensure clinical and financial sustainability:**	
Key implications			
Risk Assessment:	None identified		
Legal / regulatory:	None identified		

6.6

Resource:	None identified
Impact Assessment:	Not applicable
Conflicts of Interest:	None identified
Reference documents:	https://www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf
Assurance:	Report reviewed at Maternity Services Forum and Maternity Safety Champions meeting in July 2019.

Action Required by the Board of Directors:

It is recommended that the Board:

- **Agrees** that the evidence provided in the medical workforce planning report demonstrates achievement of this safety action to the required standard, as set out in the technical guidance document by NHS Resolution.

Safety Action 4 - **Can you demonstrate an effective system of medical workforce planning to the required standard?**

Standard

- Do you have a formal record of the proportion of obstetrics and gynaecology trainees in the trust who 'disagreed/strongly disagreed' with the 2018 General Medical Council National Training Survey question: 'In my current post, educational/training opportunities are rarely lost due to gaps in the rota.' In addition, a plan produced by the trust to address lost educational opportunities due to rota gaps?

- Is an action plan is in place and agreed at Board level to meet Anaesthesia Clinical Services Accreditation (ACSA) standards 1.2.4.6, 2.6.5.1 and 2.6.5.6. (See below)?
    - 1.2.4.6 Where there are elective caesarean section lists there are dedicated obstetric, anaesthesia, theatre and midwifery staff
    - 2.6.5.1 A duty anaesthetist is available for the obstetric unit 24 hours a day, where there is a 24 hour epidural service the anaesthetist is resident
    - 2.6.5.6.The duty anaesthetist for obstetrics should participate in labour ward rounds

Statement of Compliance

Compliant

Evidence

Obstetric Staffing

The obstetric staffing element requires that we note the the proportion of obstetrics and gynaecology trainees in the trust who 'disagreed/strongly disagreed' with the 2018 General Medical Council National Training Survey question: 'In my current post, educational/training opportunities are rarely lost due to gaps in the rota.' There were three eligible trainees; one agreed, one disagreed and one strongly disagreed. We were not a negative outlier nationally in this respect.

Appendix 1 – STANDARD OPERATING PROCEDURE TO ADDRESS LOST EDUCATIONAL OPPORTUNITIES DUE TO ROTA GAPS IN OBSTETRICS AND GYNAECOLOGY

Anaesthetic Staffing

1.2.4.6 Elective caesarean lists are carried out in main theatre with dedicated obstetric, anaesthesia, theatre and midwifery staff – see caesarean section guideline page 12 and 13 available at: http://nww.hdft.nhs.uk/planned-and-surgical-care/maternity/guidelines-and-policies/

Where an elective caesarean slot is not available elective caesareans are occasionally undertaken on Delivery Suite. This has been discussed and approved at SMT (see appendix 2 for full report) on 24th October 2014 and those minutes were seen by board in the confidential section of the next board meeting. The minutes from that discussion are reproduced here:

2.1.1 Action 237 - Arrangements for Undertaking Elective Caesarean Sections Report
Dr Johnson referred to her previously circulated report which was taken as read.

She explained she had been prompted to undertake a review of the Trust's current arrangements for the provision of elective caesarean sections in the Delivery Suite or main theatres following a joint meeting of the Executive teams from the Trust and Airedale NHS FT in July 2018.

The report explored the alternatives to the current arrangements and the associated risks and benefits.

SMT noted there was some nervousness from some clinicians in altering the current arrangements and little appetite to change considering the compromises that would have to be made. This included concerns relating to quality of care, safety and patient experience if the organisation were to move to a system where elective caesarean sections were routinely undertaken on the Delivery Suite was noted.

Dr Tolcher thanked Dr Johnson for the detailed report.

Following some deliberation, it was agreed to consider the feasibility of converting a suitable delivery room into a theatre to allow for more flexibility. It was noted the Trust's usual planning process would be followed.

Action: Mr Harrison to brief the Planning Team.

See appendix 2 for a copy of the report.

2.6.5.1 A duty anaesthetist is available for the obstetric unit 24 hours a day, where there is a 24 hour epidural service the anaesthetist is resident

Compliant

– on call rota available to view on intranet at:
http://nww.hdft.nhs.uk/corporate/switchboard/switchboard-information/on-call-today/

2.6.5.6 The duty anaesthetist for obstetrics should participate in labour ward rounds

– signed handover sheet on delivery suite evidences anaesthetic presence at handover at start of ward round on delivery suite

Appendix 1

STANDARD OPERATING PROCEDURE TO ADDRESS LOST EDUCATIONAL OPPORTUNITIES DUE TO ROTA GAPS IN OBSTETRICS AND GYNAECOLOGY

Scope

This Standard Operating Procedure (SOP) applies to all trainees and consultants in Obstetrics and Gynaecology

Procedure

This document highlights the steps in which the department of obstetrics and gynaecology take to ensure training opportunities are rarely lost due to rota gaps in the department. The SOP highlights the steps which the department will take to ensure that if rota gaps are impacting on training opportunities appropriate steps are taken.

Background

This SOP has been produced to ensure compliance with NHS Resolution CNST Incentive Scheme section Q4a – Benchmarking January 2019.

Process for trainees reporting rota gaps and impact on training

- Rota gaps may exist due to various reasons. Trainees will be expected at times on a short term basis to cover their colleagues when short term gaps arise such as due to sickness.
- Training opportunities will be discussed with trainees at their departmental induction and induction meeting with the college tutor and educational supervisor.
- These will be in accordance with the RCOG training matrix for their particular stage of training.
- Trainees will be asked to escalate lost educational opportunities to their educational supervisor ad college tutor.
- An individualised plan will be produced by their educational supervisor and college tutor to ensure that their educational training needs are met. This may include protecting training sessions, prioritising educational sessions over service provision and the use of locums to cover rota gaps.
- This plan will be escalated and approved by the Obstetrics and Gynaecology quality of care meetings (QOC).
- Following a period of one month a meeting should take place between the trainee and their educational supervisor to ensure that the plan is working.
- Where educational opportunities are still being lost this should be escalated to the QOC meetings, director of medical education and the training programme director.

Process where known rota gaps exist which may impact on training

- Prior to trainees starting their placements where rota gaps are known to exist this should be highlighted by the college tutor at the Obstetrics and Gynaecology QOC meeting.
- A plan should be formalised to ensure that rota gaps are minimised through possible use of locums and other short/ medium term medical staffing cover.
- On departmental induction the trainees will be informed where rota gaps exist and a plan agreed with their educational supervisor and college tutor to ensure educational opportunities are prioritised.
- Following a period of one month a meeting should take place between the trainee and their educational supervisor to ensure that the plan is working.
- Where educational opportunities are still being lost this should be escalated to the QOC meetings, director of medical education and the training programme director.

CONSULTATION, APPROVAL AND RATIFICATION PROCESS

The original version of this SOP was approved at the Obstetrics and Gynaecology QOC meetings.

DOCUMENT CONTROL

This is the first version of this document. .

DISSEMINATION AND IMPLEMENTATION

This SOP is published on the Trust Intranet.

MONITORING COMPLIANCE AND EFFECTIVENESS

The operation of this SOP will be subject to periodic internal audit, as appropriate.

REFERENCE AND ASSOCIATED DOCUMENTS

Author: Mr Michael Critchley
Consultant and College Tutor

Sponsors: Dr Katherine Johnson
Consultant and Clinical Director

Appendix 2

Date of Meeting:	October 24th 2018	**Agenda item:**	If known, insert paper number
Report to:	Senior Management Team		
Title:	Arrangements for Undertaking Elective Caesarean Sections		
Sponsoring Director:	Dr Ros Tolcher CEO		
Author(s):	Dr Kat Johnson Clinical Director Planned and Surgical Care		
Report Purpose:			

Decision		Discussion/ Consultation	✓	Assurance		Information	

Executive Summary:	This paper details the current arrangements for provision of elective caesarean sections via elective caesarean section slots in main theatres. The paper explores the alternatives to the current arrangements and the associated risks and benefits. There would be risk to quality of care, safety and patient experience if the organisation were to move to a system where elective caesarean sections were routinely undertaken on the delivery suite.

Related Trust Objectives

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

6.6

Key implications	
Risk Assessment:	There would be risk to quality of care, safety and patient experience if the organisation were to move to a system where elective caesarean sections were routinely undertaken on the delivery suite. Both the RCOG and RCoA consider that elective caesarean section lists should be independent of emergency work. Moving away from this arrangement risks the trust losing its ACSA accreditation.
Legal / regulatory:	none
Resource:	If all elective caesarean sections were moved to the Delivery Suite theatre, there would be a gain of approximately 7 hours of additional elective theatre time in main theatre.
Impact Assessment:	Risk to quality of care, safety and patient experience
Conflicts of Interest:	None identified
Reference documents:	Caesarean Section Clinical Guidleine 132 NICE (2011). Available at: https://www.nice.org.uk/guidance/CG132 Providing Quality Care for Women - A framework for maternity service standards. RCOG 2016. Available at: https://www.rcog.org.uk/globalassets/documents/guidelines/working-party-reports/maternitystandards.pdf RcoA accreditation standards 2018. Available at: https://www.rcoa.ac.uk/system/fils/ACSA-STDS2018.pdf

Action Required by the Senior Management Team:
It is recommended that SMT • *Notes items included within the report;*

Arrangements for Undertaking Elective Caesarean Sections

Current Arrangements

Capacity

In 2017/18 there were 1850 deliveries to 1833 mothers. Thirteen percent of these were born by category four (elective) caesarean section.

Averaged out over a 52 week year there are 4.58 elective caesarean sections per week. However, the elective caesarean sections are not evenly spread throughout the year. Reviewing the dashboard for 2017/18 the monthly rate of elective caesareans ranged from 8.8 to 16.8%.

Timing of Elective Caesarean Sections

Most elective caesarean sections are undertaken between 39 and 40 weeks. Delivery before 39 weeks is associated with an increased risk in neonatal breathing problems and admission to SCBU. Planning delivery after 40 weeks increases the risk of labour prior to the planned date of surgery and of emergency caesarean section. Emergency caesarean sections carry higher risks of intra-operative and post-operative caesarean sections.

This leaves a narrow window of 7 days in which to schedule a planned caesarean section for an individual woman.

Place of Delivery

Currently there are five elective caesarean slots per week provided in main theatres. In each week there is one list of three caesarean sections and the other two slots are provided as part of a mixed obstetric/ gynaecology list. The elective caesarean section slots are staffed by an obstetric, anaesthetic and theatre team separate from the emergency obstetrics work. This has been a longstanding arrangement of 15 years plus.

Where the demand for elective caesarean slots is in excess of the number of slots in a given week, attempts are made to identify any vacant space in main theatres. If no space is available, the additional case(s) is scheduled for delivery suite. Where possible, the cases scheduled for Delivery Suite should be the least complex.

Where the demand for elective caesarean slots is below the number of slots in a given week there is a risk that the theatre time is not fully utilised because there is insufficient time to arrange for a non-obstetric case to be brought forward.

Considerations

Safety

The complexity of an elective caesarean sections depends on number of previous procedures, placental site, maternal characteristics eg BMI and other co-morbidities.

Many obstetric units in England have more than one operating theatre and are therefore able to undertake elective caesareans with a 'back up theatre' available. One unit close to Harrogate has one obstetric theatre and undertakes elective caesareans in the obstetric theatre. However, there is an anaesthetic room in the adjacent main theatre complex equipped so an emergency caesarean can be undertaken if all other theatres are occupied.

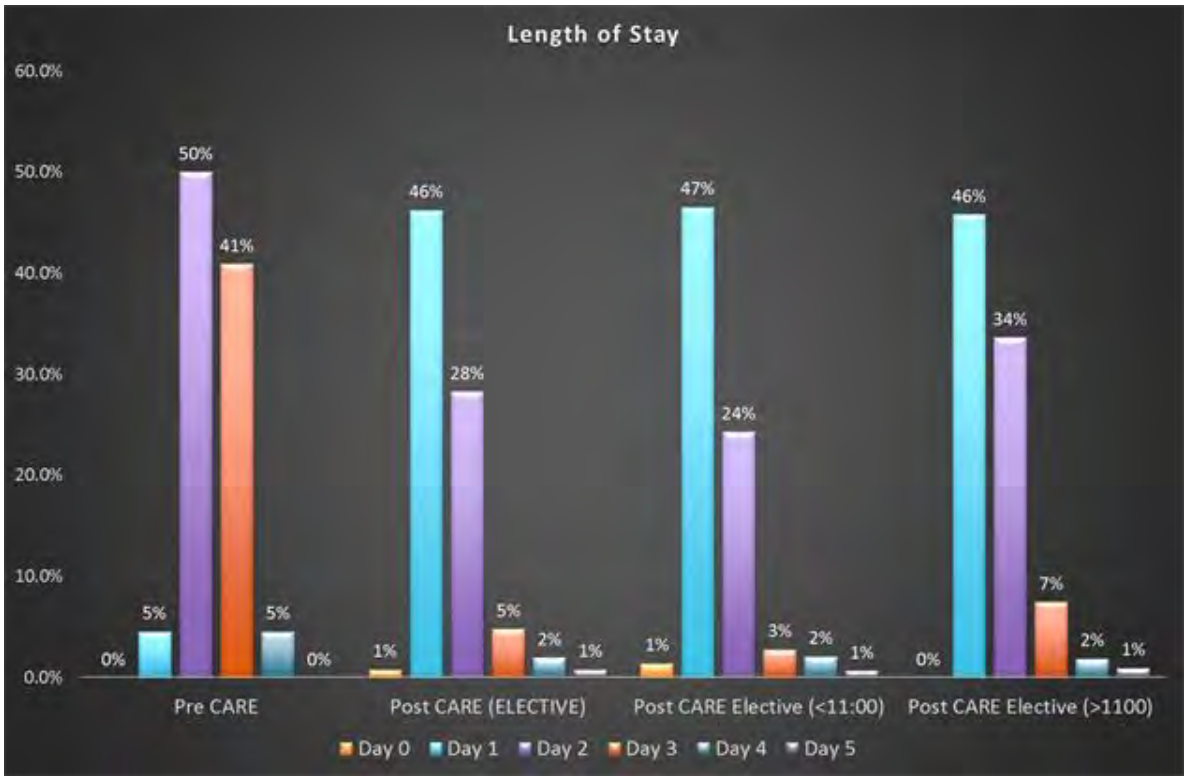
In Harrogate, there is one theatre on delivery suite and no other area equipped for operating within the maternity unit. If an urgent need for theatre arises whilst the delivery suite theatre is occupied, either the urgent case needs to wait for the labour ward theatre to become free, or the urgent case needs to be transferred to a vacant theatre in Main Theatres. The on call obstetric consultant is responsible for this decision. It is possible that if all theatres are occupied there may be a delay in managing an urgent case. The current NICE standard is that grade 1 caesarean sections, where there is immediate threat to the life of the woman or fetus, are to be performed as quickly as possible and the auditable standard is a decision to delivery interval of 30 minutes.

In practice, it is a relatively rare occurrence for a patient to be transferred across to main theatres for an emergency obstetric procedure. In 2017/18 there were 5 caesarean sections undertaken in the emergency theatre in the main theatre complex. Four occurred within normal working hours Monday – Friday and one occurred in the early hours of the morning. When elective work is scheduled on the delivery suite the obstetric and anaesthetic teams are cautious in planning the timing of delivery to reduce the risk of harm to

labouring women. This can mean that women are starved well in excess of the time mandated prior to their procedure. This is at odds with the successfully implemented enhanced recovery programme in obstetrics.

Length of Stay

The data from the enhanced recovery programme in obstetrics shows that length of stay reduced significantly after the introduction of enhanced recovery.



There is a risk that moving elective caesareans to the labour ward may result in delays to the surgery and that the positive effects of the enhanced recovery may be post, resulting in longing lengths of stay.

Patient Experience

There is a risk of labouring women waiting longer for an epidural if elective caesarean sections are undertaken on the delivery suite, unless alternative arrangements are made for a second anaesthetist to attend.

National Guidance

Providing Quality Care for Women – A Framework for Maternity Service Standards (RCOG 2016) states:

'There must be separate provision of staffing and resources to enable elective work to run independently of emergency work, in particular to prevent delays to both emergency and elective procedures and provision of analgesia in labour'.

The trust is currently accredited by the Royal College of Anaesthesia for anaesthetic clinical services. One of the mandatory standards for accreditation is:

'Where there are elective caesarean section lists there are dedicated obstetric, anaesthesia, theatre and midwifery staff'

Currently the organisation of elective caesarean sections fulfils these standards, except at times of increased demand, where there is insufficient flexibility to accommodate all elective caesarean sections in main theatres. Moving a significant proportion of elective caesarean sections alongside the emergency work risks the trust losing the ACSA accreditation.

Options for Elective Caesarean Provision

Option 1

Continue the current provision of five elective caesarean section slots in main theatre. Continue with the current arrangements for managing peaks in demand.

Strengths

Supports provision of enhanced recovery to elective caesarean sections

Reduces length of stay

Maintains excellent patient experience

Utilises vacant lists where possible to manage peaks in demand

Complies with RCOG / RcoA guidance except at times of excess demand

Weaknesses

Poorer patient experience for those undertaken in Delivery Suite theatre at times of excess demand

Risk to emergency cases when elective cases are undertaken on Delivery Suite

Breaches RCOG/ RcoA guidance at times of excess demand

Option 2

Cease all elective caesarean section slots in main theatre and manage all elective caesarean sections through labour ward theatre.

Strengths

Makes approximately 7 hours of theatre space available for elective non-obstetric work per week in main theatre

Spreads elective caesarean sections more evenly throughout the week

Weaknesses

Moves the trust from compliance with RCOG/ RcoA quality standards to non-compliance

Risks trust losing anaesthetic clinical services accreditation

Risk to patient experience and enhanced recovery with increased length of stay

Safety risk where complex caesarean sections are undertaken on Delivery Suite

Would require 1 additional midwifery shift per week (5 per week instead of current provision of 4)

May require an additional recovery team in obstetric theatre

Option 3

Reduce the number of elective caesarean slots in main theatre. Restrict the elective caesarean slots in main theatre for high risk cases only eg placenta praevia, multiple repeat caesarean sections, raised BMI, maternal diabetes.

Strengths

Makes additional theatre space available for elective non-obstetric work in main theatre

Spreads elective caesarean sections more evenly throughout the week

Reduces the risk to other emergency cases on labour ward due to the obstetric theatre being occupied for long periods for complicated cases

Weaknesses

Moves the trust from compliance with RCOG quality standards and ACSA standards to limited compliance

Risks trust losing anaesthetic clinical services accreditation

Risk to patient experience and enhanced recovery with increased length of stay

Would require 1 additional midwifery shift per week (5 per week instead of current provision of 4)

May require an additional recovery team in obstetric theatre

Option 4

Increase the number of elective caesarean section slots in main theatre in order to manage the peaks in demand by cancelling elective cases when the demand for elective caesarean sections outstrips the five available slots.

Strengths

Full compliance with RCOG and ACSA quality standards

Equity of patient experience for all elective caesarean sections

Removes risks to patients on labour ward

Weaknesses

Risk to patient experience for non-obstetric cases cancelled at short notice

Risk to trust elective activity plans and finances

References

Caesarean Section Clinical Guidleine 132 NICE (2011). Available at:

https://www.nice.org.uk/guidance/CG132

Providing Quality Care for Women - A framework for maternity service standards. RCOG 2016. Available at:

https://www.rcog.org.uk/globalassets/documents/guidelines/working-party-reports/maternitystandards.pdf

RcoA accreditation standards 2018. Available at:

https://www.rcoa.ac.uk/system/files/ACSA-STDS2018.pdf

Harrogate and District NHS Foundation Trust

6.6

Date of Meeting:	31 July 2019	**Agenda item:**	6.6
Report to:	Trust Board		
Title:	Midwifery workforce paper – NHS Resolution (safety action 5)		
Sponsoring Director:	Rob Harrison, Chief Operating Officer		
Author(s):	Alison Pedlingham, Head of Midwifery		
Report Purpose:	**Decision** ✓ **Discussion/ Consultation** **Assurance** ✓ **Information** ✓		
Executive Summary:	Standard: a bi-annual midwifery workforce planning report to be submitted to the Board that covers staffing/safety issues. Demonstration of an effective system of midwifery workforce planning to the required standard; • A systematic, evidence based process to calculate midwifery staffing establishment has been completed • The delivery suite coordinator has supernumerary status (defined as having no caseload of their own during the shift) to enable oversight of all birth activity in the service • Women receive 1:1 care in labour		

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 report is included as assurance; • There is a systematic, evidence-based process to calculate the midwifery staffing establishment using the Minimum staffing guideline (Maternity) with additional information from the Birthrate Plus acuity tool (introduced Nov 2018) • Planned versus actual midwifery staffing levels are detailed in the report • Birthrate Plus figures between March 31st – 22nd June show there were no relevant staffing factors identified for 76% of the time on delivery suite and 70% of the time on Pannal ward. During these times both areas have staffing, management and clinical actions that can be undertaken to address the situation and flexibility to move staff from one area to another to maintain safe staffing levels • 30% of the time during this 12-week period the delivery suite coordinator was identified as not supernumerary. In the escalation policy there is clear guidance on mitigation to manage any shortfalls. • The number of women receiving 1:1 care in established labour

Harrogate and District NHS Foundation Trust

	was 98.2% from the electronic birth register and 99.1% from Birthrate Plus • The recommended midwife: birth ratio is 28 births to one WTE and 1:29.5 (Birthrate Plus) midwife for hospital births; The ratio between March – June 2019 was well within these levels between 1:26.8 – 1:29.2 • The percentage of specialist midwives is 11% (Birthrate + accounts for 9%) but there is flexibility with all specialist midwives to work clinically if required to do so • Red flag events - between January 6th and June 22nd (6 months as requested by NHSR) – Delivery Suite 97% none identified, 98% none identified on Pannal ward.
Legal / regulatory:	None identified
Resource:	None identified
Impact Assessment:	The main risks identified are the delivery suite coordinator has been listed as not being supernumerary 30% of the time; • This is likely to be an over estimation as the acuity tool is sometimes completed prior to any actions having an impact (the arrival of the hospital midwife on call) and there may be more than one occasion during a 12-hour shift as the acuity tool is completed every 4 hours. Predominantly these times were during the night shift and weekends. The coordinator will not be providing 1:1 care in labour but seeing ward attenders and providing minimal care to women requiring early discharge home from the ward. There is clear guidance in the maternity escalation policy to manage any mitigation • 1:1 care in labour is 98.2% and 99.1% from the electronic birth register • Red flag events identified were only very small numbers in both areas • The hospital midwife on call was used 10 times, the community midwife used 4 times and the unit closed to admissions 10 times and 1 woman diverted to another unit. This shows appropriate escalation by the coordinator •
Conflicts of Interest:	None identified.
Reference documents:	Maternity Incentive Scheme – year 2 (NHS Resolution) https://resolution.nhs.uk/wp-content/uploads/2018/12/maternity-incentive-scheme-year-two.pdf
Assurance:	Report reviewed at Maternity Services Forum and Maternity Safety Champions group in July.
Action Required by the Board of Directors:	
It is requested that the Trust Board: • **Agrees** that the evidence provided in the maternity workforce staffing report demonstrates achievement of this safety action to the required standard as set out in the technical guidance document from NHS Resolution	

6.6

You matter most

Bi-annual midwifery staffing paper (Maternity incentive scheme – year 2)

Purpose of the paper

This is a bi-annual report to support safety action 5 of the Maternity Incentive Scheme (NHS Resolution) – year 2 that covers staffing/safety issues and requires submission to the Trust Board. This safety action needs to demonstrate an effective system of midwifery workforce planning to the required standard to include:

- **A systematic, evidence-based process to calculate midwifery staffing establishment has been completed**

The Birthrate Plus acuity tool is currently the only midwifery specific, national tool that gives the intelligence needed to be able to model midwifery numbers, skill mix and deployment and to inform decision making about safe and sustainable services. It is based on an understanding of the time required to care for women, using NICE guidance and available evidence and best practice. This acuity tool was purchased by the department in September 2018 for in-patient areas only.

The acuity tool is completed 4 hourly on delivery suite; capturing data at the time by the delivery suite coordinator. On Pannal ward it is completed 8 hourly by predicting activity for the next 6 hours (day) and 12 hours (night) by the midwife in charge of the shift.

The maternity department currently records staffing levels on the Birthrate Plus acuity tool, the maternity dashboard, the datix incident reporting system and submission of monthly safer staffing numbers. All datix forms involving staffing levels are discussed weekly at the multi-disciplinary Professional Advisory panel (PAP). Any themes, trends or concerns (numbers of times the maternity unit has closed to admissions, numbers of women diverted to other maternity units due to workload, increased use of the hospital midwife on call) are discussed at the Maternity Risk Management Group (MRMG) and escalated to the Planned and Surgical Care Quality and Governance group if required.

The time period in this report is from **March 31st – 22nd June 2019 (12 weeks).**

Delivery Suite

- There were no relevant staffing factors identified for 76% of the time.

Staffing factors contributing to this include; short term sickness (38 times), staff redeployed to another area (14 times) and no maternity support worker (37 times).

For the remaining 24% of the time the following actions were taken:

Clinical actions (57% of the time there was no action required). 43% of the time when clinical actions were taken in order to maintain a safe environment included;

Delay/postpone women having induction of labour (IOL) (11 times), delay in continuing IOL (18 times), and delay in EL LSCS on delivery suite (0) and postponed IOL from home (7 times), Delivery suite coordinator not supernumerary (151)

Management actions taken to address the situation (77% of the time no action was required, 23% of the time action was taken):
Redeploy staff from Pannal ward (42 times), staff unable to take breaks (28), review of staff on management time (2), use of specialist midwives (2), use of staff on training days (none), use of ward manager (2), use of hospital midwife on call (10), use of community midwife on call (4), unit on divert (10) and one patient in labour was diverted to another unit.

Pannal ward
70% of the time there were no relevant staffing factors, 30% of the time actions were taken. Staffing factors included unexpected staff absence - carers/emergency leave (18 times), redeployment of staff to delivery suite (15), short term sickness (16).

Clinical actions taken – 95% of the time no actions were required, 5% action was taken; no beds (2), delay in EL LSCS – cancelled or delayed on day of surgery (0), delay in discharge home > 2hours (3) and delay in ward attended being reviewed > 30 minutes (3) and no beds (2).

Management actions taken – 83% of the time no action was required, 17% action was taken; redeploy staff (12), staff unable to take breaks (11), ward manager working clinically (2), and review of staff on management time (0), use of specialist midwives (0).

This data shows that there are peaks and troughs in activity in both areas and additional staff can be utilised to address the situation and clinical actions can be taken in both areas to manage the workload at the time. As the acuity tool is completed 6 times a day on delivery suite and 3 times a day on Pannal ward, the number of times action is required could be up to 6 in one 24 hour period on delivery suite and 3 on Pannal ward. Therefore this may represent an over estimation of the number of times this occurs.

- **The obstetric unit midwifery delivery suite coordinator has supernumerary status (defined as having no caseload of their own during the shift) to enable oversight of all birth activity in the service**

The labour ward coordinator has supernumerary status (defined as having no caseload of their own during their shift) (NHS resolution 2018) to enable oversight of all the birth activity in the service. In order to ensure safe and

effective care within the Delivery Suite setting, there is always a Band 7 midwife (or in their absence an experience Band 6 midwife) coordinating each shift. The labour ward coordinator is supernumerary and is not allocated a case load for the shift. The delivery suite coordinator will always endeavour to keep themselves as supernumerary as possible, very rarely providing 1:1 care in labour but will see ward attenders and provide care to postnatal women requesting early discharge. Additional support can be gained from the consultant on call if required.

The delivery suite has a minimum of 4 midwives rostered every shift; this includes the delivery suite coordinator. The information collected from Birthrate Plus for this period shows there were 151 occasions when the delivery suite coordinator was not supernumerary, this equates to 30% of the time during March 31st – June 22nd. Predominantly these occasions were during the night and at weekends. Because of the nature of maternity services there will be periods of high and low activity and the unit has the ability to move staff accordingly. During the week (days) the delivery suite coordinator will redeploy staff from Pannal ward if appropriate and seek advice/support from ward/departmental managers or specialist midwives, who work clinically at times of increased activity, this is not an option at weekends or during the night. At night there is a hospital midwife on call and 2 community midwives on call (for home births) who can be used to support the service during times of high activity and to maintain the safety of the women and babies within the department.

- **Evidence from the acuity tool demonstrating 100% compliance with the supernumerary labour ward coordinator status and mitigation to cover any shortfalls**

To enable the delivery suite coordinator to be more supernumerary we have recently made the decision to care for women requiring induction of labour on Pannal ward from delivery suite for a trial period of 3 months, this commenced mid-June. Women requesting early discharge after delivery (6 hours) will be discharged home straight from Delivery suite. We are reviewing this on a regular basis and will monitor the number of times the coordinator is unable to be supernumerary and why.

	No. of times	**Mitigation to cover shortfalls**
Supernumerary DS coordinator	151 (30%)	Redeploy staff from Pannal ward. Use of specialist midwives and ward managers (day). Use of hospital midwife on call, if required 1st community midwife on call. Clinical actions considered – delay in IOL Discussion with ward manager (day), consultant on call (night) and a decision

		made to close temporarily to admissions and divert women in labour to another unit. Complete a datix form and escalation paperwork.

The delivery suite coordinator has the flexibility to initiate clinical, staffing and management actions in order to be supernumerary (as stated above). An analysis of this data and numbers of times these actions have been implemented indicates that the escalation process has worked. Staff are being transferred from Pannal ward (42 times = 8% of the time) and specialist midwives, ward managers are also being used. During out of hours the hospital midwife on call (10 = 2% of the time), use of community midwife on call (4 = 0.8% of the time), unit on divert (10) and one patient in labour was diverted to another unit are small numbers. The number of red flag events identified during this period is very minimal (2% on delivery suite and 3% on Pannal ward).

- **Women receive 1:1 care in labour (this is the minimum standard that Birthrate + is based on).**

NICE (2015) recommends 1:1 care in established labour for all women to ensure positive outcomes and a safe experience of giving birth.

According to the information from the Birthrate Plus there were 5 occasions when one midwife was not able to provide continuous 1:1 care and support to a woman in established labour. The information from the electronic birth register between 31st March and 22/6/19 inclusive, there were 392 women delivered (395 babies born). Of these women, 382 were listed as having 1:1 care in labour = **97.4%.**

However, a small number of women had a BBA (born before arrival) and therefore did not have any care in labour (2 women in this period with birth location 'Other', 1 additional 'Home Delivery' listed as not 1:1. So possibly only 7 women not getting 1:1 care on Labour Ward (1.8%), therefore the adjusted figure from the electronic birth register is **98.2%.**

- **A clear breakdown of Birthrate + (or equivalent calculations) to demonstrate how the required establishment has been calculated**

Staffing levels are continually reviewed by the Head of Midwifery and senior midwifery managers in line with known workload and projected maternity bookings within Maternity Services.

The minimum staffing levels are agreed within the Maternity staffing guideline for the department and the Birthrate Plus acuity tool offers additional information on these levels and the acuity of the women however it is for in-

patient areas only and does not include Antenatal clinic (ANC) or community midwifery.

Agreed minimum staffing levels in the maternity unit

	Delivery Suite	Pannal ward	ANC	Maternity Assessment Centre (MAC)	Community
09.00-17.00	N/A	N/A	2-3 (depending on day of week)		5
Bank holidays and weekends	4 4	3 3	N/A	N/A	3
E	4	3		1	
L	4	3		1	
LD	(4)	(3)		1	

There is currently a review of staffing in ANC and an assessment of the ratio of qualified to unqualified staff. There is a recommended number of women in each community midwife's caseload of 1:96 (96 women per WTE midwife). All community midwives have caseloads in line with this ratio or below (Ball and Washbrook, 2010).

- **Details of planned versus actual midwifery staffing levels**

All hospitals are required to publish information about the number of nursing and midwifery staff working on each in-patient ward.

Information about actual versus planned nursing and midwifery staffing levels is published on a monthly basis for each inpatient ward area in the Trust, including maternity inpatient areas for midwives and MSW's (Delivery Suite and Pannal ward). This data is updated on a monthly basis and is shown on the NHS choices website as well as the Trust website.

Within the hospital this information is displayed for patients and visitors in all inpatient ward areas showing planned and actual staffing available at the start of each shift on a daily basis. There is a board on both Pannal ward and Delivery Suite displaying this data.

In response to this report, the midwife in charge of the shift wears a red badge making them clearly identifiable for both staff and patients.

	Day		Night	
	Registered midwives	**MSW's**	**Registered midwives**	**MSW's**
April	91.1%	85.8%	96.4%	80%
May	95.1%	89.5%	100%	76.6%

Bi-annual midwifery workforce staffing paper
July 2019
AP

June	88.8%	87.9%	93.9%	87.5%

These figures are due to a combination of short term sickness – unable to be covered or gaps in the roster due to vacancies (staff recruited but not yet started in post). We will always aim to cover the night shift with midwives, and MSW's. During the day a decision is made depending on activity as to whether replacement MSW's are required or not. Additional staff are available (ward managers and specialist midwives) to work clinically if required.

- **An action plan has been completed to address the findings from the audit of Birthrate Plus has been undertaken.**

Where deficits in staffing levels have been identified maternity services should detail progress against the action plan to demonstrate an increase in staffing levels and any mitigation to cover any shortfalls.

The only action taken has been a decision to move women admitted for induction of labour to Pannal ward in order to support the delivery suite coordinator being supernumerary. This will be monitored closely over the pilot period for the next 3 months.

- **The midwife: birth ratio**

A decision was made at regional level to consider moving away from the midwife to birth ratio to submission of numbers of women in established labour receiving 1:1 care by a midwife. Concerns have previously been raised about the midwife to birth ratio as it does not take into consideration the acuity/requirements of the women being cared for in labour.

The ratio recommended by Safer Childbirth (Kings Fund, 2011) is 28 births to one WTE midwife for hospital births; Birthrate Plus determines this figure should be 1:29.5.

There has been no additional investment in either midwives or MSW's as this has not been required and the birth rate has consistently fallen since 2014 The midwife: birth ratio is within the gold standard stated in Safer Childbirth (2011)1:28-1:29.5.

Midwife: birth ratio

Month	Midwife: birth ratio
March	1:29.2
April	1:28.5
May	1:26.8
June	1:27.3

Bi-annual midwifery workforce staffing paper
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- **The percentage of specialist midwives employed and mitigation to cover any inconsistencies. Birthrate + accounts for 9% of the establishment which are not included in clinical numbers. This includes those in management positions and specialist midwives.**

We have the following specialist midwifery and managerial roles within the department;

Specialist/managerial role	**WTE**
Delivery Suite and MAC Manager	0.6 (management time)
Pannal ward manager	0.6 (management time)
ANC/Community midwifery manager	1.0
Risk management midwife	1.0
Professional development midwife	0.9
Infant feeding coordinator	0.8
Antenatal and newborn screening coordinator	1.0
Public health and safeguarding midwife	1.0
Parent education midwife	0.6
Total	**7.5WTE**
% of total midwifery establishment	11 %

The number (WTE) specialist midwives is above the 9% accepted by Birthrate Plus. This group of staff will all support the maternity unit if required at times high activity or acute sickness.

- **Number of red flag incidents (associated with midwifery staffing) reported in a consecutive <u>6 month period</u> within the last 12 months, how they are collected, where/how they are reported/monitored and any actions arising**

The numbers of red flag incidents, themes and trends are reviewed by the HOM and Matron on a monthly basis and discussed at Maternity Services Forum. Any information requiring further escalation will be discussed at the Maternity Risk Management Group (MRMG) and the Maternity Safety champions meeting.

Red flag events have been agreed locally and associated with midwifery staffing levels for the consecutive **<u>6-month period</u>** of January 6th – June 22nd 2019 are;

Delivery Suite – 97% no red flags identified, 3% red flags entered.

Red flag	**No of times**
Any occasion when one midwife is not able to provide continuous 1:1 care and support to a women during established labour	5
Midwife unable to provide 1:1 high	15

dependency care for (AN or PN) patient	
Delay between admission for IOL and starting process	4
Delay of 30 minutes or more between presentation and triage	1
Delayed recognition of and action on abnormal signs (e.g. sepsis or urine output)	1
There were no occasions recorded for the following red flags; Delayed or cancelled time critical activity Missed or delayed care Missed medication Delay of more than 30 minutes in providing pain relief Full clinical examination not carried out when presenting in labour Delay of 2 hours or more between admission for induction of labour and beginning the process output)	

Pannal ward

98% of the time no red flags identified, 2% red flags entered.

Red flag	No of times
Delayed or cancelled time critical event	2
Delay in providing pain relief	3
Delayed recognition of and action on abnormal vital signs	1
There were no occasions recorded for the following red flags; Delay in presentation to triage, delay in full clinical examination being completed, delay between admission for IOL and starting process	

Implementation of a Continuity of carer model (CoC)

Better Births (NHS England, 2016), a report of the National Maternity Review, set out a vision for maternity services in England which are safe and personalised putting the needs of the women, her baby and family at the heart of care; with staff who are supported to deliver high quality care which is continuously improving.

The continuity of care model and the relationship between care giver and women has shown better outcomes and improved safety for the woman and her baby, as well as offering a more positive and personal experience. This was the single biggest request from women of their services that was heard during the National Review.
Implementation of the CoC model can be agreed locally but must include the following principles;

- Consistency of car provided by a midwife and/or obstetrician during the antenatal, intrapartum and postnatal periods
- Women have a named midwife who is responsible for the coordination of their care

- That an ongoing relationship of trust exists between the midwife and the women
- Where possible this model is implemented in the hospital as well as the community setting.
- That 20% of women be on a CoC pathway by March 2019, this trajectory increases to 35% by March 2020 and by March 2021 most women are on a CoC pathway.

At Harrogate, using non-recurrent monies from the WY&H LMS we recruited a project manager (Band 7 midwife) in October 2018 to help introduce this model at local level (2 days a week). The Ivy team was introduced mid-January 2019 including a small number of hospital and community midwives who have rostered shifts including weekends and night duty. This team were not recruited above the midwifery establishment and consists of 5.2WTE – (6 midwives) who work in a geographical area of Harrogate covering 3 x GP practices (pregnant women from these practices). These midwives work flexibly across the community and hospital, working where their women are attending. The model is based on 1WTE midwife providing care to 35 women (providing care during the antenatal, intrapartum and postnatal period). We now have a consultant obstetrician attached to the team. From February 2019 the percentage of women on the pathway has been between 12-19%.

The model supports midwives to be where their women are, moving away from the rostered shifts in a certain area of the department and allows them to work more flexibly, being more responsible for their contracted hours. We made the decision to keep the rostered night and weekend shifts to support the rest of the unit.

The Birthrate + acuity tool is not designed to support the CoC model and the flexibility of staff, working in both hospital and community. We hope to work with the company to develop the acuity tool to support this model.

Conclusions

- There is a systematic, evidence-based process to calculate midwifery staffing establishment. The department also records staffing levels on the maternity dashboard, the datix incident reporting system and submission of monthly safer staffing numbers.
- Birthrate Plus figures between March 31st – 22nd June show there were no relevant staffing factors identified for 76% of the time on delivery suite and 70% of the time on Pannal ward. The staffing factors contributing to these figures include short term sickness, no MSW, staff redeployed to another area and unexpected staff absence (carers leave). During these times both areas have management and clinical actions that can be undertaken to address the situation.
- There were 151 occasions when the delivery suite coordinator was not supernumerary, this equates to 30% of the time during this 12-week period. There may be more than one occasion during a 12 hour shift as

the acuity tool is completed every 4 hours on delivery suite. This figure may therefore represent an over estimation. The coordinator will aim to have no caseload of their own but may be required to see ward attenders or postnatal women suitable for early discharge only, not to provide 1:1 care to women in established labour. Mitigation to cover any shortfalls includes redeployment of staff from Pannal ward, use of additional staff (ward managers and specialist midwives), use of the hospital midwife and community midwife on call (nights). Additional support/advice can be gained from the consultant on call if required.

- The number of women receiving 1:1 care in established labour was 98.2% from the electronic birth register and 99.1% from Birthrate Plus (5 women during this period).
- Staffing levels are continually reviewed by the Head of Midwifery, Matron and senior midwifery managers in line with known workload and projected maternity bookings within Maternity Services. The minimum staffing levels are agreed within the Maternity staffing guideline for the department and the Birthrate Plus acuity tool offers additional information on these levels and the acuity of the women however it is for in-patient areas only and does not include Antenatal clinic (ANC) or community midwifery. The impact of the continuity of carer model will be considered going forward, creating more flexibility and responsibility for staff. There is always a delivery suite coordinator (or suitably experienced band 6 midwife) rostered to be in charge on delivery suite and to be supernumerary in order to provide oversight of all birth activity in the service. A closer analysis of the data from Birthrate Plus will be undertaken on a monthly basis by the HOM and Matron by performing an audit to ensure the escalation process has worked.
- The midwife: birth ratio recommended by Safer is 28 births to one WTE midwife for hospital births; Birthrate Plus determines this figure should be 1:29.5. The ratio between March – June 2019 was well within these levels between 1:26.8 – 1:29.2
- Birthrate Plus accounts for 9% of the establishment which are not included in clinical numbers. Our ratio is 11% but there is flexibility with all specialist midwives to work clinically if required to do so.
- The number of red flag events identified in Birthrate Plus is reviewed monthly by the HOM and Matron, discussed at Maternity Services Forum and any themes identified would be escalated to Maternity Risk management group. During the 6-month period between January 6th and June 22nd – Delivery Suite 97% none identified, 98% none identified on Pannal ward.
- All maternity units in England have been required to implement a continuity of carer model (20% of women on the CoC pathway by March 2019 to increase to 35% by March 2020). The Birthrate Plus acuity tool does not currently support staffing in this model. Further discussion with the company will be required in order to develop the acuity tool and establishment.

Date of Meeting:	31 July 2019	**Agenda item:**	6.6
Report to:	Trust Board		
Title:	Maternity Incentive scheme – year 2 (maternity safety action 6) NHS Resolution		
Sponsoring Director:	Rob Harrison, Chief Operating Officer		
Author(s):	Dr Kat Johnson Clinical Director Planned and Surgical Care		
Report Purpose:	**Decision** ✓ **Discussion/ Consultation** **Assurance** ✓ **Information** ✓		
Executive Summary:	This report sets out compliance with this safety action and notes that in March 2019 the Trust reported full compliance to the Yorkshire and Humber Clinical Network. It should be noted that the standard for full compliance allowed for an alternative intervention to be put in place where resources did not allow for full adoption of the growth screening algorithm and this is described in the customised growth guideline. The Saving Babies' Lives Care Bundle version 1 has been now replaced by Version 2, published in March 2019 and the service is now working towards compliance with this version.		
Related Trust Objectives			
To deliver high quality care ✓	**To work with partners to deliver integrated care:** ✓	**To ensure clinical and financial sustainability:**	
Risk Assessment:	The Trust has been unable to fully implement the scanning algorithm described in SBL version 1 due to resource implications. \the second version of the SBL care bundle has a different approach to scanning which will require additional training and use of resources. Alternative arrangements have been put in place to monitor growth clinically where scanning is not available. A fortnightly multiprofessional meeting is in place to make progress towards full implementation of SBL version 2.		
Legal / regulatory:	None identified		
Resource:	None identified		
Impact Assessment:	Not applicable		
Conflicts of Interest:	None identified		
Reference documents:	https://www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf		

6.6

Assurance:	Report reviewed at Maternity Services Forum and Maternity Safety Champions meeting in July 2019.
Action Required by the Board of Directors:	
It is recommended that the Board: • **Agrees** that the evidence provided in the Saving Babies' Lives Care Bundle report demonstrates achievement of this safety action to the required standard as set out in the technical guidance document by NHS Resolution.	

Safety Action 6 - Can you demonstrate compliance with all four elements of the Saving Babies' Lives care bundle?

Standard

Has Board level consideration of the Saving Babies' Lives (SBL) care bundle (Version 1 published 21 March 2016) been undertaken in a way that supports the delivery of safer maternity services?

Has each element of the SBL care bundle been implemented or is an alternative intervention in place to deliver against element(s).

Evidence

The Saving Babies' Lives Care Bundle Version 1 has been considered by the quality committee of trust board and was a quality priority in 2018/19.

Each element has been implemented or an alternative is in place. In March 2019 the trust submitted full compliance to the Yorkshire and Humber maternity network.

Harrogate submission YH CN R(

Element 1- Reducing smoking in pregnancy by carrying out a carbon monoxide (CO)test at booking to identify smokers (or those exposed to tobacco smoke) and referring to stop smoking service/specialist as appropriate

The service is in wave 2 of the National Maternal and Neonatal Safety Collaborative and has focused on smoking cessation in pregnancy. This work has been reported through Quality Committee and is in the Quality Account.

Quality Report 2018_19 final v3.pdf

Element 2 – Identification and surveillance of pregnancies with fetal growth restriction

There is a local guideline on risk assessment and surveillance for fetal growth restriction which balances the recommendations of the SBL care bundle against the capacity within the ultrasound service and makes alternative recommendations where ultrasound screening cannot be offered. The guideline is available at:

In March 2019, saving Babies' Lives Care Bundle Version 2 was published. This recognises the resource limitations affecting full implementation of the screening algorithm, and makes alternative recommendations which allow scanning to be targeted at those most at risk. The service has committed to working towards implementation version 2 and this work is underway. An interim guideline has been issued (see file below), which is the first phase in moving to the new saving Babies' Lives scanning algorithm.

CUSTOMISED_GROWTH.July 2019.doc

Element 3 - Raising awareness amongst pregnant women of detecting and reporting reduced fetal movements (RFM) and ensuring providers have protocols in place, based on best available evidence, to manage care for women who report RFM.

The trust is compliant with these actions and is engaged in Local Maternity System work in this area as sadly we still see patients who do not immediately report reduced fetal movements. The trust guideline can be viewed at: http://nww.hdft.nhs.uk/planned-and-surgical-care/maternity/guidelines-and-policies/

Element 4 – Effective Fetal Monitoring During Labour

Evidence-based fetal monitoring arrangements during labour and recognition of fetal compromise with appropriate escalation are key to reducing injury and deaths from unrecognised fetal hypoxia in labour.

There is a long established guideline for systematic review of fetal monitoring and escalation of concerns.

Intrapartum stillbirth is an uncommon event. Term admissions to SCBU can be used as a proxy for fetal monitoring during labour. The data produced for the ATAIN programme details the reasons for admission to SCBU (see safety action 3).

The trust reports all cases of suspected HIE/ intrapartum deaths to NHS Resolution through Each Baby Counts.

All maternity staff involved in intrapartum care are required to have had face to face CTG training within the last twelve months and there is >90% compliance for all staff groups.

Month	FM Obs Cons	FM Obs Staff grade + ST1-7	FM Midwives	Staff unable To attend due to staffing
January	100% 6/6	62% 5/8	97%	1 band 7 MW(Prompt)
February	100% 6/6	50% 4/8	78/83 94%	
March	83% 5/6	62% 5/8	78/83 94%	
April	83% 5/6	75% 6/8	78/83 94%	1 anaes (Prompt)
May	4/6 67%	5/8 62%	78/83 94%	
June	5/7 71%	5/8 62%	78/83% 94%	
July	7/7 100%	8/8 100%	77/83 93%	

Guidance on standards for fetal monitoring are found in the labour guideline available at: http://nww.hdft.nhs.uk/planned-and-surgical-care/maternity/guidelines-and-policies/

Harrogate and District NHS Foundation Trust

6.6

Date of Meeting:	31 July 2019	**Agenda item:**	6.6
Report to:	Trust Board		
Title:	Maternity Incentive scheme – year 2 (maternity safety action 7) NHS Resolution Patient feedback mechanism		
Sponsoring Director:	Mr Robert Harrison, Chief Operating Officer		
Author(s):	Alison Pedlingham, HOM		
Report Purpose:	Decision ✓ | Discussion/ Consultation | Assurance ✓ | Information ✓		
Executive Summary:	**Standard: Demonstration there is a patient feedback mechanism for maternity services and that you regularly act on feedback.** The maternity unit gains feedback from women and their families in numerous ways; • FFT (information is collected monthly) • CQC maternity satisfaction survey (annual survey - 2018) – results received January 2019 discussed at Maternity Services Forum and Learning from Patient Experience group – no action plan required as all feedback extremely positive. The results were shared with the staff and Harrogate MVP • Constant feedback through social media routes with a maternity facebook page and twitter account – all very positive • Compliments, thank you letters received • Maternity Voice Partnership (MVP) commenced in October 2018 in line with Better Births (NHS England, 2016). The chair of the group is now in place, there are quarterly meetings and the group have completed 15 Steps challenge in Antenatal clinic and Pannal ward, attended regional MVP meetings to network and learn from other well established groups. The group continues to grow and develop with the support from HOM and Matron and has recently extended the membership to include NCT, parent education midwife and HARD CCG • Maternity services involve women and their families in maternity specific investigations – serious incidents with or without HSIB (Healthcare Investigation Branch), Perinatal mortality reviews with the support of the bereavement midwife (link between the families and maternity services after a bereavement case and sharing of any		

Harrogate and District NHS Foundation Trust

	recommendations/action plans).

Related Trust Objectives

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

Key implications	
Risk Assessment:	None identified
Legal / regulatory:	None identified
Resource:	None identified
Impact Assessment:	Not applicable
Conflicts of Interest:	None identified
Reference documents:	https://www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf
Assurance:	Report reviewed at Maternity Services Forum and Maternity Safety Champions meeting in July 2019.

Action Required by the Board of Directors:

It is recommended that the Board:

- **Agrees** that the evidence provided in the patient feedback mechanism report demonstrates achievement of this safety action to the required standard as set out in the technical guidance document by NHS Resolution.

6.6

NHS Resolution CNST Incentive Scheme – Benchmarking January 2019

NHS Resolution CNST Incentive Scheme – Criteria One		RED	AMBER	GREEN	Validation Process
Q1	**Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?**			✓	Self-certification by the trust Board and submitted to NHS Resolution using the Board declaration form. NHS Resolution will use MBRRACE-UK data to cross reference against trust self-certification the number of eligible deaths from Wednesday 12th December 2018 until Thursday 15th August 2019. Deadline 15th August 2019
Q1a	A review of 95% of all deaths of babies suitable for review using the Perinatal Mortality Review Tool (PMRT) occurring from Wednesday 12 December 2018 have been started within four months of each death'.			✓	
Q1b	At least 50% of all deaths of babies who were born and died in your trust (including any home births where the baby died) from Wednesday 12 December 2018 will have been reviewed, by a multidisciplinary review team, with each review completed to the point that a draft report has been generated, within four months of each death.			✓	
Q1c	In 95% of all deaths of babies who were born and died in your trust (including any home births where the baby died) from Wednesday 12 December 2018, the parents were told that a review of their baby's death will take place and that their perspective and any concerns about their care and that of their baby have been sought.			✓	
Q1d	Quarterly reports have been submitted to the trust Board that include details of all deaths reviewed and consequent action plans			✓	

Evidence submitted:

HDFT Public front sheet (PMRT)version

NHS Resolution CNST Incentive Scheme – Benchmarking January 2019

NHS Resolution CNST Incentive Scheme – Criteria Two		RED	AMBER	GREEN	Validation Process
Q2	**Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?**			✓	NHS Digital will issue a monthly scorecard to data submitters (trusts) that can be presented to the Board. The scorecard will be used by NHS Digital to assess whether each MSDS data quality criteria has been met and whether the overall score is enough to pass all 3 mandatory criteria and 14 of the 19 criteria (please see below for details) Self-certification of the trust Board and submitted to NHS Resolution using the Board declaration form. NHS Resolution will cross-reference self-certification against NHS Digital data.
	Mandatory categories 2.1 – 2.3 must be met to pass Safety action 2				
Q2.1	January 2019 data contained at least 90% of HES births expectation, based on number of days in month (unless reason understood)			✓	
Q2.2	MSDSv2 readiness questionnaire completed and returned to NHS Digital within required timescales			✓	
Q2.3	Submit MSDSv2 data for April 2019 by the submission deadline of end of June 2019			✓	
	14 of the 19 optional categories 2.4 – 2. 22 must be met to pass Safety action 2			✓	
Q2.4	Made a submission in each of the six months October 2018 - March 2019 data, submitted to deadlines December 2018 - May 2019			✓	
Q2.5	January 2019 data contained valid smoking at booking for at least 80% of bookings			✓	
Q2.6	January 2019 data contained valid smoking at delivery for at least 80% of births			✓	
Q2.7	January 2019 data contained all of the tables 501, 502, 404, 409, 401, 406, 408, 602 (unless justifiably blank)			✓	
Q2.8	January 2019 data contained all of the tables 101, 102, 103, 104, 112, 201, 205, 305, 307, 309, 511 (unless justifiably blank)		✓		Do not submit 112, 201, 205, 305, 307, 309
Q2.9	January 2019 data contained method of delivery for at least 80% of births			✓	
Q2.10	January 2019 data contained valid baby's first feed for at least 80% of births			✓	

NHS Resolution CNST Incentive Scheme – Benchmarking January 2019

Q2.11	January 2019 data contained valid in days gestational age for at least 80% of births			✓	
Q2.12	January 2019 data contained valid presentation at onset for at least 80% of births where onset of labour recorded			✓	
Q2.13	January 2019 data contained valid labour induction method (including code for no induction) for at least 80% of births where onset of labour recorded			✓	
Q2.14	January 2019 data contained valid place type actual delivery for at least 80% of births			✓	
Q2.15	January 2019 data contained valid site code for at least 80% of births			✓	
Q2.16	January 2019 data contained valid genital tract trauma code for at least 80% of vaginal births			✓	
Q2.17	January 2019 data contained valid Apgar score at five minutes for at least 80% of births			✓	
Q2.18	January 2019 data contained valid fetus outcome code for at least 80% of births			✓	
Q2.19	January 2019 data contained valid birth weight for at least 80% of births			✓	
Q2.20	January 2019 data contained valid figure for previous live births for at least 80% of bookings			✓	
Q2.21	MSDSv2 event or webinar attended in late 2018 / early 2019, or had 1:1 call with one of the NHS Digital team in lieu of attendance			✓	
Q2.22	January 2019 data contained valid (including “Not Stated”) ethnic category (Mother) for at least 80% of bookings.			✓	

NHS Resolution CNST Incentive Scheme – Benchmarking January 2019

NHS Resolution CNST Incentive Scheme – Criteria Three		RED	AMBER	GREEN	Validation Process
Q3	**Can you demonstrate that you have transitional care services to support the Avoiding Term Admissions Into Neonatal units Programme?**			✓	Local policy available which is based on principles of British Association of Perinatal Medicine (BAPM) transitional care where: 1. There is evidence of neonatal involvement in care planning 2. Admission criteria meets a minimum of HRG XA04 but could extend beyond to BAPM transitional care framework in practice 3. There is an explicit staffing model 4. The policy is signed by maternity and neonatal clinical leads. Data is available (electronic or paper based) on transitional care activity which has been recorded as per XA04 2016 NCCMDS. An audit trail providing evidence and a rationale for developing the agreed action plan to address local findings from ATAIN reviews.
Q3a	Have pathways of care for admission into and out of transitional care been jointly approved by maternity and neonatal teams with neonatal involvement in decision making and planning care for all babies in transitional care.			✓	
Q3b	Is a data recording process for transitional care established, in order to produce commissioner returns for Healthcare Resource Groups (HRG) 4/XA04 activity as per Neonatal Critical Care Minimum Data Set (NCCMDS) version 2.			✓	
Q3c	Has an action plan been agreed at Board level and with your Local Maternity Systems (LMS) and Operational Delivery Network (ODN) to address local findings from Avoiding Term Admissions Into Neonatal units (ATAIN) reviews.			✓	
Q3d	Has progress with the agreed action plans been shared with your Board and your LMS & ODN			✓	

NHS Resolution CNST Incentive Scheme – Benchmarking January 2019

					Evidence of an action plan to address identified and modifiable factors for admission to transitional care. Action plan has been signed off by trust Board, ODN and LMS and progress with action plan is documented within minutes of meetings at Board ODN/LMS. a) and b) by 3rd February 2019 c) by 10th March 2019 d) by 19th May 2019

Comments: Dates above were rearranged by the LMS and ODN, all maternity units in the WY&H LMS in the same position.

Evidence:

8.10 Report to Quality Committee Ma

Transitional care guidline.docx

Report to Quality Committee July 2019

NHS Resolution CNST Incentive Scheme – Benchmarking January 2019

NHS Resolution CNST Incentive Scheme – Criteria Four		RED	AMBER	GREEN	Validation Process
Q4	**Can you demonstrate an effective system of medical workforce planning to the required standard?**			✓	aQ Proportion of trainees formally recorded in Board minutes and the action plan to address lost educational opportunities should be signed off by the trust Board and a copy submitted to the RCOG at workforce@rcog.org.uk b) Board minutes formally recording the proportion of ACSA standards 1.2.3.4.6, 2.6.5.1 and 2.6.5.6 that are met. Where trusts did not meet these standards, they must produce an action plan (ratified by the Board) stating how they are working to meet the standards.
Q4a	Do you have a formal record of the proportion of obstetrics and gynaecology trainees in the trust who 'disagreed/strongly disagreed' with the 2018 General Medical Council National Training Survey question: 'In my current post, educational/training opportunities are rarely lost due to gaps in the rota.' In addition, a plan produced by the trust to address lost educational opportunities due to rota gaps?			✓	
Q4b	Is an action plan is in place and agreed at Board level to meet Anaesthesia Clinical Services Accreditation (ACSA) standards 1.2.4.6, 2.6.5.1 and 2.6.5.6. (See below)?			✓	
	1.2.4.6 Where there are elective caesarean section lists there are dedicated obstetric, anaesthesia, theatre and midwifery staff			✓	
	2.6.5.1 A duty anaesthetist is available for the obstetric unit 24 hours a day, where there is a 24 hour epidural service the anaesthetist is resident			✓	
	2.6.5.6. The duty anaesthetist for obstetrics should participate in labour ward rounds			✓	

Comments:

SOP lost training.doc Safety action 4.docx

NHS Resolution CNST Incentive Scheme – Benchmarking January 2019

NHS Resolution CNST Incentive Scheme – Criteria Five		RED	AMBER	GREEN	Validation Process
Q5	**Can you demonstrate an effective system of midwifery workforce planning to the required standard?**			✓	A bi-annual report that includes evidence to support a-c being met. This should include: A clear breakdown of Birthrate+ or equivalent calculations to demonstrate how the required establishment has been calculated. Details of planned and actual midwifery staffing levels An action plan to address the findings from the full audit or table-top exercise of Birthrate+ or equivalent undertaken. Where deficits in staffing levels have been identified maternity services should detail progress against the action plan to demonstrate an increase in staffing levels and any mitigation to cover any shortfalls. The midwife: birth ratio The percentage of specialist midwives employed and mitigation to cover any inconsistencies. Birthrate+ accounts for 9% of the establishment which are not included in the clinical numbers. This includes those in management positions and specialist midwives
Q5a	A systematic, evidence-based process to calculate midwifery staffing establishment has been done			✓	
Q5b	The obstetric unit midwifery labour ward coordinator has supernumerary status (defined as having no caseload of their own during that shift) to enable oversight of all birth activity in the service			✓	
Q5c	Women receive one-to-one care in labour (this is the minimum standard that Birthrate+ is based on)			✓	
Q5d	A bi-annual report that covers staffing/safety issues is submitted to the Board			✓	

NHS Resolution CNST Incentive Scheme – Benchmarking January 2019

					Evidence from an acuity tool and/or dashboard figures demonstrating 100% compliance with supernumerary labour ward status and the provision of 1:1 care in active labour and mitigation to cover any shortfalls. Number of red flag incidents (associated with midwifery staffing) reported in a consecutive 6-month period within the last 12 months, how they are collected, where/how they are reported/monitored and any actions arising.

Evidence submitted:

Bi-annual staffing report (March - June)

HDFT Public front sheet (midwifery staf

NHS Resolution CNST Incentive Scheme – Criteria Six	RED	AMBER	GREEN	Validation Process

NHS Resolution CNST Incentive Scheme – Benchmarking January 2019

Q6	**Can you demonstrate compliance with all four elements of the Saving Babies' Lives care bundle?**			✓	Self-certification to NHS Resolution using the Board declaration form. Board minutes demonstrating that the SBL care bundle has been considered in a way that supports delivery and implementation of each element of the SBL care bundle or an alternative put in place to deliver against the element(s)
Q6a	Has Board level consideration of the Saving Babies' Lives (SBL) care bundle (Version 1 published 21 March 2016) been undertaken in a way that supports the delivery of safer maternity services?			✓	
Q6b	Has each element of the SBL care bundle been implemented or is an alternative intervention in place to deliver against element(s).			✓	
Evidence submitted: Saving babies lives standard.docx					

NHS Resolution CNST Incentive Scheme – Benchmarking January 2019

NHS Resolution CNST Incentive Scheme – Criteria Seven		RED	AMBER	GREEN	Validation Process
Q7	**Can you demonstrate that you have a patient feedback mechanism for maternity services and that you regularly act on feedback?**			✓	Self-certification report to Board using template report. Evidence should include: Acting on feedback from, for example a Maternity Voices Partnership. User involvement in investigations, local and or CQC survey results. Minutes of regular MVP and/or other meetings demonstrating explicitly how a range of feedback is obtained, the action taken and the communications to report this back to women.
Q7a	Has user involvement has an impact on the development and/or improvement of maternity services.			✓	

Evidence submitted:

mvp minutes April 2019.doc | TOR MVP (Harrogate Final).docx | CQC maternity survey results (Harro | MVP you said. we did. Pannal themes.d | MSF Minutes (March 2019).doc | Copy of 15 Steps - ANC.xlsx | HDFT Public front sheet (Patient feedb | safety action 7 - service user feedbacl

NHS Resolution CNST Incentive Scheme – Benchmarking January 2019

NHS Resolution CNST Incentive Scheme – Criteria Eight		RED	AMBER	GREEN	Validation Process
Q8	**Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year?**			✓	Self-certification report to Board using template report. <u>You will need to evidence to your Board that you have met the 90% of each staff groups before 15th August 2019.</u>
Q8a	Does training include fetal monitoring in labour and integrated team-working with relevant simulated emergencies and/or hands-on workshops?			✓	
Q8b	Are training syllabus' based on current evidence, national guidelines/recommendations, any relevant local audit findings, risk issues and case review feedback, and include the use of local charts, emergency boxes, algorithms and pro-formas?.			✓	
Q8c	Maternity staff attendees should be 90% of **each** of the following groups: • Obstetric consultants			✓	
	• All other obstetric doctors (including staff grade doctors, obstetric trainees (ST1-7), sub speciality trainees, obstetric clinical fellows and foundation year doctors contributing to the obstetric rota			✓	
	• Obstetric anaesthetic consultants			✓	
	• All other obstetric anaesthetic doctors (staff grades and anaesthetic trainees) contributing to the obstetric rota.			✓	
	• Midwives (including midwifery managers and matrons, community midwives; birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives)			✓	
	• Maternity theatre and maternity critical care staff (Including operating				

NHS Resolution CNST Incentive Scheme – Benchmarking January 2019

	department practitioners, anaesthetic nurse practitioners, recovery and high dependency unit nurses providing care on the maternity unit) • Maternity support workers and health care assistants (to be included in the maternity skill drills as a minimum)			✓	
				✓	
Evidence: PROMPT AND FM (final 18-7-19).docx					

NHS Resolution CNST Incentive Scheme – Criteria Nine		**RED**	**AMBER**	**GREEN**	**Validation Process**
Q9	**Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions to escalate locally identified issues?**			✓	Self-certification report to Board using template report. a) All Board level safety champions and exec sponsor for MNHSC must have set up the required mechanisms for supporting quality and safety improvement activity in both the trust and the LLS by 27th January 2019. b) Must be implemented by 27th February 2019.
Q9a	Is the Executive Sponsor for the Maternal and Neonatal Health Safety Collaborative (MNHSC) actively engaging with supporting quality and safety improvement activity within: i. the trust ii. the Local Learning System (LLS)			✓	
Q9b	Have the Board level safety champions implemented a monthly feedback session for maternity and neonatal staff to raise concerns relating to relevant safety issues?			✓	

NHS Resolution CNST Incentive Scheme – Benchmarking January 2019

Q9c	Have the Board level safety champions taken steps to address named safety concerns and that progress with actioning these are visible to staff			✓	Must be implemented by 27th March 2019 with ongoing feedback to staff on a monthly basis.

Comments: No LLS dates available at the moment.

Action: safetyconcerns.nhs.net - account is now available for staff to raise safety concerns – reviewed daily (Mon-Fri) by ward managers. Monthly walkabouts from Chief Nurse now arranged (with narrative for staff completed on the aim of these).

Evidence submitted:

Agenda Maternity Safety Champions (Ju

Maternity Safety Champions action log

NHS Resolution CNST Incentive Scheme – Criteria 10		RED	AMBER	GREEN	Validation Process
Q10	**Have you reported 100% of qualifying 2018/19 incidents under NHS Resolution's Early Notification scheme?**			✓	Self-certification report to Board using template report with Commissioner sign-off. NHS Resolution to cross reference Trust report against the National Neonatal Research Database (NRRD) data and numbers reported to NHS Resolution Early Notification Scheme.
Q10a	Are you reporting of all qualifying incidents that occurred in the 2018/19 financial year to NHS Resolution under the Early Notification scheme reporting criteria			✓	

Maternity incentive scheme – year 2 (NHS Resolution)

Maternity safety action 7 - Demonstration that there is a patient feedback mechanism for maternity services and that feedback is regularly acted upon.

Standard - evidence should include;

- Acting on feedback, for example a Maternity Voices Partnership (MVP)
- User involvement in investigations, local and or CQC survey results
- Minutes of regular MVP and/or other meetings demonstrating explicitly how a range of feedback is obtained, the action taken and the communications to report this back to women.

The maternity unit receives feedback from women and their families via a variety of sources;

- **FFT** (Friends and Family test) – received monthly and shared with ward/departmental managers and individual staff if named. Women are asked at 4 different stages of their journey; antenatal, labour, postnatal hospital and postnatal community. Feedback is overwhelmingly positive with nearly all women recommending the service. Feedback is discussed at Maternity Services Forum.
- **CQC maternity satisfaction survey (2018)** – this survey is now annual and results were received in January 2019. 51% response rate, better than most trusts for 8 questions, significantly better this year for 2 questions, worse than most trusts for no questions and the same as other trusts for 43 questions. The results have been shared with staff and discussed at Maternity Services Forum (MSF)
- **Harrogate Maternity Voice Partnership group** (MVP) commenced in October 2018. This group is an independent multi-disciplinary advisory and action forum with service users at the centre. It uses both a formal committee structure, with written agendas and formal minutes of discussions and decisions, and incorporates the principles and practice of participatory co-design and co-production through regular break-out sessions and small group work in order to ensure that the five principles of MVPs are at the core of the commissioning, monitoring and continuous improvement of maternity services. It is supported by Harrogate and Rural District (HARD) Clinical Commissioning Group. The group have completed two 15 Steps Challenge (in ANC and Pannal ward), a user event in which a 'You said, we did' was completed on Pannal ward. The group continues to grow and develop and is supported by Matron and HOM. Members of the group have attended regional events to network and share good practice across the WY&H LMS. Members of the Harrogate MVP have started to attend MSF and the group has a standing agenda item at this forum to update members of the MDT.
- **Feedback through social media** – maternity services has a Harrogate and District Maternity Mums and Midwives Facebook page and a twitter account. Feedback is extremely positive.
- **Compliments, letters and cards** – these are regularly received by all members of the multi-disciplinary team.

Women and their families are involved in investigations through the use of the Perinatal Review Mortality tool (PMRT), with the bereavement midwife acting as the link between the family and maternity services, ensuring any questions the family may have are considered and any recommendations are shared with the family.

During serious incidents there is a nominated family liaison person who acts as the link between the family and lead investigator to ensure questions/queries from the family are included in the investigation and outcomes are shared with the family on completion of the process.

Harrogate and District NHS Foundation Trust

Date of Meeting:	31 July 2019	**Agenda item:**	7.0
Report to:	Board of Directors		
Title:	Finance Report		
Sponsoring Director:	Jonathan Coulter Deputy Chief Executive / Finance Director		
Author(s):	Finance Department		
Report Purpose:	**Decision** ☐ **Discussion/ Consultation** ✓ **Assurance** ✓ **Information** ✓		
Executive Summary:	• The following paper is an overview of the trust position for Quarter 1 2019/20. • The Trust reported a deficit of £2m for this period, which was a balanced position against plan. • The paper outlines risks in relation to the position, as well as cashflow and UoR risk ratings.		

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

Key implications	
Risk Assessment:	The paper outlines the financial risks facing the Trust.
Legal / regulatory:	None directly identified.
Resource:	The document outlines the financial challenges the Trust is currently managing.
Impact Assessment:	A number of quality impact assessments are undertaken on elements of the recovery plan and CIP programme.
Conflicts of Interest:	None
Reference documents:	

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

6.7

Harrogate and District
NHS Foundation Trust

Financial Summary

Board of Directors – 31st July 2019

6.7

Financial Position

Harrogate and District NHS Foundation Trust

The Trust reported a deficit position of £256k in June, £30k ahead of plan. The overall position for Q1 is a deficit of £2m incl. PSF funding.

As a result of this performance, the Trust achieved the control total expectation from NHSE/I and should receive £414k of PSF funding for the quarter.

Overall performance and performance against the control total position are outlined below

HDFT Monthly Financial Performance (£'000s)

	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12
Actual	-1,677	-67	-256									
Internal Plan	-2,111	349	-286	328	-508	-270	1,003	613	579	1,479	1,049	1,833

HDFT Cumulative Financial Performance (£'000s)

	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12
Actual	-1,677	-1,744	-2,000									
Internal Plan	-2,111	-1,762	-2,048	-1,720	-2,228	-2,498	-1,495	-882	-303	1,176	2,225	4,058

HDFT Monthly Control Total Performance (£'000s)

	Mont h 1	Mont h 2	Mont h 3	Mont h 4	Mont h 5	Mont h 6	Mont h 7	Mont h 8	Mont h 9	Mont h 10	Mont h 11	Mont h 12
Performance against Control Total	(2,020	(410)	(514)									
Control Total (excl PSF)	(2,426	34	(600)	(33)	(869)	(630)	550	160	126	980	550	1,334

HDFT Cumulative Control Total Performance (£'000s)

	Mont h 1	Mont h 2	Mont h 3	Mont h 4	Mont h 5	Mont h 6	Mont h 7	Mont h 8	Mont h 9	Mont h 10	Mont h 11	Mont h 12
Performance against Control Total	(2,020	(2,430	(2,944									
Control Total (excl PSF)	(2,426	(2,392	(2,992	(3,025	(3,894	(4,524	(3,974	(3,814	(3,688	(2,708	(2,158	(824)

Financial Position

NHS
Harrogate and District
NHS Foundation Trust

Key Risks

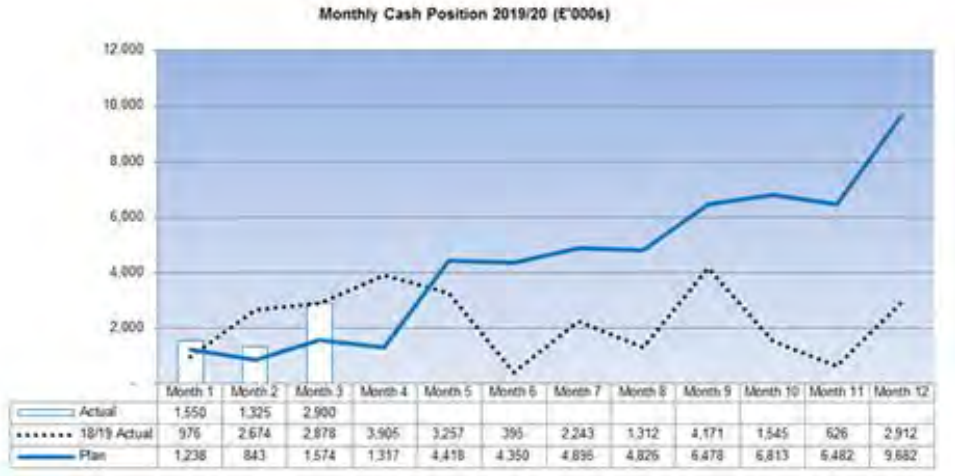
The following key risks were identified through Directorate Resource Review meetings, and outlined in more detail at the Resources Committee.

- Leeds Referrals and Activity
- Delivery of HaRD transformation programme
- Medical Staffing Expenditure Pressures
- Nursing Care Support Worker Vacancies
- CCCC forecasted run rate
- CIP Delivery
- HIF

Addressing these areas are key to ensuring the current run rate improves in lien with the Trust plan.

Cashflow

Cashflow remains a significant concern for the Trust, and while the balance appears positive against plan below this is only due to a significant pre payment on the last day of June. Actions in relation to cashflow will be discussed at the Resources Committee.



Use of Resources Financial Metrics

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

As outlined in the IBR, the Trust is reporting a UoR rating of 3.

The ratings of 4 in relation to Capital Service Cover and I&E Margin reflect the current deficit position.

The forecast UoR rating is 1. This reflects the improvement in I&E performance expected as part of the Trusts plan.

Harrogate and District NHS Foundation Trust

6.9

Date of Meeting:	31 July 2019	**Agenda item:**	7.2
Report to:	Board of Directors		
Title:	Capital Investment Programme Update		
Sponsoring Director:	Jonathan Coulter Deputy Chief Executive / Finance Director		
Author(s):	Finance and Planning Departments		

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

Executive Summary:	• The following report outlines the updated planning position for capital expenditure in 2019/20. As a result of the national position in relation to capital significant changes have been required. • The report also outlines the current forecast capital expenditure for the Trust against the original plan and control total. • Appended to the report is the accompanying letter sent to NHS Improvement with the updated plan.

Related Trust Objectives

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

Key implications

Risk Assessment:	This paper outlines the risks related to the 2019/20 capital programme
Legal / regulatory:	Amendment to annual plan as submitted to NHSI
Resource:	N/A
Impact Assessment:	N/A
Conflicts of Interest:	N/A
Reference documents:	N/A
Assurance:	N/A

Action Required by the Board of Directors:

The Board of Directors is requested to:

- **Note** the issues in relation to capital funding and programme.
- **Approve** the revised Capital Programme for 2019/20

Harrogate and District NHS Foundation Trust

6.9

Capital Investment Programme: Update

Report from Jonathan Coulter Deputy Chief Executive

Report Purpose: For Discussion

1. Background

1.1 In April 2019 the Trust submitted a draft plan to NHS Improvement that included a capital programme of £5,192k. This programme was the conclusion of a significant prioritisation process within the Trust, with a wider list of £12m schemes risk assessed and ranked.

1.2 In May 2019 the Trust submitted the final plan which included a revised schedule. All Trusts had at this point been asked to consider their capital programmes as nationally resources were overcommitted. The Trust resubmitted the programme, allowing for £150k of managed slippage.

1.3 Subsequently the national position has not improved, with a 25% reduction required. Each ICS was given a control total position and within the ICS indicative control totals have been set for capital. The Trust control total is outlined as £4,409k. Attached at Appendix One is the letter from Julian Kelly outlining the national position.

1.4 This paper outlines the original capital resource calculation and plan, as well as an updated position pre control total, and a subsequent forecast for 2019/20.

1.5 Finally, appendix two is the letter that accompanied the updated capital return to NHS Improvement. This gives the context to which the Trust has agreed to this change, pending approval at Board of Directors.

Harrogate and District NHS Foundation Trust

2. Original Capital Programme

2.1 The table below outlines the original resource the Trust planned for the 2019/20 capital programme.

	Original Plan (£'000s)
Resources	
Trust Depreciation	5,192
HIF Depreciation	140
Total Depreciation	**5,332**
Planned Surplus	4,058
Less cash resilience	(2,500)
Carried forward resource	427
Loan Requirements	(2,125)
Additional Resource	
Total Resource	**5,192**

2.2 The programme based on this resource is outlined below.

Programme	
18/19 schemes - Plan Stage	
Endoscopy	330
Primary Care	8
WEB V	990
Gamma Camera	211
WiFi Services	47
Ambulatory Care	11
IT Carried Over	80
Plant and Machinery Carried Over	183
Works Carried Over	210
Total 18/19 Schemes	**2,070**
18/19 Additions	
See new schemes schedule	
19/20 Schemes - Plan Stage	
IT Allocation	300
Cath Lab Imaging	915
ED X-ray Room	490
CT Scanner	317
HIF Backlog Maintenance	500
Total 19/20 Schemes	**2,522**
19/20 Additions	
See new schemes schedule	
Contingency	**600**
Total Programme	**5,192**

6.9

2.3 Outside of this programme, further schemes were either outlined to be supported through external bids for capital, charitable funds/fundraising, or deemed to not be a priority for 2019/20 against the above.

2.4 The programme equates to 2.1% of consolidated Trust turnover.

3. Updated Programme

3.1 Prior to the "control total" requirement, the resource for the capital programme had been updated to reflect changes in the programme. The resource changes are outlined in the table below, and related to PSF receipt and donations.

	Original Plan (£'000s)	Revised Plan (£'000s)	Notes
Resources			
Trust Depreciation	5,192	5,192	
HIF Depreciation	140	140	
Total Depreciation	**5,332**	**5,332**	
Planned Surplus	4,058	4,077	Risk in relation to I&E performance
Less cash resilience	(2,500)	(2,500)	
Carried forward resource	427	427	
Loan Requirements	(2,125)	(2,125)	
Additional Resource		1,334	CT scanner and £1m of additional PSF
Total Resource	**5,192**	**6,545**	**0**

3.2 The following changes were also going to be made to the planned programme, based upon resource changes.

	Original Plan (£'000s)	Revised Plan (£'000s)	Notes
Programme			
18/19 schemes - Plan Stage			
Endoscopy	330	611	Awaiting final settlement
Primary Care	8	66	Scheme delayed in 18/19
WEB V	990	990	
Gamma Camera	211	206	
WiFi Services	47	51	
Ambulatory Care	11	13	
IT Carried Over	80	152	
Plant and Machinery Carried Over	183	0	Offsets some of the additions
Works Carried Over	210	0	Offsets some of the additions
Total 18/19 Schemes	**2,070**	**2,089**	
18/19 Additions			
See new schemes schedule		**957**	
19/20 Schemes - Plan Stage			
IT Allocation	300	300	
Cath Lab Imaging	915	1,020	
ED X-ray Room	490	27	Delayed to avoid disruption
CT Scanner	317	304	
HIF Backlog Maintenance	500	500	
Total 19/20 Schemes	**2,522**	**2,150**	
19/20 Additions			
See new schemes schedule		**625**	
Contingency	**600**	**75**	
Total Programme	**5,192**	**5,896**	

3.3 Whilst the programme was to be increased, resources were available to support this, and the proposed revisions were below the resource available.

3.4 During Q1, contingency has been utilised on emerging schemes as expected, as well as the change in timing related to the Emergency Department X-ray Room.

3.5 Before this revised plan could be brought for updated approval, the national funding position changed.

4 Capital 'Control Total'

4.1 At the start of July the ICS were effectively given a control total for capital expenditure from NHS Improvement in order to support the national capital position, which was overcommitted. Discussions in relation to how this expectation would be met were quickly brought together between finance colleagues across the ICS, concluding in the following updated position. The control total agreed for HDFT is £4.4m.

4.2 As mentioned previously, Appendix two outlines the context in which the Trust has indicatively agreed to this.

4.3 It should be noted that whilst all organisations will be carrying risk as a result of these changes, we will essentially be spending less than the resource available through depreciation by approx. £800k.

4.4 We have therefore reviewed the programme and timings to develop a revised capital plan for the year. It should be noted that in our response to NHSI in relation to this issue, that we have said that we will undertake best endeavours to deliver the reduction, but that if risks emerge that require capital expenditure to mitigate, that we will spend the money as necessary.

4.5 Appendix two contains the letter that was sent to NHSI in respect of the revised capital 'control total'.

Harrogate and District NHS Foundation Trust

5 Capital Investment Programme

5.1 On the basis of the proposed control total of £4.4m, the Capital Programme for 2019/2020 has been revised as follows:-

Capital "Control Total"	Original Plan (£'000s)	Forecast at Q1 (£'000s)
Programme		
18/19 schemes – Plan Stage		
Endoscopy	330	330
Primary Care	8	55
WEB V	990	990
Gamma Camera	211	150
WiFi Services	47	20
Ambulatory Care	11	13
IT Carried Over	80	152
Plant and Machinery Carried Over	183	0
Works Carried Over	210	0
Total 18/19 Schemes	**2,070**	**1,710**
18/19 Additions		
See new schemes schedule		517
19/20 Schemes – Plan Stage		
IT Allocation	300	300
Cath Lab Imaging	915	420
ED X-ray Room	490	27
CT Scanner	317	304
HIF Backlog Maintenance	500	500
Total 19/20 Schemes	**2,522**	**1,550**
19/20 Additions		
See new schemes schedule		625
Contingency	600	0
Total Programme	**5,192**	**4,402**

6.9

You matter most

Harrogate and District NHS Foundation Trust

6 Conclusion

6.1 In conclusion, while the Trust had already undertaken a robust prioritisation process in relation to setting a responsible capital programme for 2019/20, the challenged national position has resulted in significant reduction in planned expenditure.

6.2 While this could potentially be managed through careful management, risks are emerging across the organisation as well as a number of asks to develop the Trust infrastructure and estate.

6.3 The Board of Directors is asked to –

- Note the current position in respect of the capital programme for 2019/20
- Approve the revised programme, noting that the risks and mitigations, including those outlined in our letter to NHSI

APPENDIX 1
Letter from Julian Kelly to Trust

APPENDIX 2
Letter from HDFT to NHSI in response to NHSI regarding the revised capital programme

To:
STP LEADERS AND ALL PROVIDER TRUST CHIEF EXECUTIVES

Julian Kelly
Chief Financial Officer
Skipton House
80 London Road
London
SE1 6LH

England.chieffinancialofficer@nhs.net

2 July 2019

Dear colleagues

Next steps regarding NHS capital spend in 2019/20

I am writing further to my letter of 7 May to thank you for your support to date and set out next steps regarding NHS capital spend in 2019/20.

We recognise the importance of capital investment to the delivery of services and are making a strong case for the funding the NHS needs in this and future years through the Spending Review. In the meantime, plans proposed by providers for 2019/20 currently substantially exceed the current limit set by Parliament for the Department of Health and Social Care (DHSC). The key consequence would be that there would be no headroom for the DHSC to fund emergency loans for critical safety issues in 2019/20.

Revised capital plans submitted in May only reduced average provider spend by around 3%. To address the issues outlined above, in particular creating headroom for timely emergency lending, we would collectively need to identify at least a 20% reduction compared to the 4 April plans. We are applying the same discipline to nationally-held budgets so that the impact on self-financed spend is proportionate.

Following consultation with sector representatives including chairs, CEOs, FDs and NHS Providers, we are now asking providers to work together on an STP/ICS footprint to prioritise capital expenditure consistent with the limit set by the DHSC. Your Regional Director will set out a financial envelope. You have asked us to maximise your flexibility across the widest range of spend. Envelopes will therefore cover self-financed expenditure as well as emergency loan requests, STP capital, PDC and loans previously agreed by the DHSC. Systems can also assume that the net book value of any asset disposals not in initial plans will be available for reinvestment as part of this exercise. Greater realism on likely spend and delivery should also help.

We recognise that this is a significant piece of work but to avoid the process slipping into the second half of the year I ask that affordable plans are submitted by STP leads to regional teams by 15 July. Any necessary formal governance approvals can

then be obtained over the subsequent fortnight. Revised 2019/20 plans should be reflected in provider capital forecasts submitted at month 4.

A quicker process now will mean that emergency loan funding, where agreed as a local priority within an affordable envelope, can be released to providers without further delay. We expect regions to manage emergency finance needs for the remainder of the year within their envelope. We would also expect systems to ensure their plans include any investment that is necessary to ensure effective cross-system preparedness and resilience for winter pressures.

Whilst no-one can make any specific commitments about future levels of capital spend in advance of the Spending Review, we are asking you to defer and re-phase approved investment or self-financed plans over the next couple of years. In doing so, we also want to avoid further top-down regulation being imposed on us from outside the NHS, and ongoing uncertainty and approval delays for the remainder of the year where there is a real need.

In our conversations with the sector, there was a shared recognition of the need for a contingency plan. We will therefore be publishing a consultation on regulatory levers we may need to use, as a last resort and on a highly targeted basis, where affordable plans are not agreed by an STP/ICS. Over the summer as part of Long Term Planning we will engage with the NHS on the future financial framework to support our collective efforts to plan, allocate and prioritise capital spend.

Yours sincerely

Julian Kelly
Chief Financial Officer
NHS England and NHS Improvement

Cc: Provider Trust FD/CFOs
Regional Directors, NHSE&I
Regional Finance Directors, NHSE&I
Simon Stevens, NHSE&I
Lord David Prior, NHS England
Baroness Dido Harding, NHS Improvement

NHS
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Direct Dial: (01423) 554545
Email: jonathan.coulter@hdft.nhs.uk

15th July 2019

6.9

Cathy Kennedy
Director of Operational Finance
Yorkshire and Humber
North East & Yorkshire Region
Sent Via Email

Dear Cathy,

Resubmission of HDFT Annual Plan - capital

Following recent communications in regard to Capital Planning, we have been in dialogue with the ICS and agreed a revised (reduced) capital plan for 2019/20. This revision has been uploaded onto the portal.

Alongside the submission of the numbers, I would like to highlight the following:

- The Trust has reduced the planned spend in 2019/20 by a further £633k, this is in addition to the £150k reduction agreed in May. This has been done based on the intention to defer some work at the end of the year into 2020/21.
- The change has been made with reluctance but in recognition of the ICS/national position in relation to availability of resource and cash coverage.
- We have agreed to this reduction despite having set a small resource for 2019/20 relative to both the ICS and National plans., Our capital spend to turnover is planned to be only 2%, significantly below the ICS average, and requiring no external funding support. Based on this change the capital programme for 2019/20 will be below the retained depreciation level for the Trust.
- While the resource outlined is relatively small, the Trust has a number of demands which had already been through a significant prioritisation process. The overall ask for schemes equated to approx. £12m for 2019/20, and this will need to be recognised in planning for 2020/21 and beyond, along with other developments that will arise.

Harrogate and District NHS Foundation Trust

- The proposed slippage will require further active management, potentially some early audit discussions, and removes any contingency being held for emergency work
- If emergency spend is required due to our assessment in relation to clinical risk, we will undertake the investment, even if this puts at risk the achievement of the revised plan
- Notwithstanding the above, I can assure you that we do all that we can to live within the revised target
- Given the timing of the letter from Julian Kelly and the deadline for submission, the submission has not been through our formal governance processes, so will be subject to Board approval at the end of July

In the interests of transparency it would be useful to understand the relative capital expenditure for other ICS regions and peer group organisations in order to reassure our Board on the impact of this.

As always, if you have any questions in relation to the resubmission, please do not hesitate to contact me.

Yours Sincerely

J. Coulter

Jonathan Coulter
Deputy Chief Executive / Finance Director
Harrogate and District NHS Foundation Trust

Cc Paul Corlass, NHSI
Jordan McKie, HDFT

Board Committee report to the Board of Directors

Committee Name:	Pensions Committee
Committee Chair:	Angela Schofield
Date of last meeting:	26 June 2019
Date of Board meeting for which this report is prepared	31 July 2019

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

1. The Committee was established to determine the policy in respect of any pension restructuring payments for staff, where the Trust has authority to make such payments.
2. The Board determined that any Board members who had an existing or perceived conflict of interest would be excluded from membership of the Committee. The Committee membership was composed solely of Non-Executive Directors.
3. The Committee met on 26 June to review the existing Lifetime Allowance Pension Restructuring Payment policy, which had been established in 2017. Under this policy those staff who were approaching the national Lifetime Allowance (currently set by the Government at £1.05m) who were members of the NHS Pension Scheme, could leave the Scheme and receive the employer's contribution paid by the Trust whilst they were members (after deductions) as a supplement to their salaries.
4. In preparation for the review the members of the Committee had received a detailed briefing from an expert external to the Trust.
5. In reviewing the policy, the Committee also took into account the need to consider whether or not the Trust should extend it to include staff who were similarly affected by the Annual Allowance, which currently has a threshold of £50,000 per annum.
6. The Committee considered a number of options, using an agreed set of principles including, but not exclusively, fairness, equality of access, system acceptability and affordability.
7. These options were:
    - Continue with the current policy and current scope
    - Extend the scope of the existing policy to also include access for those who incur a tax liability as a result of the Annual Allowance
    - Extend the scope of the existing policy to also include access for anyone wishing to exit the pension scheme (regardless of reason)
    - Remove the existing Lifetime Allowance policy
8. The Committee gave very thorough consideration to the issues involved and after a significant amount of discussion made the decision not to extend the existing policy to cover the Annual Allowance at this time, and to remove the

existing Lifetime Allowance policy. The Committee gave careful consideration to the potential impact of pension taxation, but did not feel an Annual Allowance policy was appropriate in the context of the Trust's other responsibilities.

9. The decision was communicated to Trust staff soon after the meeting.

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

- There are no significant risks for noting by the Board.

Matters for decision

Nil

Harrogate and District NHS Foundation Trust

6.11

Date of Meeting:	31 July 2019	**Agenda item:**	**7.4**
Report to:	**Trust Board of Directors**		
Title:	Report by the Director of Workforce and Organisational Development		
Sponsoring Director:	Mrs Angela Wilkinson, Director of Workforce and Organisational Development		
Author(s):	Mrs Joanne Harrison, Deputy Director of Workforce and Organisational Development		
Report Purpose:	**Decision** ☐ **Discussion/ Consultation** ✓ **Assurance** ✓ **Information** ✓		
Executive Summary:	This purpose of this report is to highlight key issues from the workforce metrics and other areas for Board information and assurance.		
Related Trust Objectives			
To deliver high quality care ✓	**To work with partners to deliver integrated care:** ✓	**To ensure clinical and financial sustainability:** ✓	
Key implications			
Risk Assessment:	Any identified risks are included in the Directorate and Corporate Risk Registers and the Board Assurance Framework.		
Legal / regulatory:	Fit and Proper persons regulations are part of the CQC guidance.		
Resource:	None identified		
Impact Assessment:	Not applicable		
Conflicts of Interest:	None identified.		
Reference documents:	None appropriate		
Assurance:	Not applicable.		
Action Required by the Board of Directors:			

The Board of Directors is requested to:

- **Notes** the content of the report and comments as required

Harrogate and District NHS Foundation Trust

1. **Sickness Absence**
   The Trust sickness absence rate in June was 4.17% which is a reduction from May's rate of 4.76%. This remains above the Trust target of 3.9%. In addition to the focus within directorates, the HR team have commenced a review of the Managing Attendance and Promoting Health and Wellbeing policy as part of improving our people practices work. Stakeholder groups are being established this month to coproduce our Trust approach.

2. **Retention**
   Turnover for June shows a slight increase to 13.14% from 12.98% in May. This has remained fairly static and the recruitment and retention group continue to meet on a monthly basis to monitor and manage retention inititiatves.

3. **Appraisal Rate**
   There has been a further reduction in appraisal rates to 76.89% in June from 79.17% in May and from 83.48% in April 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. So far 25% of appraisals have been completed during the appraisal period which is behind our trajectory of 50% to meet our 90% compliance rate. Therefore Directorates are being asked to provide assurance that appraisals are planned in the diary during this period.

4. **Fit and Proper Persons Test**
   The fit and proper person regulation (FPPR) requirements came into force for all NHS Trusts and Foundation Trusts in November 2014. The regulations require the Trust to seek the necessary assurance that all executive and non-executive directors – permanent, interim and associate positions, irrespective of their voting rights are suitable and fit to undertake the responsibilities of their role.

   As part of the CQC preparation process during 2018, feedback from other Trusts in relation to the Fit and Proper Persons Test (FPPT) indicated the CQC paid particular attention to elements of the legislation taking a broad interpretation in relation to the storage of original qualifications and evidence of a recruitment and selection process.

   Following this feedback the opportunity was taken to review the current Trust process in relation to FPPT.

   As a result of the review the existing guidance was updated (Appendix 1). Specific changes to the guidance and related documentation include:

   - A requirement for an annual declaration as part of appraisal processes to be undertaken
   - Confirmation that only qualifications and professional registration specifically referenced in the Person Specification for the role should be checked
   - A full checklist detailing the specific Trust standards which each individual must meet
   - A requirement for any variations from the required standards to be documented on the FPP checklist alongside an auditable note on the decision making process

Harrogate and District NHS Foundation Trust

The Trust has 25 colleagues who are required to undertake the FPPT at commencement of employment with the Trust or since the regulation came into force and every three years thereafter. I can confirm that all 25 colleagues have completed their FPPT including the additional information now been included in the guidance and remain suitable and fit to undertake their roles.

A Wilkinson
Director of Workforce and Organisational Development
July 2019

Appendix 1
GUIDANCE FOR THE REQUIREMENTS OF THE FIT AND PROPER PERSONS TEST (FPPT)

From 27th November 2014 the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was amended to introduce Regulation 5 the Fit and Proper Persons Test. Regulation 5 is applicable to directors – executive and non-executive, permanent, interim and associate positions, irrespective of voting rights. This requirement is defined within Monitor's Provider Licence –Condition G4 and also relates to the Care Quality Commission's Regulation 19.

It is a condition of all directors sitting on the Board that the meet the requirements of the Fit and Proper Persons Test. These requirements are:

- You are of good character; (Schedule 4)
  (You are not of good character if:
  - you have been convicted in the United Kingdom of any offence or been convicted elsewhere of any offence which, if committed in any part of the United Kingdom, would constitute an offence as deemed by the Trust;
  - You have been erased, removed or struck-off a register of professionals maintained by a regulator of health care or social work professionals).

- You have the qualifications, competence, skills and experience which are necessary for the relevant office or position or the work for which you are employed;

- You have continued to maintain your professional registration as required by the Persons Specification related to your role (or explanation as to why it is no longer maintained);

- You are able by reason of your health, after reasonable adjustments are made, of properly performing tasks which are intrinsic to the office or position for which you are appointed (or to the work for which you are employed);

- You have not been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity, and

- None of the grounds of unfitness apply to you:

  - You are an undischarged bankrupt or a person whose estate has had sequestration awarded in respect of it and who has not been discharged;

  - You are the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland;

  - You are a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986;

  - You have made a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it;

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- You are included on the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland;

- You are prohibited from holding the relevant office or position or from carrying on the regulated activity, by or under any enactment.

The following positions within the Trust will be required to undertake this test prior to their commencement of employment at Harrogate and District NHS Foundation Trust

- Executive directors - existing, interim or permanent
- Non-executive directors
- Clinical Directors who are members of the board, irrespective of their voting rights.
- Deputy Directors who deputise for the Executive Directors.

To complete the FPPT, the following process is required to be completed prior to commencement and every 3 years thereafter:-

1. Completed Pre-employment Checks in line with the six NHS Employment Check Standard. A full checklist of all FPP requirements will be completed upon conclusion of the recruitment process and counter signed by a HR senior representative manager.
2. Signed copy of the Self Declaration included with the Director's Offer of employment
    a. Prior to employment has commenced the declaration will be sent to the Director separately
3. Completed Enhanced DBS Clearance check with Adult and Child Barring
4. Satisfactory Call Credit Financial Check - CallReport enables employers to run a financial soundness check on an individual. It provides access to adverse public data in the form of County Court Judgments (CCJs), Bankruptcies (BAIs) and Individual Voluntary Arrangements (IVAs). It also provides up to 6 years of address history and address links which enable users to identify any bad debt at their previous addresses.
5. Confirmation that they are not prohibited from holding the office in question by undertaking a check from Companies House. The included both the Companies Act and the Charities Act.
6. There is an expectation that appraising managers will document that an individual has confirmed that they remain Proper as part of the annual appraisal process. An e-mail to all appraising managers who appraise FPPs will be circulated annually to remind them of this expectation.

Reference Documents

This guidance should be read alongside the following guidance documents:-

- Regulation 5 of the Health and Social Care Act 2008 and associated CQC guidance.
- Schedule 4 of Regulation 5 for a definition of good character and unfit person test.
- 7 Nolan Principles of Public Life
- 6 NHS employment check standards
- Joint Guidance issued by NHS Employers, NHS Confederation and NHS Providers

Last Updated: July 2019

Date of Meeting:	31 July 2019	**Agenda item:**	7.5
Report to:	**Trust Board of Directors**		
Title:	Workforce Race Equality Standard		
Sponsoring Director:	Mrs Angela Wilkinson, Director of Workforce and Organisational Development		
Author(s):	Mrs Angela Wilkinson, Director of Workforce and Organisational Development		
Report Purpose:	**Decision** ✓ **Discussion/ Consultation** ✓ **Assurance** ✓ **Information** ✓		
Executive Summary:	• **The Trust is required to publish data on an annual basis on a series of metrics relating to the experiences of BAME staff across the Trust.** • **The Trust is able to compare the metrics year on year and can report positive progress in some metrics, particularly staff entering a disciplinary process.** • **Metrics relating to staff experience taken from the staff survey require further consideration as part of overall work being undertaken through the people plan.**		

Related Trust Objectives

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

Key implications	
Risk Assessment:	Any identified risks are included in the Directorate and Corporate Risk Registers.
Legal / regulatory:	The publication of WRES metrics is a requirement of the NHS Standard Contract.
Resource:	None identified.
Impact Assessment:	Not applicable.
Conflicts of Interest:	None identified.
Reference documents:	None appropriate.
Assurance:	Not applicable.

Action Required by the Board of Directors:

The Board of Directors is requested to:

- **Note** the content of the data report and comment as required
- **Approve** the submission of the included data
- **Comment** on the draft action plan, with a particular focus on areas to strengthen

Workforce Race Equality Standard 2019

There is robust evidence that a diverse workforce in which all staff members' contributions are valued is linked to good patient care. Studies shows that a motivated, included and valued workforce helps deliver high quality patient care, increased patient satisfaction and better patient safety.

With over one million employees, it is important that the NHS can demonstrate actions in relation to valuing workforce diversity. The Workforce Race Equality Standard (WRES) enables Trusts to monitor progress on an annual basis and drive improvement across the Trust to ensure that all staff are treated fairly and diversity is valued. WRES consists of nine metrics to indicate the workplace experiences of Black, Asian and Minority Ethnic (BAME) staff, including a specific indicator to address the low numbers of BAME board members across organisations. The metrics are monitored on an annual basis with a requirement for the Trust to demonstrate progress year on year through an action plan.

The WRES is a mandated requirement of the NHS standard contract, it should be noted that as with previous WRES submissions Trusts will not be managed on their performance against these metrics, though it remains important for the Trust to demonstrate progress in continually developing the culture across the Trust.

When analysing the data collected for the 2019 submission, the Trust is able to demonstrate improvements in some key metrics with some areas showing a deteriorating position. The full submission is included as Annex A, however key points to highlight include:

- BAME candidates are 2.11 times less likely to be appointed following shortlisting than white candidates. This has improved compared to 2018 where it was 2.14 times less likely.
- BAME members of staff are 0.92 times more likely to be disciplined than white members of staff. This has seen a significant improvement since 2018 where it was 2.38 times more likely.
- 33.3% of BAME staff reported harassment from patients, relatives and the public in the last 12 months (24% for white staff). This has increased significantly compared to 2018 of 27.78% for BAME staff (21.97 for white staff)
- 31.2% of BAME staff reported harassment, bullying or abuse from staff in last 12 months (24% for white staff). This has reduced from 34% in 2018.
- 77.3% of BAME staff believe the Trust provides equal opportunities for career progression or promotion (90.7% for white staff). This has decreased greatly compared to 2018 where it was 96.3% for BAME staff.

Whilst improvements can be demonstrated in some areas, there remains a worrying deterioration in relation to the experiences of BAME staff with respect to harassment. Included in the submission is an action plan which will be owned by the Workforce Equality Group to help the Trust work towards improvements over the next 12 months. The Trust is required to publicise the metrics and action plan by 30 August 2019 on the external website. In addition, further analysis is being undertaken to understand the metrics further.

The metrics and action plan will be shared at the Workforce and Organisational Development Steering Group and Senior Management Team. Board members are asked to note the contents of the metrics and action plan and approve for publication on the Trust website on 30 August 2019.

Angela Wilkinson
Director of Workforce and Organisational Development
July 2019

Annex A - Workforce Race Equality Scheme (WRES) action plan 2019

Number	Indicator	Data for reporting year Clinical Workforce (CW) and Non Clinical Workforce NCW)	Narrative - the implications of the data and any additional background explanatory narrative	Actions required	Owner	Timescale
1	Percentage of staff in each of the Agenda for Change (AfC) Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce. Organisations should undertake this calculation separately for non-clinical and for clinical staff.	CW - Apprentice 0.00 CW - Band 2 12.01 CW - Band 3 6.08 CW - Band 4 0.82 CW - Band 5 10.61 CW - Band 6 2.93 CW - Band 7 2.82 CW - Band 8a 1.06 CW - Band 8b 0.00 CW - Band 8c 0.00 CW - Band 8d 100.00 CW - Band 9 0.00 CW - VSM 0.00 CW - Consultants 19.05 CW - Career Grade 25.19 CW - Trainee Grade 22.66 NCW - Below band 1 0.00 NCW - Band 1 0.00 NCW - Band 2 4.56 NCW - Band 3 0.52 NCW - Band 4 0.87 NCW - Band 5 5.56 NCW - Band 6 4.08 NCW - Band 7 6.25 NCW - Band 8a 0.00 NCW - Band 8b 0.00 NCW - Band 8c 0.00 NCW - Band 8d 0.00 NCW - VSM 0.00	• This data indicates that a greater understanding of progression routes and career pathways may be required in relation to BAME staff.	• A new starter questionnaire to be rolled out to understand the experinces of new starters and their views on the recruitment process. Consideration will be given to how we can include individuals who were not appointed following shortlisting. • Following the initial work for listening events within Fair and Just culture further engagement work to identify and determine what actions need to be taken forward to encourage progression within the organisation. Establish a staff network to discuss the experiences of BAME colleagues across the organisation.	Workforce Equality Lead/ Call to Action Lead/ Chief Executive	
2	Relative likelihood of BAME staff being appointed from shortlisting compared to that of White staff being appointed from shortlisting across all posts.	2018-2.14 2019-2.11	This shows that a BAME applicant is less likely to be appointed following shortlisting than a white candidate. This has improved from 2.14 times in 2018	• Continue to run nurse recruitment open days alongside considering what different advertising methods can be used to access underrepresented groups. • Assess the impact of unconcious bias training for managers in Pathway to Management and continue to consider a wider roll out. • Review and consider alternative shortlisting and appointment techniques, to include consideration of internal and external processes. Consider the introduction of a standing shortlisting panel to reduce bias	Workforce Equality Lead/ Workforce Equality Group	
3	Relative likelihood of BAME staff entering the formal disciplinary process, compared to that of White staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation* *Note: this indicator will be based on data from a two year rolling average of the current year and the previous year.	2018 - 2.36 2019-0.92	This shows a BAME member of staff is more likely to enter a formal disciplinary process than a white member of staff. This has reduced since 2018 to 0.92 times from 2.36 times	Review the impact of the unconcious bias training for managers and monitor the BAME staff entering the Disciplinary process and outcomes. Continue with the Improving People Practices work to ensure that HR policies are fit for purpose and support the principles of fairness and equality.	Workforce Equality Lead	
4	Relative likelihood of BAME staff accessing non-mandatory training and Continued Professional Development (CPD) as compared to White staff	2018 BAME- 0.03 2019 BAME -0.02 2018 White- 1.11 2019 White -0.91	This shows that BAME members of staff are less likely to access non-mandatory training and CPD compared to white staff and has fallen slightly from 0.03 in 2018.	• The Trust will continue listening events to explore staff experiences across the Trust and determine whether more can be done to encourage progression and devlopment within the organisation.	Workforce Equality lead/ Chief Executive	
5	KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	2018 White - 21.97% 2019 White -24% 2018 BAME - 27.78% 2019 BAME -33.3%	BAME staff report higher levels of bullying and harasssment from patients, relatives and the public in the last 12 months than white staff. 2018 survey saw an increased response to this question with 1420 white respondants and 108 BAME respondants	• Workforce Equality Group to engage with BAME staff to understand the response rates for all staff survey responses. LInk with staff network once established. • The Trust People Plan contains work relating to fair and just culture, this will include the experiences of BAME staff. .The Trusts Pathway to Management training is being developed to give line managers more confidence in dealing with concerns early and aligning this to the values and behaviours framework across the Trust	Workforce Equality Group/ Site Security Manager	
6	KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	2018 White - 19.24% 2019 White -24% 2018 BAME - 34% 2019 BAME -31.2%	BAME staff report higher levels of bullying and harasssment from staff in the last 12 months than white staff. There is a recued % differential between white and BAME staff respondants and an a reduction in BAME staff reporting bullying and harassment from colleagues. Increased respondants in 2018 survey saw 1425 white respondants to this question and 109 BAME staff responding	• Workforce Equality Group to engage with BAME staff to drive participation in the National Staff Survey. • The focus on the Fair and Just culture in relation to Bullying and Harassment which will pay particular attention to the experiences of BAME staff. • The Trusts Freedom to Speak up Guardian has recruited Fairness Champions who support individuals who may be experiencing harassment or bullying and embed the Speaking Up principles across the Trust	Workforce Equality Group / Freedom to Speak up Guardian	

7	KF 21. Percentage believing that Trust provides equal opportunities for career progression or promotion	2018 White - 90.67% 2019 White- 90.7% 2018 BAME - 96.30% 2019 BAME - 77.3%	A greater percentage of white staff than BAME staff believe that the Trust does not offer them equal opportunities for career progression. This has seen a worsening factor for BAME staff and a slight reduction for White staff. 2018 survey saw an increase in respondants to this questions with 969 white staff and 66 BAME staff responding	• The Workforce Equality Group to engage with BAME staff to drive participation in the National Staff Survey. • The Trust's Pathway to Management training programme for managers is currently being reviewed with a focus on unconscious bias training. • Specific work is being undertaken across the Trust to educate managers in how to support progression. • The Nurse Recruitment and Retention group is exploring options in relation to career coaching as a route to improve progression across the Trust.	Workforce Equality Lead/ Workforce Equality Group / Nurse Recruitment and Retention Group	
8	Q17. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues	2018 White- 3.97% 2019 White 4.8% 2018 BAME - 0% 2019 BAME- 17%	A greater percentage of BAME staff than white staff believe that they have experienced discrimination from their manager or other colleagues. White staff have increased by 4% while BAME has increased significantly to 17%. White respondants to this question were 1406 woth BAME being 106 in the 2018 Staff survey	• Continue training for new line managers with the Trust's Pathway to Management program with regards to equality and employment law. • Evaluate the Trust's Pathway to Management training programme for managers new focus on unconscious bias training and having difficult conversation in order to address matters at an early stage. • Workforce Equality Group to engage with BAME staff to drive participation in the National Staff Survey. The Trusts Freedom to Speak up Guardian has introduced Fairness Champions who will be able to support individuals who may be experiencing discriminatory behaviour and embed the Speaking Up principles across the Trust	Recruitment Manager/ Workforce Equality Lead/ Workforce Equality Group	
9	Percentage difference between the organisations' Board voting membership and its overall workforce.	White - 17.8% BAME - -7.4%	This shows that white board members are overrepresented compared to the demography of the workforce, and BAME board members are underrepresented compared to the demography of the workforce.	• Ensure Board level positons are broadly advertised when they arise. • Review and consider alternative shortlisting and appointment techniques to improve diversity.	Company Secretary/ Workforce Equality Lead	

Date of Meeting:	**31 July 2019**	**Agenda item:**	7.6
Report to:	**Trust Board of Directors**		
Title:	Workforce Disability Equality Standard		
Sponsoring Director:	Mrs Angela Wilkinson, Director of Workforce and Organisational Development		
Author(s):	Mrs Angela Wilkinson, Director of Workforce and Organisational Development		
Report Purpose:	**Decision** ✓ **Discussion/ Consultation** ✓ **Assurance** ✓ **Information** ✓		
Executive Summary:	• **From July 2019 the Trust is required to publish data and an action plan based on a series of metrics relating to the experiences of disabled staff.** • **The overall results show that improvements are needed to improve the experiences of disabled staff across the Trust, there is also work to do to ensure that a higher number of individuals feel comfortable to disclose their disability status.**		

Related Trust Objectives

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

Key implications	
Risk Assessment:	Any identified risks are included in the Directorate and Corporate Risk Registers.
Legal / regulatory:	The publication of WDES metrics is a requirement of the NHS Standard Contract.
Resource:	None identified.
Impact Assessment:	Not applicable.
Conflicts of Interest:	None identified.
Reference documents:	None appropriate.
Assurance:	Not applicable.

Action Required by the Board of Directors:

The Board of Directors is requested to:

- **Note** the content of the report and comment as required
- **Approve** the submission of the included data
- Accept the recommendation that data is published relating to capability cases.

6.13

Workforce Disability Equality Standard 2019

The NHS draws on a rich diversity of staff to provide kind and compassionate care to patients, service users and their relatives.

The Board will already be familiar with the Workforce Race Equality Standard which the Trust reports on annually however a new standard has been introduced this year called the NHS Workforce Disability Equality Standard (WDES). This is designed to understand and seek to improve workplace experiences and career opportunities for disabled people working, or seeking employment, in the NHS.

The WDES is similar to the Workforce Race Equality Standard . There is a series of evidence-based Metrics that provide a snapshot of the experiences of disabled staff in key areas to understand where differences lie and for actions to address the differences be put in place.

As part of the WDES requirements, an action plan is required to take forward any differences in equality and the full submission is included as Annex A.

Key points to highlight include:

- As at 31 March 2019 there were 133 members of staff who were recorded as having declared themselves disabled, 967 staff do not record their disability status.
- The relative likelihood of a disabled candidate being appointed from shortlisting is 1.26. A figure below 1:00 indicates that Disabled staff are more likely than Non-Disabled staff to be appointed from shortlisting.
- The relative likelihood of disabled staff entering the formal capability process compared to non-disabled staff is 13.18.
- 32.1% of disabled staff reported harassment from patients, relatives and the public in the last 12 months (22.8% for non-disabled staff).
- 51% of disabled staff said the last time they experienced harassment, bullying or abuse they or a colleague reported it in the last 12 months (47% for non-disabled staff).
- The percentage of disabled staff saying that their employer has made adequate adjustments to enable them to carry out their work is 72.1%.
- The overall engagement score for disabled staff is 6.9 compared to the overall Trust engagement score of 7.2

6 Capability cases were in place over the 2 year period of reporting, and 2 of these related to disabled members of staff, equating to 33% of capability cases. As this is the first year of publication, we are not obliged to publish data relating to staff entering formal capability process, however for transparency it is recommended that we publish this.

The overall results show that improvements are needed to improve the experiences of disabled staff across the Trust, there is also work to do to ensure that a higher number of individuals feel comfortable to disclose their disability status. The submission of the action plan will be owned by the Workforce Equality Group to help the Trust work towards improvements over the next 12 months. The Trust is required

to publicise the metrics in August and an action plan by 30 September 2019 on the external website. In addition, further analysis is being undertaken to understand the metrics further.

The metrics and action plan will be shared at the Workforce and Organisational Development Steering Group and Senior Management Team. Board members are asked to note the contents of the metrics and approve for submission in August 2019.

Angela Wilkinson
Director of Workforce and Organisational Development
July 2019

RCD Harrogate and District NHS Fou

METRIC	INDICATOR
1	Percentage of staff in AfC paybands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce. The data for this Metric should be a snapshot as at 31 March 2019

2	**Relative likelihood of Disabled staff compared to non-disabled staff being appointed from shortlisting across all posts.** Note: i) This refers to both external and internal posts. ii) If your organisation implements a guaranteed interview scheme, the data may not be comparable with organisations that do not operate such a scheme. This information will be collected on the WDES online reporting form to ensure comparability between organisations.
3	**Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure.** Note: i) This Metric will be based on data from a two-year rolling average of the current year and the previous year (2017/18 and 2018/19). ii) This Metric is voluntary in year one.
4	**a) Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from:** i. Patients/service users, their relatives or other members of the public ii. Managers iii. Other colleagues **b) Percentage of Disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it. The data for this Metric should be a snapshot as at 31 March 2019**
5	**Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion.**
6	**Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.**

7	**Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.**
8	**Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.**
9a	**a) The staff engagement score for Disabled staff, compared to non-disabled staff and the overall engagement score for the organisation.**
9b	**b) Has your Trust taken action to facilitate the voices of Disabled staff in your organisation to be heard? (yes) or (no)** Note: For your Trust's response to b) If yes, please provide at least one practical example of current action being taken in the relevant section of your WDES annual report. If no, please include what action is planned to address this gap in your WDES annual report. Examples are listed in the WDES technical guidance.
10	**Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated:** • By Voting membership of the Board **The data for this metric should be a snapshot as of 31st March 2019**

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DATA ITEM	
	1a) Non Clinical Staff
1	Bands 1
2	Bands 2
3	Bands 3
4	Bands 4
5	Bands 5
6	Bands 6
7	Bands 7
8	Bands 8a
9	Bands 8b
10	Bands 8c
11	Bands 8d
12	Bands 9
13	VSM
14	Other
15	Cluster 1 (Bands 1 - 4)
16	Cluster 2 (Band 5 - 7)
17	Cluster 3 (Bands 8a - 8b)
18	Cluster 4 (Bands 8c - 9 & VSM)
	1b) Clinical Staff
19	Bands 1
20	Bands 2
21	Bands 3
22	Bands 4
23	Bands 5
24	Bands 6
25	Bands 7
26	Bands 8a
27	Bands 8b
28	Bands 8c
29	Bands 8d
30	Bands 9
31	VSM
32	Medical & Dental Staff, Consultants
33	Medical & Dental Staff, Non-Consultants career grade
34	Medical & Dental Staff, Medical and dental trainee grades
35	Other
36	Cluster 1 (Bands 1 - 4)
37	Cluster 2 (Band 5 - 7)
38	Cluster 3 (Bands 8a - 8b)
39	Cluster 4 (Bands 8c - 9 & VSM)
40	Cluster 5 (Medical & Dental Staff, Consultants)

41	Cluster 6 (Medical & Dental Staff, Non-Consultants career grade)
42	Cluster 7 (Medical & Dental Staff, Medical and dental trainee grades)
43	Number of shortlisted applicants
44	Number appointed from shortlisting
45	Relative likelihood of shortlisting/appointed
46	Relative likelihood of Disabled staff being appointed from shortlisting compared to Non-Disabled staff
47	Number of staff in workforce
48	Number of staff entering the formal capability process
49	Likelihood of staff entering the formal capability process
50	Relative likelihood of Disabled staff entering the formal capability process compared to Non-Disabled staff
51	% of staff experiencing harassment, bullying or abuse from patients/service users, their relatives or other members of the public in the last 12 months
52	% of staff experiencing harassment, bullying or abuse from managers in the last 12 months
53	% of staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months
54	% of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it in the last 12 months
55	% of staff believing that the Trust provides equal opportunities for career progression or promotion.
56	% of staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.

57	% staff saying that they are satisfied with the extent to which their organisation values their work.
58	% of disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.
59	The staff engagement score for Disabled staff, compared to non-disabled staff and the overall engagement score for the organisation.
60	Has your Trust taken action to facilitate the voices of Disabled staff in your organisation to be heard? (yes) or (no)
61	Total Board members
62	*of which: Voting Board members*
63	*: Non Voting Board members*
64	Total Board members
65	*of which: Exec Board members*
66	*: Non Executive Board members*
67	Number of staff in overall workforce
68	Total Board members - % by Disability
69	Voting Board Member - % by Disability
70	Non Voting Board Member - % by Disability
71	Executive Board Member - % by Disability
72	Non Executive Board Member - % by Disability
73	Overall workforce - % by Disability
74	Difference (Total Board - Overall workforce)
75	Difference (Voting membership - Overall Workforce)
76	Difference (Executive membership - Overall Workforce)

v2.0

	DISABLED				
	Total Disabled		% Disabled / ratio		Total Not
MEASURE	Pre-Populated	Verified data	Pre-Populated	Verified data	Pre-Populated
Headcount	1	0	3%	0%	13
Headcount	15	7	5%	8%	234
Headcount	6	0	3%	0%	181
Headcount	1	0	1%	0%	92
Headcount	0	0	0%	0%	63
Headcount	2	2	4%	5%	40
Headcount	0	0	0%	0%	32
Headcount	0	0	0%	0%	28
Headcount	2	2	9%	11%	18
Headcount	0	0	0%	0%	4
Headcount	0	0	0%	0%	7
Headcount	0	0	0%	0%	0
Headcount	0	0	0%	0%	3
Headcount	0	1	0%	20%	2
Total	23	7	3%	4%	520
Total	2	2	1%	2%	135
Total	2	2	4%	4%	46
Total	0	0	0%	0%	14
Headcount	0	0	0%	0%	4
Headcount	16	23	4%	4%	331
Headcount	10	14	3%	3%	246
Headcount	3	4	1%	1%	167
Headcount	20	25	3%	3%	588
Headcount	29	30	3%	3%	759
Headcount	15	15	4%	4%	269
Headcount	4	4	4%	4%	62
Headcount	1	1	9%	9%	9
Headcount	0	0	0%	0%	4
Headcount	0	0	0%	0%	0
Headcount	0	0	0%	0%	0
Headcount	0	2	0%	50%	8
Headcount	2	1	1%	1%	97
Headcount	0	2	0%	1%	54
Headcount	2	0	1%	0%	117
Headcount	0	0	0%	0%	42
Total	29	41	3%	3%	748
Total	64	70	3%	3%	1616
Total	5	5	5%	5%	71
Total	0	2	0%	18%	12
Total	2	1	1%	1%	97

Total	0	2	0%	1%	54
Total	2	0	1%	0%	117
Headcount		207			
Headcount		37			
Auto-Populated		0.18			
Auto-Populated				1.26	
Headcount		133			
Headcount		2			
Auto-Populated		0.02			
Auto-Populated				13.18	
Number of Respondents/%	234	234	32.1%	32.1%	1052
Number of Respondents/%	232	232	19.4%	19.4%	1049
Number of Respondents/%	229	229	27.1%	27.1%	1044
Number of Respondents/%	102	56	49.0%	51.0%	324
Number of Respondents/%	163	163	83.4%	83.4%	704
Number of Respondents/%	157	157	28.0%	28.0%	503

Number of Respondents/%	233	233	43.3%	43.3%	1051
Number of Respondents/%	136	136	72.1%	72.1%	
Number of Respondents/Score	235	235	6.9	6.9	1060
(yes) or (no)		Yes			
Headcount		0			
Headcount		0			
Auto-Populated		0			
Auto-Populated		0			
Headcount		0			
Auto-Populated		0			
Headcount		133			
Auto-Populated		0%			
Auto-Populated		0%			
Auto-Populated		0%			
Auto-Populated		0%			
Auto-Populated		0%			
Auto-Populated		3%			
Auto-Populated		-3%			
Auto-Populated		-3%			
Auto-Populated		-3%			

31st MARCH 2019					
NON-DISABLED			DISABILITY UNKNOWN OR NU		
Disabled	% Not Disabled / ratio		Total Unknown or Null		% Unknown
Verified data	Pre-Populated	Verified data	Pre-Populated	Verified data	Pre-Populated
0	37%	0%	21	1	60%
72	71%	82%	80	9	24%
43	77%	81%	49	10	21%
30	74%	88%	32	4	26%
48	81%	84%	15	9	19%
31	75%	78%	11	7	21%
22	78%	81%	9	5	22%
27	90%	90%	3	3	10%
15	82%	79%	2	2	9%
3	67%	60%	2	2	33%
5	100%	100%	0	0	0%
0	0%	0%	0	0	0%
9	75%	82%	1	2	25%
4	100%	80%	0	0	0%
145	72%	82%	182	24	25%
101	78%	81%	35	21	20%
42	87%	86%	5	5	9%
17	82%	81%	3	4	18%
0	80%	0%	1	0	20%
420	78%	79%	75	87	18%
357	80%	80%	52	74	17%
230	71%	70%	66	94	28%
625	82%	82%	106	116	15%
774	76%	75%	215	222	21%
285	71%	71%	96	102	25%
70	68%	70%	25	26	27%
9	82%	82%	1	1	9%
4	80%	80%	1	1	20%
0	0%	0%	1	1	100%
0	0%	0%	1	1	100%
1	89%	25%	1	1	11%
114	67%	71%	45	46	31%
144	68%	74%	25	49	32%
151	84%	81%	20	36	14%
12	82%	86%	9	2	18%
1007	77%	77%	194	255	20%
1684	77%	77%	417	440	20%
79	70%	71%	26	27	25%
5	75%	45%	4	4	25%
114	67%	71%	45	46	31%

144	68%	74%	25	49	32%
151	84%	81%	20	36	14%
3651					
823					
0.23					
3505					
4					
0.00					
1052	22.8%	22.8%			
1049	10.4%	10.4%			
1044	14.8%	14.8%			
183	47.5%	47.0%			
704	91.8%	91.8%			
503	21.1%	21.1%			

1051	52.0%	52.0%			
1060	7.2	7.2			
10				3	
4				2	
6				1	
10				3	
4				2	
6				1	
3505				913	
77%				23%	
67%				33%	
86%				14%	
67%				33%	
86%				14%	
77%				20%	
0%				3%	
-10%				13%	
-10%				13%	

LL	OVERALL STAFF	
or Null / ratio	Total	
Verified data	Pre-Populated	Verified data
100%	35	1
10%	329	88
19%	236	53
12%	125	34
16%	78	57
18%	53	40
19%	41	27
10%	31	30
11%	22	19
40%	6	5
0%	7	5
0%	0	0
18%	4	11
0%	2	5
14%	725	176
17%	172	124
10%	53	49
19%	17	21
0%	5	0
16%	422	530
17%	308	445
29%	236	328
15%	714	766
22%	1003	1026
25%	380	402
26%	91	100
9%	11	11
20%	5	5
100%	1	1
100%	1	1
25%	9	4
29%	144	161
25%	79	195
19%	139	187
14%	51	14
20%	971	1303
20%	2097	2194
24%	102	111
36%	16	11
29%	144	161

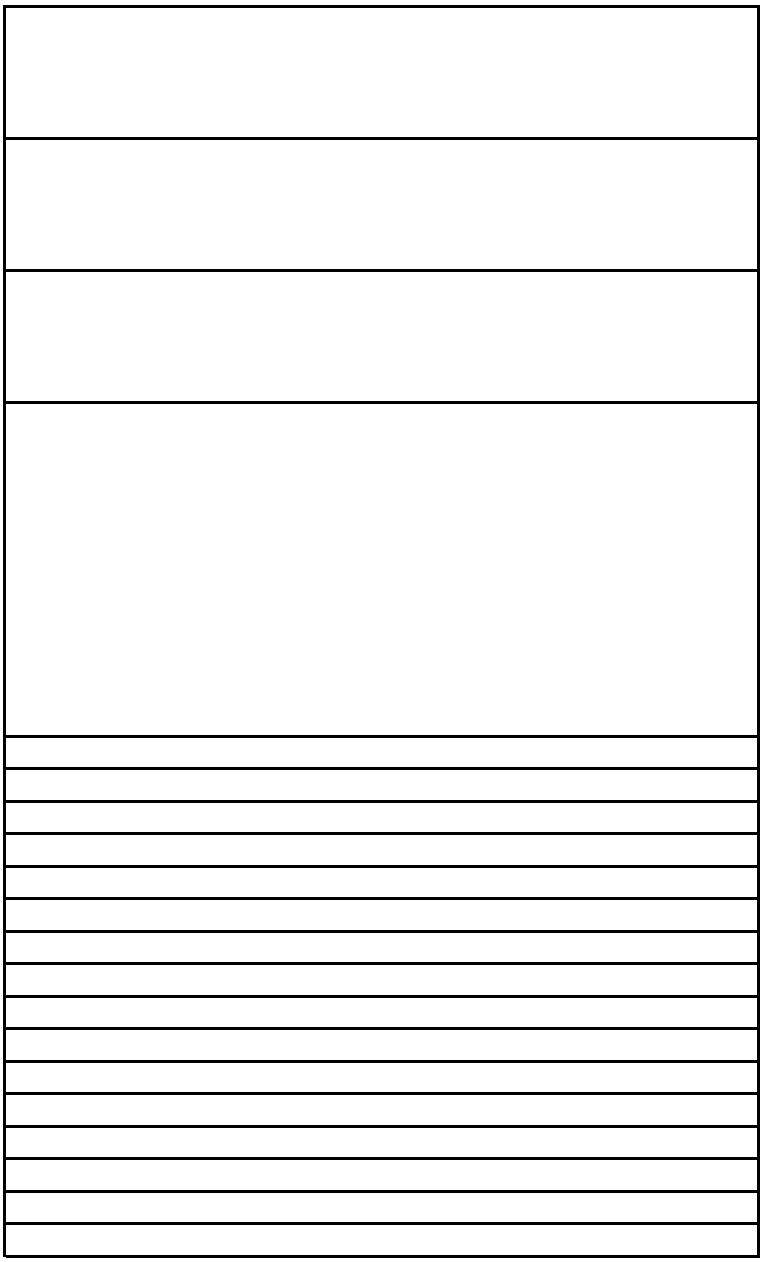
25%	79	195
19%	139	187

	7.2	7.2
	13	
	6	
	7	
	13	
	6	
	7	
	4551	

Notes

6.13

A figure below 1:00 indicates that Disabled staff are more likely than Non-Disabled staff to be appointed from shortlisting.
A figure above 1:00 indicates that Disabled staff are more likely than Non-Disabled staff to enter the formal capability process.



Harrogate and District NHS Foundation Trust

Date of Meeting:	31 July 2019	**Agenda item:**	8.0
Report to:	Board of Directors		
Title:	Board of Directors Terms of Reference		
Sponsoring Director:	Mrs Angela Schofield, Chairman		
Author(s):	Mr Andrew Forsyth, Interim Company Secretary		
Report Purpose:	**Decision** ✓ **Discussion/ Consultation** **Assurance** **Information**		
Executive Summary:	• The Board of Directors has Terms of Reference which require annual review. • The Board last considered the draft Terms of Reference in July 2018 • The amendments which have been proposed are minor in nature – two versions are presented for consideration, one showing the proposed changes and the other the Terms of Reference with the proposals incorporated.		

Related Trust Objectives

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

Key implications	
Risk Assessment:	None identified.
Legal / regulatory:	The Board is required to have terms of reference to support the legal requirements outlined in the constitution and standing orders.
Resource:	None identified.
Impact Assessment:	Not applicable.
Conflicts of Interest:	None identified.
Reference documents:	Board Terms of Reference
Assurance:	Not applicable, this matter is reserved to the Board.

Action Required by the Board of Directors:

It is recommended that the Board **considers** and **approves** the updated Terms of Reference.

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Harrogate and District NHS Foundation Trust

Harrogate and District NHS Foundation Trust Board of Directors

Terms of Reference

1. Introduction

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

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

2. Membership

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

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

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

2.3 The Deputy Chief Executive shall be selected from the Executive Director cohort. This role is currently filled by the Director of Finance.

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

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

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

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3.0 Voting

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

4. Quorum

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

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

5. Frequency

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

6.0 Notice of Meetings

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

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

6.3 The agenda of the Board of Director meetings held in public shall be forwarded to the Council of Governors prior to the meeting, and the agenda, minutes and supporting papers are to be made available publicly on the Trust's website at least three working days before the meeting.

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

7.0 Meetings Administration

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

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

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

8.0 Main Responsibilities

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

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

8.2.1 The strategic direction of the Trust;

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

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

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

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

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

9.0 Duties

9.1 Leadership and Culture. The Board:

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

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

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

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

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

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

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

9.2 Strategy. The Board:

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

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

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

9.3 Quality and Performance. The Board:

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

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

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

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

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

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

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

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

9.1.9 Ensures that the organisation promotes clinical research.

9.4 Finance. The Board:

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

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

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9.5 Governance. The Board:

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

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

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

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

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

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

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

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

9.5.11 Maintains oversight of the Trust's wholly owned subsidiary company (Harrogate Healthcare Facilities Management).

9.6 Risk Management and Internal Control. The Board:

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

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

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

9.7 Communication and Engagement. The Board:

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

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

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

11. Review and revision

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

Approved July 2019

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11. Review and revision

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

Approved July ~~2018~~2019

Harrogate and District NHS Foundation Trust

Date of Meeting:	31 July 2019	**Agenda item:**	9.1
Report to:	Board of Directors		
Title:	Insert title of the paper		
Sponsoring Director:	Robert Harrison, Chief Operating Officer		
Author(s):	Sally Bell, Senior Assurance Manager NHS England		
Report Purpose:	**Decision** ✓ **Discussion/ Consultation** ✓ **Assurance** ✓ **Information** ✓		
Executive Summary:	• The key focus of the planning for the UCI 2019 event is to ensure that the Trust is able to operate as business as usual as much as practicably possible during the event. • Plans have been put in place to mitigate the risk of staff not being able to get into their place of work due to the event. A policy has been drafted to assist staff and managers with their travel planning. • A command and control structure has been put in place to ensure the resilience of the Trust during this period. • Local authorities and partnerships have been consulted throughout the planning and a complete Health Plan has been established to support the Trust and partnership organisations throughout the event.		
Related Trust Objectives			
To deliver high quality care ✓	**To work with partners to deliver integrated care:** ✓	**To ensure clinical and financial sustainability:** ✓	
Key implications			
Risk Assessment:	There is a risk to business as usual during the event, with a particular risk to staff attendance due to travel disruption. The event poses a risk to the Trust as there will be road closures in the area which will have an impact on the following; - Patient access and egress - Staff access and egress - Patient presentation at ED and GPOOH (it is expected that there will be a surge in attendance during the evenings and following the end of the event. This report is being presented to Board to seek assurance regarding the processes and documentation that has been put in place to support the UCI 2019 event.		
Legal / regulatory:	Compliance with the Civil Contingencies Act (2004) and NHS England EPRR guidance and supporting materials including: NHS England Core Standards for Emergency Preparedness, Resilience & Response (EPRR) and NHS England Business Continuity Management Framework (service resilience)		
Resource:	We are expecting that there will be a financial impact on the Trust due to the UCI 2019 event. We are currently working through the costings for this. We do not expect to have a final cost implication for this event until after September 2019.		

7.1

Harrogate and District NHS Foundation Trust

Impact Assessment:	An impact assessment has been completed for this event. The main risks identified are; - Risk to the performance of the Trust. - Risk to patient safety - Risk to reputation of the Trust
Conflicts of Interest:	None Identified
Reference documents:	Please refer to UCI 2019 Special Event Travel Policy for further information.
Assurance:	Operational Delivery Group has been receiving weekly briefs regarding planning progress and have been appraised of the issues and challenges faced throughout the planning.
Action Required by the Board of Directors:	
The Board of Directors is requested to: • **review** the plans and **comment** as appropriate, in particular on the governance arrangements between the CCG and local authorities with regards to the planning.	

UCI World Road Cycle Championships September 2019

1. Purpose

This paper has been written to inform the Board about preparations, plans and assurance mechanisms in place for the Trust and wider NHS in advance of the UCI 2019 World Road Cycle Championships to be held in Harrogate from 21st to 29th September 2019.

It provides an update on the following areas:

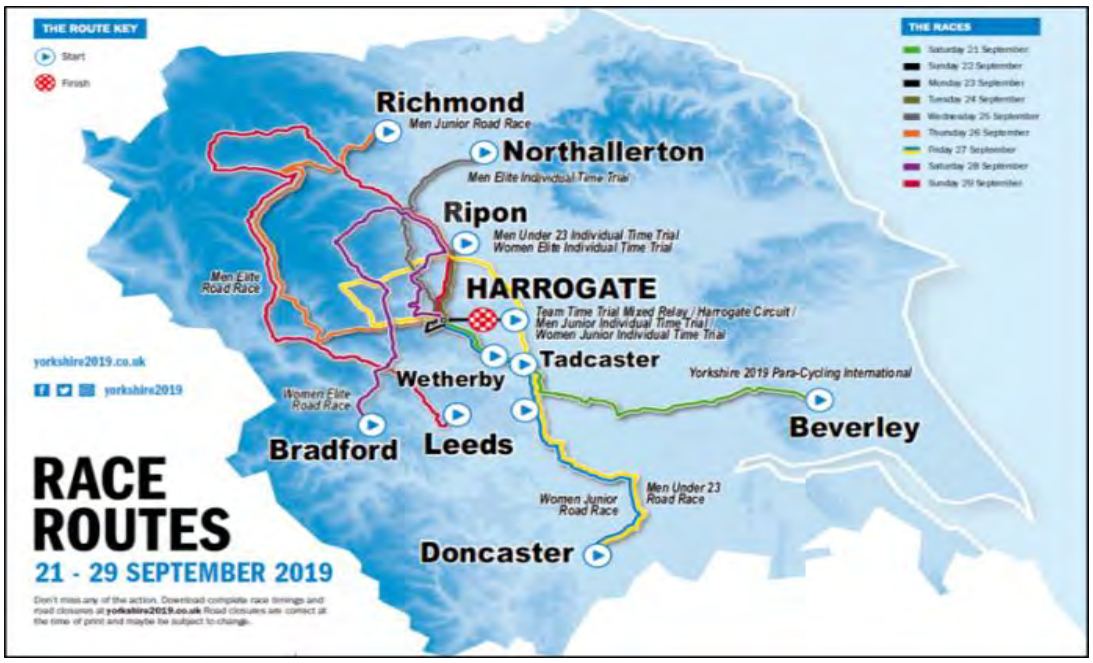
- Race background
- Governance and assurance processes
- Communications and media
- Future actions

2. Race Background

Over the past six years Harrogate District Foundation Trust has worked with NHS organisations and local partners across Yorkshire and the Humber to plan and mitigate risks that could impact on NHS services for a number of national and international cycling events.

The key difference for the 2019 UCI Road World Championships is that Harrogate is the finishing venue and at the centre of the event over a nine -day period. As well as rolling road closures across North Yorkshire, there are full road closures for a number of hours on most days.

The map below provides an overview of the race starts noting that the majority are in North Yorkshire, with race starts in North Allerton, Richmond and Ripon.



Summary of races by day

Day	Date	Race	Commentary
1	Saturday 21	Yorkshire 2019 Para-Cycling International	Impact in the afternoon and early evening in Harrogate
2	Sunday 22	Team Time Trial Mixed Relay and the Sportive	2 circuits Landlocked area in Harrogate Three separate races involving members of the public of mixed ability.
3	Monday 23	Women Junior Individual Time Trial and Men Junior Individual Time Trial	Landlocked area in Harrogate affected through the day
4	Tuesday 24	Under 23 Men Time Trial and Women Elite Individual Time Trial	Impact on Ripon Hospital Landlocked area in Harrogate during the day
5	Wednesday 25	Men Elite Time Trial	No circuits – impact on Harrogate afternoon and early evening
6	Thursday 26	Men Junior Road Race and	Landlocked area in Harrogate during the day
7	Friday 27	Women Junior Road Race Men U23 Road Race	Landlocked area in Harrogate Schools close an hour earlier this afternoon Race passes Harrogate Hospital
8	Saturday 28	Women Elite Road Race	Landlocked area in Harrogate Expecting high numbers of spectators
9	Sunday 29	Men Elite Road Race	Landlocked area in Harrogate Expecting high number of spectators

The UCI 2019 website: https://worlds.yorkshire.com/ provides detailed information about each of the race days.

The map below shows the Harrogate Circuit which is landlocked at different on a number of the event days.

3. Governance and assurance processes

Up to May 2019, NHS update meetings for the UCI 2019 had taken place between NHS England and local NHS organisations to include Trust and CCG staff with responsibility for Emergency Planning Resilience and Response (EPRR).

In May 2019 Sarah Tomlinson, Head of EPRR, (Yorkshire and the Humber) agreed to provided dedicated support by assigning Sally Bell, Senior Assurance Manager from NHS England and Improvement to chair the Harrogate Health and Social Care System Planning Group and support the development of a local health plan.

Since May 2019 this system -wide group has been meeting with the brief to produce a system-wide plan that plan together with a risk assessment and an equality and quality impact assessment.

The objectives of this plan are to:

1. Ensure patients continue to receive high quality care and to minimise the impact of the UCI 2019, associated and concurrent events
2. Ensure spectators are kept safe and able to access appropriate healthcare if required
3. Assist multi agency partners in delivering a successful event through minimising the implications for health and provide enhanced support where necessary
4. Enable healthcare organisations to plan appropriately to minimise disruption from the UCI 2019
5. Ensure consistent sharing of relevant information to health partners, their staff and patients

6. Influence multi-agency partners to ensure health concerns and opportunities are considered as part of the planning process
7. Ensure plans for responding to incidents during UCI 2019 are appropriate and reflect any increased risk ratings
8. Establish the command, control and communications arrangements for health during UCI 2019

Through the initial assessment of risks that will impact on the delivery of safe healthcare the following areas have been identified as requiring mitigation plans:

1. Patient and staff access
2. Patient and staff egress
3. Sustainability of services over a nine- day period
4. Pharmacy and supply chain
5. Potential surges for services in the evening and both weekends
6. Understanding of the differences between the Tour de Yorkshire and this event where detailed travel plans will be required because of its duration

An outline NHS plan was produced for the Group so that it could be tested at the North Yorkshire County Council Exercise 'Rainbow Rose' held on 13th June 2019 which was to test multi-agency plans. The exercise was planned to take place 101 days before the start of the event with 180 delegates from across Yorkshire attending to include police, fire and rescue, Yorkshire Ambulance Service, local Authorities, NHS organisations– acute services, community services, CCG.

3.1 Progress to date

The plan is underpinned by a project plan detailed below:

Harrogate UCI Health & Social Care Plan Project Plan 2019

Group membership has named representation from each Directorate and team and has also been extended to include a practice manager and GP representation.

A single point of contact has been established through an email address for all staff to use throughout the planning of this event. It is: uci2019@hdft.nhs.uk

Since May, weekly management briefs have been produced by the Chair of the Planning Group to ensure Directors and senior managers are informed of progress as well as plans to mitigate risks. They have been discussed at the weekly Organisational Delivery Group meeting. The briefing papers will continue to be produced up to the start of the event.

A revised staff travel policy has been developed for this event that has been circulated to members of the Operational Delivery Group and approved by the Trust Policy Advisory Group in July 2019.

A briefing paper for Harrogate District Foundation Trust Board and each of the North Yorkshire CCG Governing Bodies have been produced to ensure all local NHS organisations are aware of preparations and they are endorsed through local governance mechanisms.

The final system plan will be completed before the end of August 2019 and it will require sign off by the Chief Executive and Chief Operating Officer (as Accountable Officer and Accountable Emergency Officer respectively) in conjunction with their respective colleagues in the North Yorkshire CCGs. This will then be presented to the North Yorkshire LHRP on 3rd September 2019.

In addition, the four Yorkshire and Humber Local Health Resilience Partnership Boards (LHRPs) have been provided with an overview of the event at their meetings in May and June 2019. In June all NHS organisations in Yorkshire and the Humber received a communication bulletin together with a business continuity check list for all organisations to undertake a self- assessment.

In support of the additional anticipated pressures on Yorkshire Ambulance Service a memo was sent out from NHS England and Improvement to all NHS EPRR Leads and chief operating officers for acute hospital services to advise them about the Yorkshire Ambulance activity forecasting. Modelling data that suggests that over the 2-week period Yorkshire Ambulance Service will experience a 4.5-8% increase in demand.

NHS England and Improvement have asked healthcare systems across Yorkshire to undertake a review of local plans to mitigate known pressure points with a particular focus on weekend staffing and ambulance handover delays for the duration of this event.

NHS England and Improvement are preparing a Yorkshire and Humber Plan that will be informed by assurance provided by NHS systems to that includes their command and control arrangement for the duration of the event.

3.2 Work in progress

The timetable below details work currently being undertaken by the Health Planning Group

July 23rd	Command and control and governance arrangements
August 15th	Briefing about Every Hour Matters and review risks
August 29th	Final mitigation plans and communication update and arrange debrief
September 3rd	Attend Multi-agency test at 'Exercise Traffic'
September 12th	Health Table top exercise

4.Communications and media plans

On 14th June 2019 a media campaign began with the 100 day count down to the start of the event. Harrogate District Acute Hospital and Communication the CCG and Teams are

working together to produce a local communications plan which is aligned to the UCI 2019 Communication team and NHS England's communication strategy.

Areas the communication team have asked lead managers to note are:

- Staff and patient on-site communications – *encouraging all staff to use the intranet site*
- Staff and patient out of hospital communications – *messaging - posters and information boards*
- Public communications – *which includes pharmacist, dentist, opticians, care and nursing homes*

A patient information letter written by the Trust's Planning Team has been circulated to all members of the Health and Social Care Planning Group and made available to general practice through the UCI 2019 Hospital intranet pages. These pages include school closure information. To ensure consistent and up to date information about the event the communications strategy is also to continue to sign post staff and patients to the UCI 2019 website. https://worlds.yorkshire.com/

4. Future actions

The UCI 2019 Health and Social Care Plan will be agreed at the Harrogate A&E Delivery Boards in August 2019.

This will then be submitted to the Trust Board and 3 NY CCGs Governing Bodies for approval.

The learning from this event will be shared following a debrief event which is planned for early October 2019. This will include the financial implications and impact the event has had on Harrogate District Foundation Trust as well as the three North Yorkshire CCGs.