NHS
Harrogate and District
NHS Foundation Trust

Board of Directors Meeting (to be held in public)
will be held on Wednesday, 27 May 2020 from 9.00am
in the Boardroom, Trust Headquarters
(via video conferencing)

AGENDA

Item No.	Item	Lead	Action	Paper
1.0	**Welcome and Apologies for Absence**	Chairman	Note	Verbal
2.0	**Declarations of Interest and Register of Interests** *To declare any new interests and any interests in relation to open items on the agenda*	Chairman	Note	**Attached**
3.0	**Minutes of the Previous Board of Directors meeting held on 29 April 2020**	Chairman	**Approve**	**Attached**
4.0	**Matters Arising and Action Log**	Chairman	Discuss	Verbal **Attached**
5.0	**Overview by the Chairman**	Chairman	Discuss	Verbal
6.0	**Chief Executive Report**	Chief Executive	Discuss	**Attached**
7.0	**Integrated Board Report**	Executive Directors	Discuss/ Note	**Attached**
7.1	**Covid-19 Assurance Report**	Chief Operating Officer		**Attached**
7.2	**Operational Performance Report**	Chief Operating Officer		**Attached**
7.3	**Chief Nurse Report including IPC Assurance**	Chief Nurse		**To Follow**
7.4	**Medical Director Report**	Medical Director		**Attached**
7.5	**Workforce and Organisational Development Update Report**	Director of Workforce & OD		**Attached**
7.5.1	**Diverse Representation in Decision Making and Workforce Equality**	Director of Workforce & OD		**To Follow**
7.6	**Finance Report including Revised Operational Plan**	Director of Finance		**Attached**
8.0	**Learning from Deaths (Q4) Report**	Medical Director	Note	**Attached**

You matter most

9.0	**NHS Provider Licence Annual Self-assessment**	Chief Executive	Note/ Approve	**Attached**
10.0 **10.1** **10.2** **10.3** **10.4**	**Reports from Committee Chairs:** Quality Committee – 1 April 2020 Quality Committee – 6 May 2020 Audit Committee – 25 April and 5 May 2020 Resource Committee – 25 May 2020	Committee Chairs	Note	 **Attached** **Attached** **Attached** **To Follow**
11.0	**Any other Business** *By permission of the Chairman*	Chairman	Note/ Discuss/ **Approve**	Verbal
14.0	**Board Evaluation**	Chairman	Discuss	Verbal
15.0	**Date and Time of next meeting** Wednesday, 24 June 2020 at 9.00am			
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.*				

In light of the Government's guidelines in relation to COVID-19, Harrogate and District NHS Foundation Trust has taken a decision to not hold meetings of the Board of Directors in Public whilst the guidance on social distancing is in place. Board meetings will be held virtually and the Trust's Governors will have the opportunity to observe these meetings.

The minutes and papers will continue to be published on the Trust website. This decision will be reviewed as the guidance evolves with further communication published on the Trust's website in due course.

Details of the Government response can be found at: https://www.gov.uk/government/topical-evetns/cooronavirus-cofid-19-uk-government-response

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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 on 1 March 2020.

Name	Position	Interests Declared
Ms Sarah Armstrong	Non-Executive 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) 2. Company director for the flat management company of current residence 3. 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)
Mr Jeremy Cross	Non-Executive Director	1. Chairman, Mansfield Building Society 2. Chairman, Headrow Money Line Ltd 3. Director and Shareholder, Cross Consulting Ltd (dormant) 4. Trustee – Forget me not children's hospice, Huddersfield 5. Governor – Grammar School at Leeds 6. Director, GSAL Transport Ltd
Mrs Jill Foster	Chief Nurse	None
Mr Robert Harrison	Chief Operating Officer	1. Charity Trustee of Acomb Methodist Church, York 2. Chair of Directors of Strategy and Operations WYAAT 3. Harrogate Place representative on the WY&H Cancer Alliance Board 4. Member of the Harrogate and Rural Alliance Board 5. Director of ILS and IPS Pathology Joint Venture (from 1 October 2019)
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.

Mr Andrew Papworth	Non-executive Director	1. Director of People Insight and Cost at Lloyds Banking Group
Ms Laura Robson	Non-Executive Director	1. Familial relationship with Alzheimer's Society
Mr Steve Russell	Chief Executive	None
Mr Wallace Sampson OBE	Non-executive Director	1. Chief Executive of Harrogate Borough Council.
Mrs Angela Schofield	Chairman	1. Member of WYAAT Committee in Common 2. Vice-Chair, West Yorkshire and Harrogate ICS Partnership 3. Volunteer with Supporting Older People (charity). 4. Chair of NHSE Northern Region Talent Board
Dr David Scullion	Medical Director	1. Member of the Yorkshire Radiology Group 2. Familial relationship 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. 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
Ms Angela Wilkinson	Director of Workforce and Organisational Development	1. Director of ILS and IPS Pathology Joint Venture (from 1 October 2019)

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
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	1. Member, WYAAT Temporary Staffing Cluster Group
Mr Paul Nicholas	Deputy Director of Performance and Informatics	None
Ms Shirley Silvester	Interim Deputy Director of Workforce and Organisational Development	None
Dr Sylvia Wood	Deputy Director of Governance & Freedom to Speak Up Guardian	1. Familial relationship with Medical Director

Harrogate and District NHS
NHS Foundation Trust

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Board of Directors Meeting (held in Public)

29 April 2020 at 9am

in the Boardroom, Trust Headquarters, Harrogate District Hospital

In order to comply with the restrictions on social distancing due to the Coronavirus Covid-19 pandemic, the meeting was held by video conference.

Present
Mrs Angela Schofield, Chairman
Ms Sarah Armstrong, Non-executive Director
Mr Jeremy Cross, Non-executive Director
Mr Andy Papworth, Non-executive Director
Ms Laura Robson, Non-executive Director/Senior Independent Director
Mr Richard Stiff, Non-executive Director
Mrs Maureen Taylor, Non-executive Director
Mr Wallace Sampson OBE, Non-executive Director (*from item BoD/04/02/20/7.9*)
Mr Steve Russell, Chief Executive
Mr Jonathan Coulter, Finance Director/Deputy Chief Executive
Mrs Jill Foster, Chief Nurse
Mr Robert Harrison, Chief Operating Officer
Dr David Scullion, Medical Director
Ms Angela Wilkinson, Director of Workforce and Organisational Development

In attendance
Ms Lynn Hughes, Interim Company Secretary
Dr Kat Johnson, Clinical Director for Planned and Surgical Care Directorate
Dr Natalie Lyth, Clinical Director for Children's and County Wide Community Services Directorate
Dr Matt Shepherd, Clinical Director for Long Term Conditions and Unscheduled Care Directorate

Observing
Mrs Claire Cressey, Lead Governor

BoD/04/20/01 **Welcome and Apologies for Absence**

1.1 The Chairman welcomed members to the meeting which was held by video conferencing facility to comply with the restrictions on social distancing due to the Coronavirus Covid-19 pandemic. The papers are shared with Governors and made available to members of the public via the Trust's website and Council of Governors are able to observe the meeting by video conferencing or the teleconference facility. The Chairman reminded members that in view of the circumstances of the need to focus attention on the management of Covid-19 it would be assumed that all papers had been read and that any questions and comments would relate to immediate issues.

1.2 There were no apologies for absence.

BoD/04/20/02 **Declarations of Interest and Register of Interests**

2.1 It was noted that Mr Coulter and Ms Armstrong are Directors of Harrogate Integrated Facilities (HIF). Mr Sampson is Chief Executive of Harrogate Borough Council.

2.2 There were no interests declared in relation to open agenda items.

BoD/04/20/3 **Minutes of the Meeting held on 12 February 2020**

3.1 **Resolved:** the minutes were agreed as a correct record subject to 9.1 should read the Trust was on track to achieve its adjusted plan and allowable offset against its control total.

BoD/04/20/4 **Matters Arising and Action Log**

4.1 **Matters Arising**

There were no matters arising in addition to those included on the agenda.

4.2 **The Action Log**

All completed actions were agreed to be closed. Open actions with due deadline dates were discussed in turn:

Ref 12.2 Advance Care Planning – It was noted that there are interim measures in place during Covid and an RPIW would be carried out at an appropriate time. It was agreed to leave this action open.

Ref 13.3 Learning from Deaths Non-executive Director Lead – It was noted that the Chairman planned to discuss with Non-executive Directors and it was agreed to leave the action open.

BoD/04/20/5 **Overview by the Chairman**

5.1 The Chairman referred to the very sad news of Josiane Ekoli's death and on behalf of the Board paid sincere condolences to Josiane's family. The Board noted that the UK had held one minute silence to commemorate NHS staff and key workers who had died with coronavirus which was very moving.

5.2 All of the Non-executive members of the Board were very grateful for the dedication shown by staff working through the Covid-19 pandemic which has been outstanding in all areas of the organisation.

5.3 The Chairman reminded members that it was five weeks since the Board last met when they were updated on the plans in place to establish the Nightingale Hospital in London. Since then significant progress has been made with the development of a NHS Nightingale Hospital for Yorkshire and The Humber which has been mobilised in the Harrogate Convention Centre. The Chairman thanked the Chief Executive for taking on the Chief Executive role to lead the significant project in such a short space of time and thanked Mr Harrison for his work in supporting the project whilst also taking a lead on the Gold Command structure at the Trust. . She particularly commended Jonathan Coulter for his leadership as Acting Chief Executive during the period Steve Russell had been seconded to the Nightingale Hospital.

5.4 The Chairman explained she has continued to communicate with the Council of Governors through a variety of methods including weekly briefings and a conference call which proved most productive with 12

Governors managing to join and participate. Governors had been provided with nhs.net accounts to enable them to receive daily updates which are also communicated to staff and Non-executive Directors.

5.5 The HIF Chair recruitment campaign was underway with the support of GatenbySanderson and the Chairman was pleased to announce that Dr Jackie Andrews had been appointed as the Trust's Medical Director. Her date of commencement was under discussion but she was looking forward to working with her.

5.6 Ms Armstrong made reference to the Governors meeting which had gone very well and colleagues were working well together with the remote working arrangements in place. In response the Chairman confirmed that the Governors appreciated the time taken to update them during the Covid-19 pandemic.

5.7 **Resolved:** the Chairman's Overview was noted.

BoD/04/20/6 **Proposal to Establish a People and Culture Committee**

6.1 The Chairman explained that the Board agreed at its 29 January 2020 meeting that a People Committee should be established. This was in response to the need for the Board to oversee actions to support the Trust's values and to ensure that there is leadership and oversight arrangements in place for the culture required to sustain these values.

6.2 It was noted that at the outset it will be important for the Committee to focus on the basic features of the organisation culture which underpin the Trust's values, particularly regarding the care for all those who are employed by the Trust and to develop a framework for oversight which will include the identification of sources of information to support their workplan.

6.3 Membership of the Committee was agreed to include Mr Cross as Chair, Mr Papworth, Ms Armstrong and Ms Robson, Non-executive Directors; Steve Russell would be the lead executive director. Ms Wilkinson and Mrs Foster would also be members. The Committee would decide if others should attend meetings regularly or by invitation.

6.4 Draft Terms of Reference were received and it was agreed that the Terms of Reference of the People and Culture Committee will be finalised by the Committee and presented to the Board for approval.

6.5 **Resolved:**
i) the establishment of a People and Culture Committee was agreed which will report direct to the Board;
ii) the Chair and membership of the Committee were agreed.
iii) Terms of Reference of the People and Culture Committee will be finalised by the Committee and presented to the Board for approval.

BoD/04/20/7 **Chief Executive's Report**

7.1 The Chief Executive's report covered a retrospective view and a forward focussed view. Mr Coulter had been Acting Chief Executive for the past few weeks whilst Mr Russell had focused on the responsibilities of being the Chief Executive of the NHS Nightingale hospital in Harrogate.

7.2 Mr Coulter recorded his thanks to all colleagues in the Trust for their fantastic support over the last month and particularly his Executive colleagues who had supported him during this time.

7.3 Over the past month significant work has taken place to reorganise the site, to ensure staff are trained and working in areas of greatest need and that they are communicated with and equipped with PPE equipment in line with national guidance.

7.4 The Trust has provided significant support to the development of the NHS Nightingale hospital in Harrogate along with support from the NHS in Yorkshire and the Humber. Mr Coulter paid particular credit to Mr Russell for the significant and amazing achievement within such a short space of time.

7.5 He highlighted how well the NHS has worked together and the Trust had continued over the past month to work with local ICS's, the Local Resilience Forum, WYAAT, the NY SLE, and Commissioners in the North East.

7.6 The significant work that has taken place over the last month during Covid-19 pandemic had also some very sad outcomes with a number of deaths in hospital, and the loss of Josiane Ekoli's a member of the nursing profession who had worked regularly at Harrogate Hospital.

7.7 An annual review of the endoscopy service at the Trust has resulted in Joint Advisory Group accreditation for GI Endoscopy for another year until 7 February 2021. Mr Coulter commended all the staff at the endoscopy service for their continued hard work in achieving these standards.

7.8 The Trust has achieved its revised financial target for the year and will receive the final PSF payment. Mr Coulter was pleased to report that WY&H ICS as a whole has delivered against the ICS control total, which highlights the successful partnership working across the ICS during 2019/20.

Mr Sampson joined the meeting.

7.9 Risk - Detailed discussion took place around the risks that had been reviewed by the Corporate Risk Group and at the Director Team meeting to consider the operational risks and mitigations in place in relation to the Covid-19 pandemic. The updated summary Corporate Risk Register was discussed and noted.

7.9.1 Ms Wilkinson explained that additional support and resources had been put in place to support the health and wellbeing of staff.

Mr Samson and Ms Robson sought assurance around the plans in place to support employees and the mitigations in place if there is an additional peak. In response Mrs Foster explained that the Trust is open and honest with its workforce and were working to ensure plans were in place for the next 12 to 18 months to support people to ensure the highest standards of care is provided whilst supporting the health and wellbeing of staff. The Chairman explained that a Board workshop in the near future would enable further discussion and debate around the health and wellbeing support provided to staff.

7.9.2 Mrs Foster confirmed that additional support and advice is being offered to people who report that they feel at risk of domestic abuse. End of life support and palliative care is being increased in and out of the hospital setting with additional staff supporting community teams.

7.9.3 Plans are in place to manage the operational risks and the longer term strategic risks in the Board Assurance Framework would be developed over the coming weeks for the Board to consider through its next phase of operating in a different working environment.

7.10 **Going forward** – Mr Russell, Chief Executive paid thanks to everyone at the Trust who had been incredibly flexible and supportive of the necessary changes that have been made. The original assumption had been that there would be a steep peak of demand for critical care, and a potential breaching of critical care capacity at a regional level, but at this time the impact on critical care has been more limited than what was originally expected. The incident is now been accepted as a medium term issue and the Executive Team is considering what governance arrangements will need to be put in place to adjust to the medium term Covid pandemic period.

7.11 **Resolved:** the Chief Executive report was noted.

BoD/04/20/8 Board Assurance Report during Covid-19 Pandemic

8.1 **Integrated Board Report**

The Integrated Board Report for the month ending 31 March 2020 was noted.

8.2 Mrs Foster confirmed that the Trust continued its focus on meeting infection control standards for Covid and Non-covid patients. She advised that there had been one Serious Incident (SI) reported in February and one in March 2020 with no Never Events reported for the year-to-date.

8.3 It was noted that there has been Covid related complaints received from patients and staff which were being looked at and responded to as part of the Trust's routine processes. The Trust has experienced challenges with PPE with staff adjusting to different working practices with some staff feeling anxious about whether they have the right PPE. The Trust has ensured continued compliance to the changing national guidance and despite challenges has managed to provide sufficient levels of PPE to staff.

8.4 The Chairman queried what support is provided to the frail and elderly. In response Mrs Foster explained that the Trust's community services

have increased support to the frail and elderly in the community which includes care homes.

8.5 Ms Armstrong drew reference to the 4 hour Accident and Emergency standard and queried: i) if there had been any issues raised by people sitting near one another when waiting in the Accident and Emergency (A&E) department; and ii) if staff have received any advice on social distancing requirements for A&E. In response to Ms Armstrong's first query, Dr Shepherd explained that over the last month the Trust had seen on average a 50/60% reduction in A&E attendances. The increased patient safety and social distancing factors associated to providing care during Covid has proved challenging to meet the 4 hour target, despite the reduction in attendances. During Covid the Trust had seen patients being admitted straight onto wards and not waiting in A&E. Mr Harrison confirmed that performance against the 4 hour A&E target is 93.2% against the 95% target but noted that as the lockdown conditions change, admissions are likely to increase nationally which in turn will impact on the ability to see patient's within the target.

8.6 In response to Ms Armstrong's second query, the Chief Executive explained that the Trust follows current national guidance and further guidance is expected imminently on requirements to segregate into Covid and non-Covid areas. These changes will help to ensure services can be provided safely for patients and lower the risk of infection by reducing patient movement across services. A further update on the changes the Trust is making in response to national guidance will be provided to the Board going forward.

8.7 Mr Cross queried when the decrease of A&E attendances started. In response Mr Harrison confirmed that the decline was noted from the third week of March 2020. The Trust had continued to treat as many cancer patients as possible during March and April but there had been a 90% reduction in all primary care referrals in April in comparison to April 2019.

8.8 Mr Papworth queried if it is anticipated that there will be a shortage of staff against demand in some areas going forward. In response Mr Harrison explained that the national guidance is expected to describe how hospitals estates and services need to be provided for Covid and non-Covid areas. If necessary staff will be moved between these two areas.

8.9 **Resolved:** the IBR was noted.

BoD/04/20/9 **Quality and Patient Safety Report**

9.1 Mrs Foster spoke to the report which aimed to provide assurance around patient safety and quality of care during the response to the Covid 19 pandemic. The Board noted the report which included updates specifically around: i) End of Life Care; ii) Children's Safeguarding; iii) Adult Safeguarding; and iv) Incident Reporting in relation to Covid issues.

9.2 Mrs Foster drew reference to the children's service which forms part of the Community Service which has developed plans to support schools when they reopen.

9.3 **Resolved:** the Quality and Patient Safety Report was noted.

BoD/04/20/10 **Workforce Safety and Wellbeing Report**

10.1 Ms Wilkinson spoke to the Workforce Safety and Well-being report and drew reference to COVID19 - Workforce Planning and Supply. She emphasised that maintaining safe staffing levels throughout the duration of the pandemic is critical and the Trust is continuing its external recruitment activity through the usual channels, but is also actively pursuing other sources of workforce supply. There are 173 new starters planned to join the Trust in the near future and any emerging temporary workforce gaps, or new roles that are required as a result of alternative working are being filled by deployment of existing staff.

10.2 There were no questions raised. It was noted that there had been a full discussion at the Resource Committee around workforce.

10.3 **Resolved:** the Workforce Safety and Wellbeing report was noted.

BoD/04/20/11 **Finance Report**

11.1 The financial position in March 2020 was noted as a £960,000 surplus which has resulted in a year-end surplus of £682,000, £3.4m behind the original plan but in line with the revised target as agreed with the ICS and NHSI. The achievement of the revised total will result in receipt of PSF money for the year because the variance to original plan was offset within the ICS and as such was an agreed variance. The Use of Resources rating for the year-end is 2 as a result of the Trust not achieving its original plan. Risks and mitigations in relation to the achievement of the 2020/21 financial plan were discussed and noted which will impact on the strategic discussions that were previously taking place at Organisational, Place and System level.

11.2 Mr Sampson queried the reasoning behind the £6m over 90 days debt owed to the Trust and if these are in relation to small or a number of large debts; the plans in place to recover the debts owed and how this is planned to be described in the annual accounts. In response Mr Coulter explained that there were a number of large debts owed to the Trust and the Trust is in discussion with North Yorkshire CCG to resolve these.

11.3 Ms Robson queried the CIP position and if the Trust had added funds to some schemes if they were under achieving in order to support the year end position. In response Mr Coulter explained that no money had been used to support schemes, all schemes achieved their plans. The Board commended the work that had taken place to achieve the CIP 2019/20 target.

11.4 Ms Robson queried how the charitable funds raised by Captain Tom and others would be distributed amongst NHS providers. In response Mr Coulter explained that the Trust had received a considerable amount of charitable donations during Covid which included an amount from the national fund which was being managed by the National Association of NHS Charities. The Trust's Charitable Funds Committee will consider how the donations can be allocated.

11.5 **Resolved:** the finance report was noted.

BoD/04/20/12 **Reports from Committee Chairs**

12.1 **Resource Committee**

Mrs Taylor, Chair of Resource Committee spoke to the Chair's report from the meeting held on 27 April 2020 which was noted.

12.2 Mrs Taylor drew reference to the significant risks which were agreed to be reported to the Board which included the CoVID-19 risks; receivables that are over 60 days totalled circa £8m and the progress made to collect the outstanding sums owed.

12.3 **Resolved:** the Chair's report from the Resource Committee meeting held on 27 April 2020 was noted.

BoD/04/20/13 **Audit Committee**

13.1 Mr Stiff, Chair of the Audit Committee confirmed he had nothing to escalate to the Board.

BoD/04/20/14 **Quality Committee**

14.1 Ms Robson, Chair of Quality Committee reported on the meeting held on 1 April 2020. She advised that the Clinical Advisory Group had been meeting on a daily basis during Covid and it had been agreed that minutes of those meetings would be provided to Quality Committee going forward for information and assurance. Ms Robson asked the Board to note the reappointment of Dr Childs as the Director of Infection Prevention and Control (DIPC and that a DIPC report was planned to be provided to the Committee at its next meeting. The summary Chair's report would be included in the papers for the next Board meeting. **ACTION (L Hughes)**

14.2 **Resolved:** the Committee Chairs reports were noted from the Resource Committee held on 27 April 2020 and the Quality Committee held on 1 April 2020.

BoD/04/20/15 **Changes to Year End Reporting Arrangements**

15.1 It was noted that due to the current and estimated impact of Covid-19 NHSE/I have worked with the Department of Health and Social Care (DHSC) to amend arrangements for year-end accounts for 2019/20. It was noted that the Quality Report is no longer required to be included within the Annual Report. All NHS providers are still required to produce a Quality Account and DHSC is working to amend regulations to postpone the completion date to after 30 June 2020.

15.2 The revised completion and submission dates were noted which included the Trust's requirement to submit its Annual Report and Audited Accounts to NHSI by 25 June 2020. Audit Committee and the

Board would meet to consider the approval of these documents in advance of the submission date.

15.3 **Resolved:** the changes to the year-end reporting arrangements were noted.

BoD/12/20/16 **Any other Business**

16.1 There was no other business.

BoD/12/20/17 **Board Evaluation**

17.1 The Chairman welcomed feedback from Non-executive Director colleagues on how they felt the meeting had gone that day in addition to the facts presented and discussed. In response Mr Cross made reference to Mrs Foster's report and specifically how the Trust is supporting local Care Homes during Covid and he drew reference to the number of Care Homes locally which is above the national average and how important it is that the Trust has a role in supporting them during this unprecedented time.

17.2 The Chairman queried if the CCG had a role in supporting Care Homes during Covid. In response Mrs Foster confirmed that the CCG were also supporting the Nursing Homes.

17.3 It was noted that the meeting had enabled discussion and debate before any decision was reached.

Confidential Motion

Resolved: to exclude members of the press and public in accordance with the Health Services Act 2006 (Schedule 7 Section 18(E)) (as amended by the Health and Social Care Act 2012) and in view of publicity being prejudicial to the public interest.

NHS Harrogate and District NHS Foundation Trust

Board of Directors (held in Public) Action Log as at May 2020

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.

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Ref	Meeting Date	Item Description	Director/Manager Responsible	Completion date	Detail of progress
148	September 2019 (minute 9.6)	Overview of Trust Learning Disabilities policies and application. Agreed would be discussed at a Board workshop by the end of year. To be added to the Board workshop forward plan.	Mrs Foster, Chief Nurse Ms L Hughes, Interim Company Secretary	**November** 2020	Open (included on Board Workshop workplan for October 2020)
Actions from 29 January 2020 Meeting					
Ref	**Meeting Date**	**Item Description**	**Director/Manager Responsible**	**Completion date**	**Detail of progress**
12.2	29 January 2020 Medical Director Report	Advanced Care Planning update report would be circulated to the Board.	Dr D Scullion, Medical Director	**Date to be agreed**	Open (interim measures in place during Covid and an RPIW would be carried out at an appropriate time.)
13.3	29 January 2020 *Learning from Deaths Q3 19/20 Report*	Leaning from Deaths Lead NED to be discussed at next NED meeting. The Chairman agreed to discuss with the Non-executive Directors Noted at the 25 March meeting that a report would be made to the board later in the year.	Mrs Schofield, Chairman	**29 July 2020**	Open
13.2	29 January 2020 *NHS Resolution Report*	NHS Resolution Report to be presented to the July 2020 Quality Committee prior to submission to Board for sign-off. Dr Johnson/ Dr Scullion to inform Ms Hughes of intension to present to July or September 2020 Board meeting.	Mrs Foster, Chief Nurse/ Dr D Scullion, Medical Director	**30 September 2020**	On track Included on workplans
17.3	29 January 2020 *EDS2 Report*	It was agreed that 1.4, 3.4, 4.3, 3.1 and 3.6 would be strengthened and further work was required to further develop the 2020 plan. An updated report would be presented to the Board at 27 May for consideration.	Mrs J Foster, Chief Nurse	**31 May 2020**	Open

Harrogate and District NHS Foundation Trust

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Actions from 29 April 2020 Meeting					
Minute No	**Meeting Date**	**Item Description**	**Director/ Manager Responsible**	**Completion date**	**Detail of progress**
BoD/04/20/14.1	29 April 2020	**Quality Committee -** The summary Chair's report would be included in the papers for the next Board meeting	L Hughes, Interim Co Secretary	27 May 2020	Completed Included in the papers

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Date of Meeting:	27 May 2020	**Agenda item:**	6.0
Report to:	Board of Directors		
Title:	Chief Executive's Report		
Sponsoring Director:	S Russell, Chief Executive		
Author(s):	S Russell, Chief Executive L Hughes, Interim Company Secretary		
Report Purpose:	**Decision**		**Discussion/ Consultation**		**Assurance**	✓	**Information**	✓
Executive Summary:	This report sets out key points and activities from the Chief Executive.		

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:	Updated Corporate Risk Register to reflect Covid-19 is included within the report.
Legal / regulatory:	Trust Licence NHSE/I The Equality Act 2010 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
Resource:	Not applicable
Impact Assessment:	Not applicable
Conflicts of Interest:	None identified
Reference documents:	Not applicable
Assurance:	Directors Team

Action Required by the Board of Directors:

The Board is asked to note the content of this report.

Board of Directors

27 May 2020

Chief Executive's Report

1.0 Coronavirus

The NHS remains in a Level 4 incident, with the NHS' response to COVID-19 being led by NHS England. The Trust continues to have an Incident Command Centre (ICC) in place to support the Trust's activities, with the role of 'Gold' being taken into the Trust's usual governance arrangements through the Executive Team.

As at 17th May 2020, the Trust has diagnosed 230 patients with COVID-19, with 170 being admitted to hospital. 100 have been treated and discharged, and sadly 57 patients did not survive. On average, the length of stay for patients with COVID-19 has been 11 days, and where they have needed critical care support this has been for a period of 7 days.

The number of new infections has decreased with an average of 1 per day in May, compared to 4 per day in April.

The "R-number" is a way of assessing the current transmission rate. It refers to the number of people 'infected' by someone who has COVID-19, and the goal is to keep it below 1. It is estimated that the R is currently 0.75 for England (0.72 to 0.77 at 95% confidence intervals) and 0.8 (0.76 to 0.83 at 95% confidence intervals) for the North East and Yorkshire.[1]

1.1 Letters from loved ones

As visiting was, and remains, restricted compared to our usual arrangements a scheme allowing relatives to send in letters to their friends or relatives was put in place. To date, over 250 letters have been received and passed to patients with very positive feedback.

1.2 Coronavirus and our people

123 colleagues at HDFT are subject to shielding, currently until the end of June 2020. 851 colleagues have been absent from work either due to self-isolation or because of household isolation. To date, the average period of absence for self -solation has been 8.9 days.

There is much that is still unknown about the virus, but the data so far suggests a disproportionate impact on certain groups. One of these is colleagues from a BAME background. National data suggests that after adjusting for age, sex and other

[1] Source MRC Biostatistics Unit

geographical factors the likelihood of mortality is between 1.7 and 3.5 times higher for people from a BAME background (dependent upon specific ethnicity).

We, along with other NHS organisations, are therefore focusing additional support to our colleagues. At HDFT we have started individual risk assessments, the main purpose of which is a dialogue about reducing risk between a line manager and their colleague. In addition to this we have set up a specific task-force to support our activities and have held two on-line listening events.

1.3 Care Home Support

There is significant concern over the situation in Care Homes, and NHS England has asked local systems to put in place dedicated and enhanced support. HDFT is supporting this with NYCC and NYCCG who have been leading on work to put in place an enhanced care home support model across North Yorkshire. HDFT have been involved in these discussions as part of the Harrogate and Rural Alliance (HARA) which was agreed as the most appropriate vehicle to progress this work in the Harrogate and Rural area.
From within the existing resource HARA will be providing a link nurse to residential homes and also input into a weekly MDT to discuss any care homes that require Covid-19 support. A proposal is being developed to provide weekly MDT with each Residential Home which includes Primary Care Network's (PCNs), community adult teams. From a health perspective the offer to care homes involves bringing forward the Directed Enhanced Service (DES) specification for enhanced care home support to be delivered by the PCN's. NYCC are putting in place a Gold, Silver, Bronze structure to identify any trends and risks in care homes and required actions to support.

1.4 Activity & Waiting times

The Trust has seen about 50% of the level of A&E attendances that would usually be expected; 60% of emergency admissions; 25% of elective day cases and inpatients and 43% of outpatients. Referrals from primary care dropped by 85%.

Whilst the most urgent cancer cases have continued to be treated, in line with national clinical guidelines a number of patients have had treatment deferred. Waiting times for patients on the Trust's PTL with a cancer diagnosis have increased by around 20 days.

Similarly, the number of patients on the Trust's waiting list has fallen (mainly due to the significant drop in referrals from primary care) but waiting times have increased.

1.5 Restoration of services

In order to reduce face to face contact, and to direct resources towards supporting patients in their own homes and to prepare for a surge in critical care demand the Trust cancelled most other activities in line with the national direction. Patients were clinically prioritised and those who required urgent, treatment which could not be safely delayed have continued to be treated.

The requirement to maintain the reduction in face to face contact where possible still exists as this is an important measure in reducing the transmission rate.

The NHS is now planning for the next phase of the year, with Phase 2 (to June 2020) focusing on restarting urgent treatment and Phase 3 (to March 2021) focusing on maintaining the ability to respond to COVID-19 related demand but also building up the level of routine activity. There are a number of constraints which mean that the Trust will be operating at reduced levels of productivity for some time.

It is expected that the NHS will receive light touch planning guidance setting out the framework within which the NHS will work until the end of the financial year during June.
The Trust has undertaken a comprehensive piece of work to consider the arrangements that will need to be put in place and the level of activity that can be resumed. This is covered in detail in a separate paper on the agenda.

1.6 Learning from the response to the pandemic

It is regularly remarked that significant changes have been made in a very short space of time, a number of which are recognised as transforming the way in which some services have been provided (outpatients is a good example), the way in which people have worked and the way in which patients have responded.

An important part of the recovery planning is to ensure that some of the gains that have been made in change and transformation are 'locked in' so that we do not simply revert to previous ways of working. To support this, the Trust has commenced a piece of work to allow colleagues from across the Trust to contribute their reflections and learning and to set out what changes should remain, which were time-limited, those which need to be continued and those which need further work to embed because they were implemented quickly.

This has focused internally, but it is critically important we consider the experience of patients in this and as such we plan to extend the work to seek the views of patients about the changes to their care.

2.0 NHS Financial Framework

The usual financial arrangements were suspended to support the NHS to focus on the pandemic. The current arrangements (until XX 2020) are based on three components; an estimate of the Trust's expenditure based on spend between December 2019 and February 2020 adjusted for inflation; a top up payment to enable the Trust to break even; and funding for costs incurred due to COVID-19.

The Trust has reviewed the budgets that were previously approved to remove the efficiency requirement that was set, and the income proposed by NHS Improvement. There is a 11m gap between the income proposed and the revised budget. We consider this to be a consequence of the assumptions used by NHS Improvement

which did not fully accounting for the Trust's actual run-rate. Further detail is set out in the report from the Director of Finance.

3.0 Cultural Review

Two sub-committees of the Board have been established to consider the final report from Deloitte. Once their initial work is concluded the Trust will start to discuss the findings of the report internally with colleagues.

4.0 Senior Management team (SMT)

At its most recent meeting on 20 May 2020, SMT's discussions focussed on:

- COVID-19
  - Recovery Plan
  - Infection Prevention and Control
  - Procurement and Supplies
  - IM&T – use of video consultations and videoconferencing
  - Health and Wellbeing Support for Staff
- Financial Position
- Operational Plan 2020/21

5.0 Risk

5.1 Corporate Risk Register Summary

The Corporate Risk Register (Appendix 1) was reviewed at the Corporate Risk Review Group meeting on 15 May 2020 and the management and mitigations in place with regards to Covid-19 was discussed in detail. (Changes to the risks are highlighted in red font.) The risk register was then further reviewed by SMT at its 20 May 2020 meeting.

5.2 Board Assurance Framework Summary

Following the last Board meeting further discussion has taken place with the Chairman and Non-executive Directors on the Board Assurance Framework. Further discussion is planned to take place at a Board workshop to reassess strategic risks and opportunities to ensure we continue to have a strategic focus during the Covid-19 pandemic and beyond.

6.0 Annual Slavery and Human Trafficking Statement 2020/21

In line with Section 54 of the Modern Slavery Act 2015 the Trust has prepared an annual slavery and human trafficking statement. The Slavery and Human Trafficking statement sets out what steps organisations have taken to ensure modern slavery does not take place in the Trust or its supply chains. The Trust aims to follow good practice and take steps to prevent slavery and human trafficking.

Attached at Appendix B is the Trust's Annual Slavery and Human Trafficking Statement for 2020/21.

The Board is asked to review and approve the Annual Slavery and Human Trafficking Statement for publication on our website.

6.0 Recommendation

The Board of Directors is asked to:

1. note this report; and
2. approve the Annual Slavery and Human Trafficking Statement for publication on our website.

Appendix A

Corporate Risk Register Summary of Changes: Updated 15 May 2020						
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; no-deal EU Exit *(added 08/03/2019);* impact of Covid-19 *(added 13/03/2020).***	**8**	↓	**2**	***Jun-20***	***Risk has been downgraded due to mitigations in place as part of the working arrangements for COVID-19 and the significant reduction in hospital activity***
CR5	**Risk to the quality of service delivery and patient care due to failure to fill registered nurse, ODP and health visitor vacancies due to the national labour market shortage, local shortages in some areas e.g. Stockton, and impact of Covid-19 *(added 13/03/2020).***	**8**	↓	**2**	***Oct-20***	***Risk has been downgraded due to mitigations in place as part of the working arrangements for COVID-19 and the significant reduction in hospital activity***
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***	***Mar-20***	***On hold for 4 months will be reassessed at the end of July***
CR18	**Risk to provision of service and not achieving national standards in cardiology due to potential for lab equipment breaking down**	**8**	↓	***1***	***Aug-20***	***Risk score reduced due to elective activity of the COVID-19 activity***
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***	***May-20***	***Paused 24/04/2020***
CR41	**CR41 Summary RTT risk - Risk to patient safety, performance, financial performance and reputation due to increasing waiting times across a number of specialties, including as a result of the impact of Covid 19 *(added 13/03/2020)***	**15**	↔	***tbc***	***tbc***	***Due to COVID-19 recovery plans to be developed and target date to be confirmed once national guidance is issued***
CR44	**ED 4 hour standard Risk of failure to meet the 4 hour standard and poor patient experience including as a result of the impact of Covid 19 *(added 13/03/2020)***	**9**	↓	***2***	***Jun-20***	***Risk score reduced as lower footfall through ED***
CR45	**MAU/CAT Clinic. Risk to service provision due to current service being covered by single consultant. No provision to cover the service in his absence. MAU consultant is a locum.**	**12**	↔	***2***	***Oct-20***	***Paused 24/04/2020. Risk is currently mitigated due to current working arrangements within the COVID-19 incident***
CR48	**Mental health services for ED patients**	**12**	↔	***tbc***	***Jun-20***	

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Ref	Description	Current risk score	Risk movement	Current progress score	Target date for risk reduction	Notes
CR49	ED Imaging Risk of delayed imaging causing potential extended waiting in ED department due to risk of x ray equipment failure (1998).	16	↔	*5*	*tbc*	*Risk score increased as failure would impact on Covid pathways*
CR51	Patients: Quality of patient care Risk to patient safety, quality of care and staff welfare due to: the increased workload within the community - increased discharges from hospital / EoL / patient reluctance to attend hospital / COVID infections within care homes / reduction in primary care access	9	↓	*tbc*	*tbc*	*Mitigated by increased staffing numbers due to redeployment*
CR52	Patients: Delayed cancer diagnostics, treatment and care Risk to patient safety, quality of care and psychological impact of delays in diagnostics, treatment plans and surveillance on patients and families	16	↔	*tbc*	*May-20*	*Risk due to changes in patient pathways as part of the COVID-19 response following national guidance*
CR53	Patients: Increased wait for elective treatments and procedures Risk to patient safety and patient experience as there continues to be an increase to waiting times for elective procedures	15	↔	*tbc*	*tbc*	*Risk due to changes in patient pathways as part of the COVID-19 response following national guidance*
CR54	Staff: Staff well-being and morale Risk to staff wellbeing and morale in the context of the Covid pandemic and: a) Staff having to manage increased pressures of caring for acutely unwell and dying patients. b) Staff managing increased work pressures alongside concerns for their own health and safety, increased workload and hours due to staff absence, potential childcare concerns, family health concerns and potential bereavement. c) Staff working in unfamiliar environments with concerns about PPE use and availability, personal risks e.g. due to pregnancy, LTC, immunosuppresion, ethnicity, proximity to Covid risk d) Once the Covid peak has passed and HDFT returns to BAU services, further pressure will be put on staff to manage an increase in BAU caseload pressures and patients presenting with higher acuity due to delays. e) Risk of further Covid19 peaks emerging f) Longer term impacts include the potential to develop PTSD.	12	↔	*tbc*	*tbc*	

Ref	Description	Current risk score	Risk movement	Current progress score	Target date for risk reduction	Notes
CR55	Trust: Demand during recovery phase Risk to patient safety and experience if service provision is overwhelmed by demand during recovery phase resulting in: a) increased waiting times for non-urgent outpatient appointment b) increased levels of safeguarding issues identified as children return to school ("surge") c) ability to manage changes required for new contracts in NY and Durham while returning to BAU d) increased demand for non-acute services as they re-open e.g. podiatry; dental	12	↔	*tbc*	*tbc*	
CR56	Trust: Governance processes Risk of harm to the quality of service delivery and reputation as a result of alternative governance processes in place during Covid-19	12	↔	*tbc*	*tbc*	
CR57	Patients: Quality of patient care Risk to patient safety, quality of care and staff welfare due to: increased levels of domestic abuse and children's safeguarding - increased presentation at ED with unintentional injuries, increased opportunities for online abuse, decreased opportunity for monitoring and observation of children and young people by professionals, increased demand on social care and other community services for safeguarding work, shielding and vulnerabilities	16	↔	*tbc*	*tbc*	
CR58	Respiratory service Risk to reputation of Trust due to breaching national targets for patient treatment caused by increased referrals and lack of capacity, increased pressure due to the demands of COVID, emerging guidance re requirement for respiratory f/u of patients post COVID Risk of 52 week breaches. Risk to patient experience due to long waits and lack of choice	12	New	*tbc*	*tbc*	

Appendix B

Modern Slavery and Human Trafficking Annual Statement

Harrogate and District NHS Foundation Trust is committed to ensuring that there is no modern slavery or human trafficking in any part of our business, including our supply chains.

The aim of this statement is to demonstrate that the Trust follows best practice and that all reasonable steps are taken to prevent slavery and human trafficking.

Policies relating to Modern Slavery

All members of staff have a personal responsibility for the successful prevention of slavery and human trafficking with the procurement department taking responsibility for overall compliance.

The Trust has internal policies and procedures in place that assess supplier risk in relation to the potential for modern slavery or human trafficking. The Trusts internal Safeguarding Adults Policy and Procedures supports our staff to identify and report concerns about slavery and human trafficking. In addition, the Trust has

Our Speaking Up policy and procedures also provide supportive guidance for our employees to raise concerns about poor working practices.

Our People

We confirm the identities of all new employees and their right to work in the United Kingdom and pay all our employees above the National Living Wage.

Our Supply Chain

Our procurement senior team are all Chartered of Institute of Purchasing and Supply (CIPs) qualified and abides by the CIPs code of professional conduct. The procurement team follows the Crown Commercial Service standard and includes a mandatory exclusion question regarding the Modern Slavery Act 2015.

When procuring goods and services, we additionally apply NHS Terms and Conditions (for nonclinical procurement) and the NHS Standard Contract (for clinical procurement). Both require suppliers to comply with relevant legislation.

Our Performance

We know the effectiveness of the steps that we are taking to ensure that slavery and/or human trafficking is not taking place within our business or supply chain if:
No reports are received from our staff, the public, or law enforcement agencies to indicate that modern slavery practices have been identified.

Risks associated with this Act are managed in accordance with the Trust's Risk Management Policy.

This statement is made pursuant to section 54(1) of the Modern Slavery Act 2015 and constitutes the Harrogate and District NHS Foundation Trust slavery and human trafficking statement for the financial year ending 31 March 2020.

Harrogate and District NHS Foundation Trust

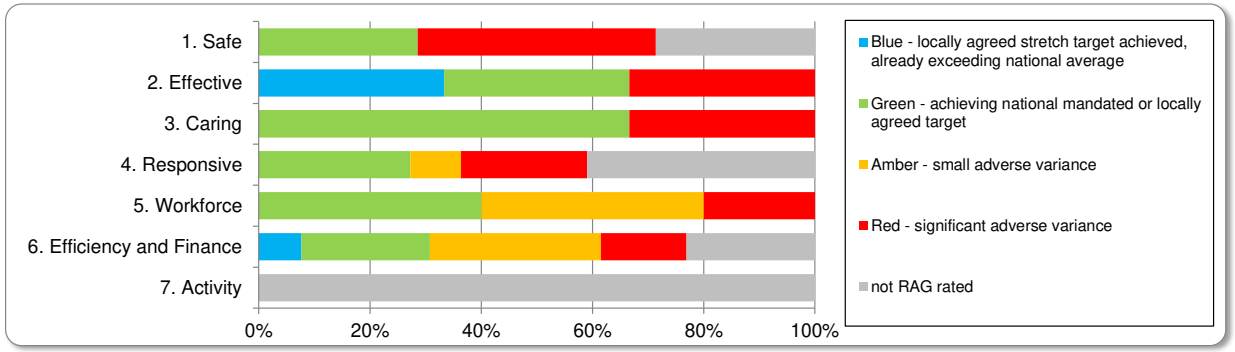
Integrated board report - April 2020

Key points this month

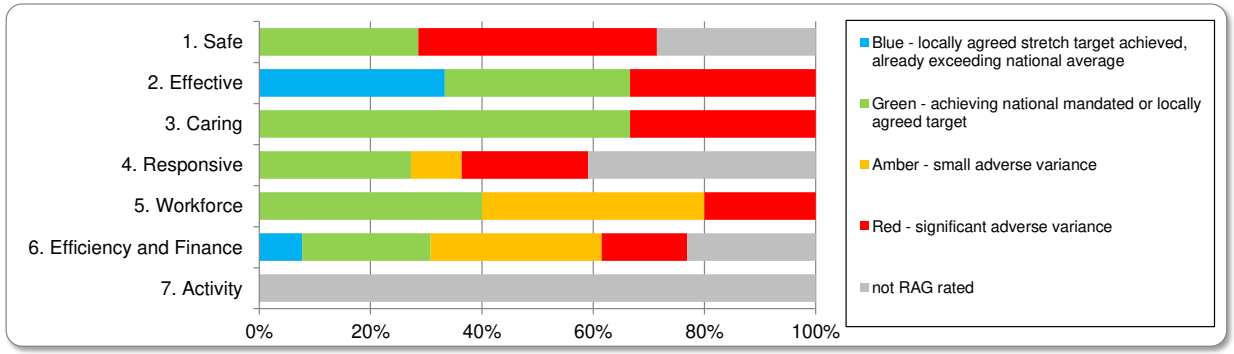
1. The Trust reported a balanced position in month 1, in line with the national expectation for providers. This position is supported by a £2,050k top up payment, supporting the costs of Covid19 and some underlying variances as a result of the plan.
2. HDFT's performance against the A&E 4-hour standard was below 95% in April (92.6%). This was an improvement on last month and for the year 2019/20 performance was at 90.7%. In April ED activity was around 50% lower than the average number of monthly attendances in 2019/20 pre-Covid19.

3. Provisional data indicates that 4 of the 7 applicable cancer waiting times standards were achieved in April, with the 14 day suspected cancer, 62 day Screening, and 31 day surgical subsequent treatment standards not delivered (further details contained in this report).

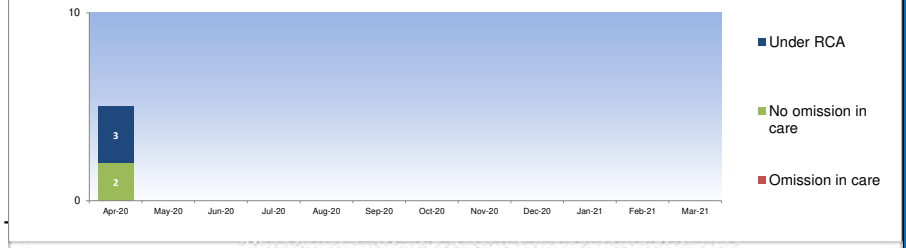
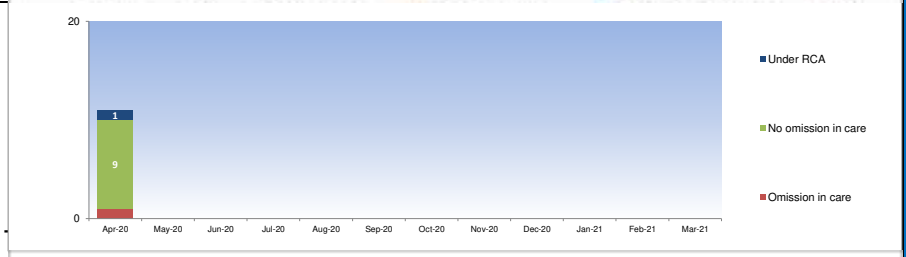
Summary of indicators - current month



Summary of indicators - year to date

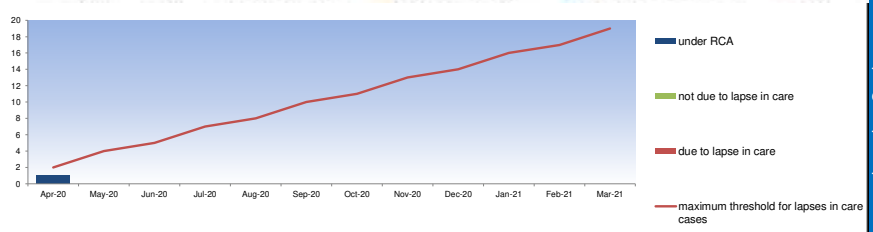
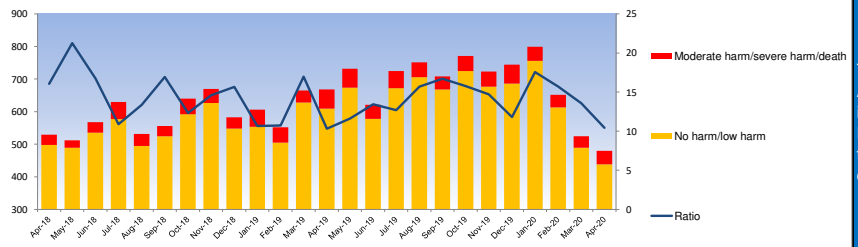
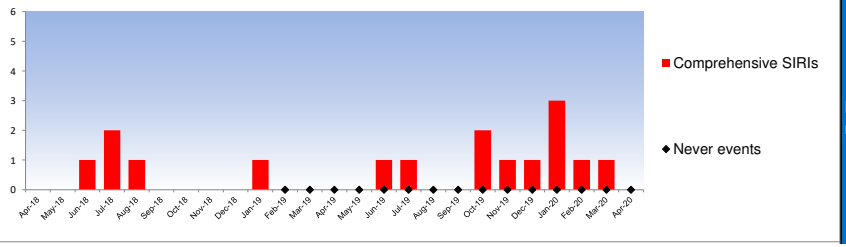


Section 1 - Safe - April 2020

Indicator number	Indicator name / data quality assessment	Trend chart	Interpretation
1.1a	Pressure ulcers - hospital acquired		There were 5 hospital acquired category 3 and above pressure ulcers reported in April (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 5* reported there were 2 no omission in care and 3 under RCA. *from 01/01/2020 DTI subcategories are reported as LOW harm, no RCA required
1.1b			The number of hospital acquired category 2 and above pressure ulcers reported in April was 23. The reported number is inclusive of device related and device related mucosal pressure ulcers.
1.2a	Pressure ulcers - community acquired		There were 22 community acquired category 3 and above pressure ulcers reported in April (including device related and device related mucosal). The average per month reported in 2018/19 was 11. Of the 22* reported there was 1 omission in care, 9 no omission in care and 1 under RCA *from 01/01/2020 DTI subcategories are reported as LOW harm, no RCA required
1.2b			The number of community acquired category 2 and above pressure ulcers reported in April was 41. The number reported is inclusive of device related and device related mucolsal pressure ulcers.

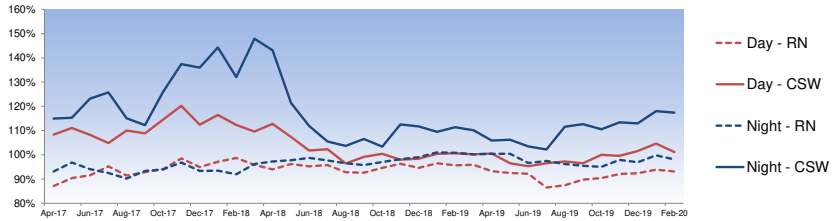
Harrogate and District NHS Foundation Trust

Section 1 - Safe - April 2020

Indicator number	Indicator name / data quality assessment	Trend chart	Interpretation
1.3	Falls		The rate of inpatient falls was 12.5 per 1,000 bed days in April. This is higher than the average HDFT rate for 2019/20 (6.2). The higher rate this month is largely due to
1.4	Infection control		There was 1 case of hospital apportioned C. difficile reported in April. No MRSA cases have been reported in 19/20 or 20/21. The annual maximum threshold for lapses in care cases for 2019/20 is 19. This data is yet to be finalised by Infection Control.
1.5	Incidents - all		The latest published national data (for the period Apr 19 - Sep 19) shows that Acute Trusts reported an average ratio of 46.6 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 13, a decrease on the last publication and remaining in the bottom 25% of Trusts nationally. HDFT's latest local data for April gives a ratio of 10, a decrease on the March position of 13.
1.6	Incidents - SIRIs and never events		Never Events or SIRIs were reported for the year-to-date. No Never Events were reported in 2017/18, 2018/19 or 2019/20.

Harrogate and District NHS Foundation Trust

Section 1 - Safe - April 2020

Indicator number	Indicator name / data quality assessment	Trend chart	Interpretation
1.7	**Safer staffing levels** DQ		Owing to ward reconfiguration in response to COVID19, there is no update for March/April. The Safer Staffing national return has been suspended until further notice

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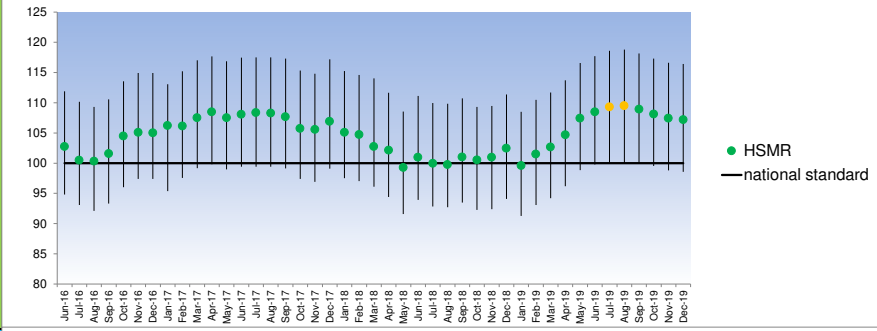
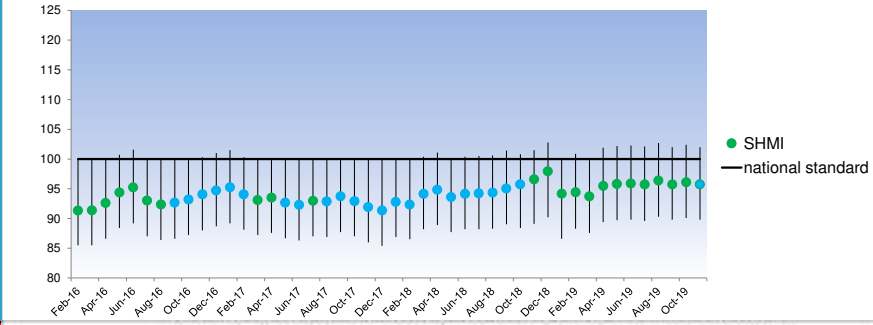
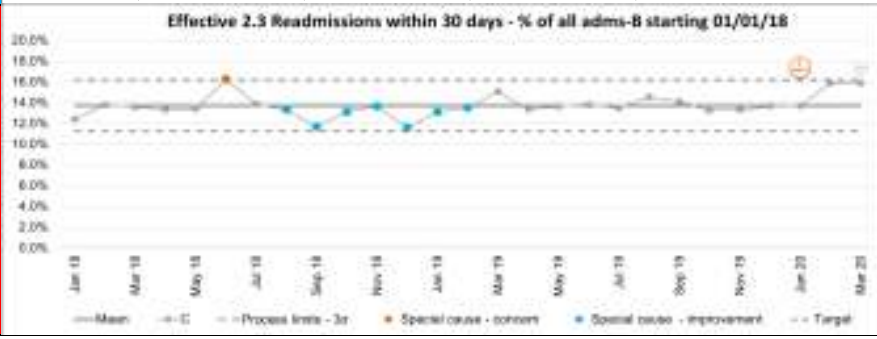
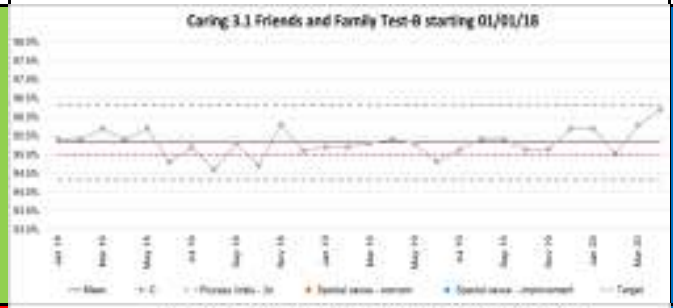
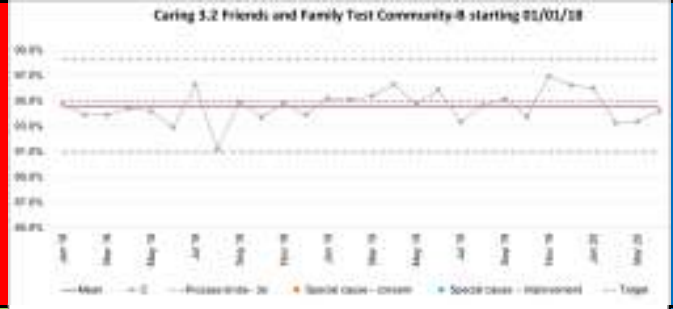
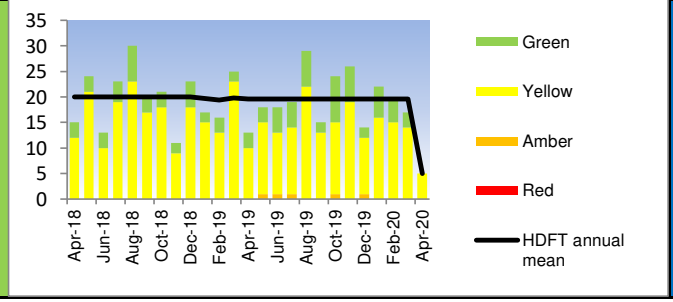
Harrogate and District NHS Foundation Trust

Section 2 - Effective - April 2020

Indicator number	Indicator name / data quality assessment	Trend chart	Interpretation
2.1	Mortality - HSMR		HDFT's HSMR has decreased to 107.21 for the rolling 12 months ending December 2019, remaining within expected levels. Three specialties have a higher than expected standardised mortality rate: Geriatric Medicine, Respiratory Medicine and Paediatrics. Analysis on the data with HED and auditing the notes of affected specialties/diagnostic groups has been concluded and no concerns have been identified. HED has confirmed clarification on how risk is allocated for those care spells where the admitting provider is different from the provider of care at the time of death. Examples of this type of pathway include Stroke and Vascular patients who receive the acute phase of the care at a specialist centre and then are transferred to Harrogate for remaining care. Analysis confirmed there is a negligable impact on the HDFT mortality ratio. *The delay in calculating and publishing is linked to the requirement that all episodes are clinically coded and therefore there is at least a 2 month delay before they can start to look at the data.
2.2	Mortality - SHMI		HDFT's SHMI for the rolling 12 months ending November 2019 is 95.74, remaining below expected levels. At specialty level, four specialties (Gastroenterlogy, Respiratory Medicine, Geriatric Medicine and Anaesthetics) have a standardised mortality rate above expected levels. *The delay in calculating and publishing is linked to the requirement that all episodes are clinically coded and therefore there is at least a 2 month delay before they can start to look at the data. SHMI is slightly later than HSMR as it includes deaths within 30-days of discharge from hospital that will cause a further delay to the publication
2.3	Readmissions		Emergency Readmissions increased to 15.9% in March This is above the 2019/20 average of 14.0%.

NHS
Harrogate and District
NHS Foundation Trust

Section 3 - Caring - April 2020

Indicator number	Indicator name / data quality assessment	Trend chart	Interpretation
3.1	Friends & Family Test (FFT) - Patients DQ		96.2% of patients surveyed in April would recommend our services remaining above the latest published national average (93.3%). 945 patients responded to the survey this month of which 909 would recommend our services.
3.2	Friends & Family Test (FFT) - Adult community services		94.2% of patients surveyed in April would recommend our services, an increase on last month (93.4%). Current national data (February 2020) shows 95.6% of patients surveyed would recommend the services. 86 patients from our community services responded to the survey this month of which 81 would recommend our services.
3.3	Complaints DQ		5 complaints were received in April which is 12 less than March and lower than the average for 2019/20 of 20. All 5 complaints were yellow.

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Harrogate and District NHS Foundation Trust

Section 4 - Responsive - April 2020

NHS Improvement Single Oversight Framework

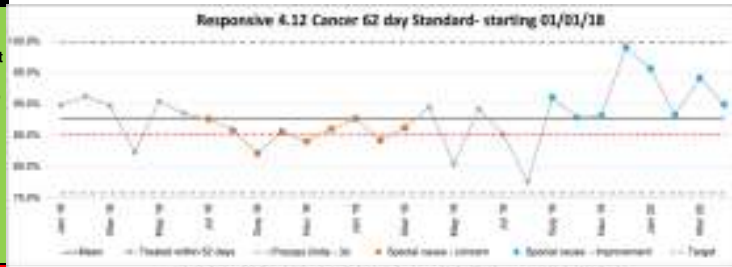
	NHS Improvement Single Oversight Framework	Standard	Q1	Q2	Q3	Q4	YTD
4.1		RTT incomplete pathways					
		A&E 4-hour standard	92.6%				92.6%
		Cancer - 62 days	90.0%				90.0%
		Diagnostic waits					
		Dementia screening - Step 1	81.2%				81.2%
		Dementia screening - Step 2	100.0%				100.0%
		Dementia screening - Step 3	50.0%				50.0%

4.2 RTT Incomplete pathways performance

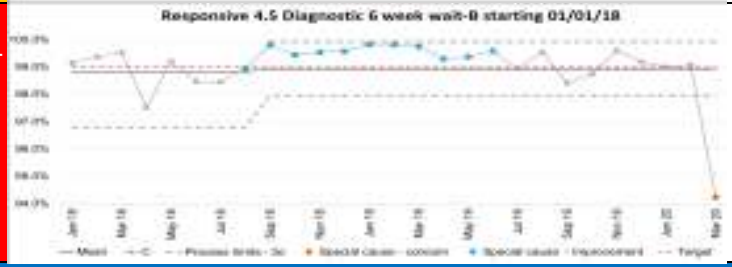
4.3 A&E 4 hour standard

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

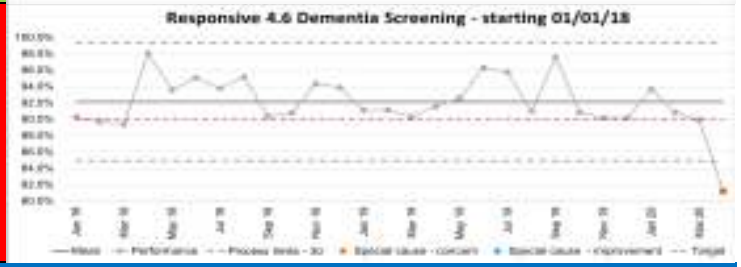
DQ



4.5 Diagnostic waiting times - 6-week standard



4.6 Dementia screening



Narrative

Performance against the A&E 4-hour standard was below 95% in April (92.6%), an improvement on last month. As a consequence of the Covid-19 pandemic the number of ED attendances dropped by around 50% in April when compared to the average monthly attendance between April 2019 and February 2020 (4,396 vs 2,157).

Provisional data shows that performance against the 62 day cancer standard in April was at 90.0 %, a decrease on the March figure of 94.1% (see a more detailed summary below).

Data shows diagnostic waiting times below 99% in March at 94.24%. The increase in patients waiting beyond 6 weeks are a result of the appointments being deferred following the stepping down of elective services in response to COVID19.

Dementia Screening - provisional data indicate that steps 1 and 3 will not be delivered for April. Final data will be submitted in the fourth week of May.

Harrogate and District NHS Foundation Trust

Section 4 - Responsive - April 2020

Cancer waiting times standards

4.7	Cancer - 14 days max wait from urgent GP referral for suspected cancer	Responsive 4.7 Cancer 14 Day Suspected Cancer Standard- starting 01/01/18	4.8	Cancer - 14 days maximum wait from GP referral for symptomatic breast patients	Responsive 4.8 Cancer 14 day Breast Symptom Standard- starting 01/01/18
4.9	Cancer - 31 days maximum wait from diagnosis to treatment for all cancers	Responsive 4.9 Cancer 31 day First Treatment- starting 01/01/18	4.10	Cancer - 31 day wait for second or subsequent treatment: Surgery	Responsive 4.10 Cancer 31 day Subsequent Surgery - starting 01/01/18
4.11	Cancer - 31 day wait for second or subsequent treatment: Anti-Cancer drug	Responsive 4.11 Cancer 31 day Subsequent Drugs- starting 01/01/18	4.12	Cancer - 62 day wait for first treatment from urgent GP referral to treatment	Responsive 4.12 Cancer 62 day Standard- starting 01/01/18
4.13	Cancer - 62 day wait for first treatment from screening service	Responsive 4.13 Cancer 62 day Screening- starting 01/01/18	4.14	Cancer - 62 day wait for first treatment from consultant upgrade	Responsive 4.14 Cancer 62 day Consultant Upgrade- starting 01/01/18

DQ

Harrogate and District NHS Foundation Trust

Section 4 - Responsive - April 2020

Narrative

Provisional data indicates that 4 of the 7 applicable cancer waiting times standards were achieved in April, with 14 day suspected cancer, 31 day surgical subsequents, and 62 day Screening performance below the operational standards.

There has been a significant reduction in the number of 2WW referrals received by the Trust since the outbreak of Covid-19, resulting in more than a 50% reduction in first attendances. This, combined with various Covid-related delays (i.e. patients shielding, isolation, staff sickness, patients choosing to postpone their appointments), have also led to longer waits, meaning 14 day suspected cancer performance was just below the operational standard at 92.9% (provisional data). In order to minimise the number of delays, telephone consultations have taken place where appropriate in order to assess and manage the risks associated with deferring diagnostics and treatment for suspected cancer patients. The number of referrals has been gradually increasing in May, and current expected performance is above 93% for both 14 day standards.

Covid-19 has also affected delivery of diagnostics for cancer patients as all non-emergency endoscopic procedures were suspended in April and early May. The Trust is working with the WY cancer alliance in order to understand the volume of patients affected, the risk level of these patients, and the capacity available regionally. Alongside the Trust's own recovery plans, the aim is to optimise all available capacity so that diagnostics and treatments can be safely delivered for patients on a cancer pathway.

62 day standard performance is expected to be delivered in April. Provisionally there were 50.0 accountable treatments in April with 5.0 accountable over 62 days, meaning performance was at 90.0%. Of the 11 tumour sites treated in April, performance was above 85% for all but 2 (Head and Neck – 1 treatments and 1 breach; Lung – 5 treatments and 4 breaches). No patients waited over 104 days for treatment in April.

Provisional data indicates that 60% (6/10) of tertiary patients treated in April were transferred by day 38.

Delivery of the 62 day Screening standard for bowel patients continues to be a significant challenge as outlined above. Provisional data indicates that 3 breast patients and 2 bowel patients were treated in April, with the 2 bowel patients treated outside 62 days (1 Leeds and 1 York). This translates to an accountable denominator of 2.5 with 1.0 outside 62 days (60%).

1 skin patient received their surgcial subsequent treatment on day 39 due to patient choice - with a total of 10 patients treated, this means performance was below the 94% standard at 90%.

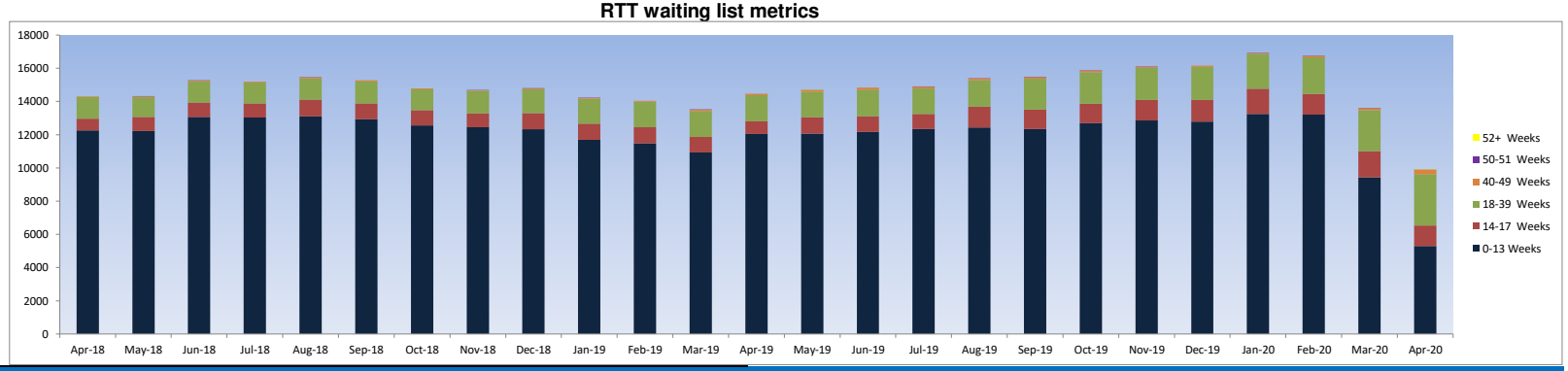
Harrogate and District NHS Foundation Trust

Section 4 - Responsive - April 2020

RTT waiting list split by weeks

4.15

DQ



Narrative

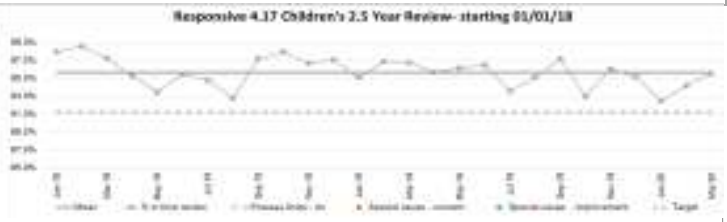
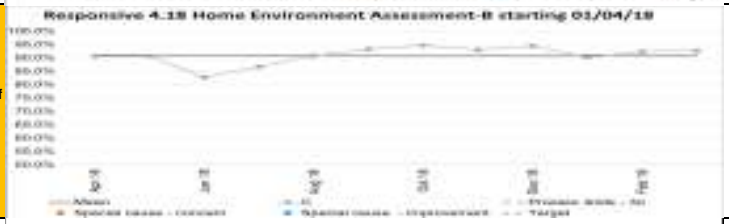
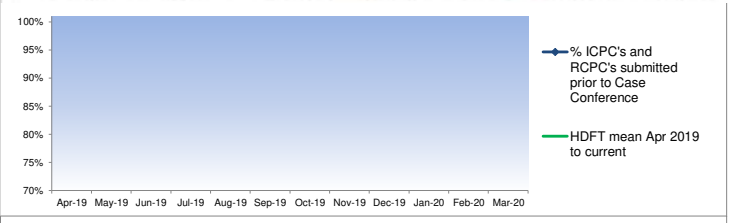
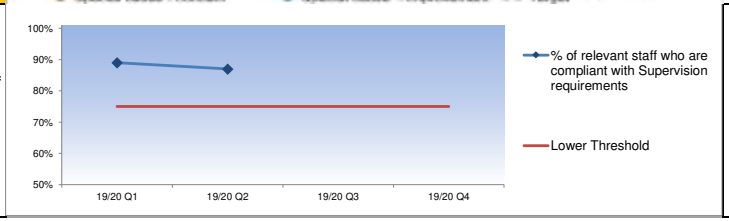
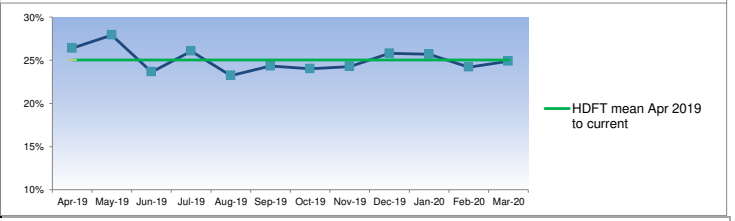
Provisional data shows that there were a total of 9,931 patients on the RTT waiting list at the end of April. There were 18 patients waiting over 52 weeks at the end of the month. The large reduction in the total number of patients waiting is linked to the reduction in elective referrals received following the stepping down of elective services in response to COVID19.

8

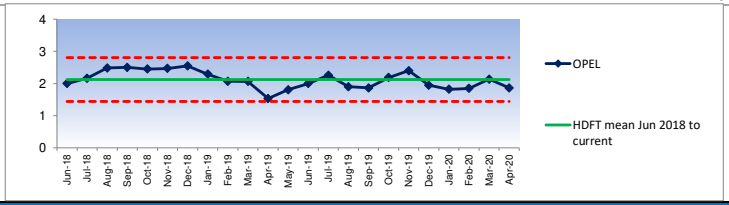
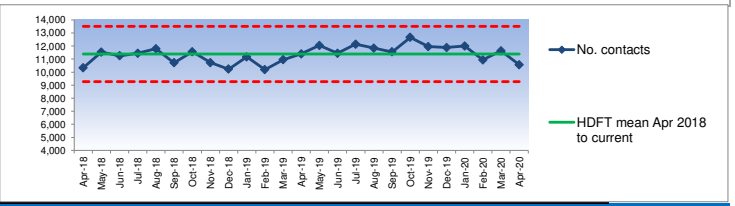
Harrogate and District NHS Foundation Trust

Section 4 - Responsive - April 2020

Children's Services metrics

4.16	Children's Services - 10-14 day new birth visit		4.17	Children's Services - 2.5 year review	
4.18	Children's Services - Use of the Home Environment Assessment Tool		4.19	Children's Services - Reports for Initial and Review Child Protection Case Conferences	
4.20	Children's Services - Staff compliance with Safeguarding Supervision.		4.21	Children's Services - Reports for Achievement of KPI for Breast Feeding Prevalence.	

Adult Community Services metrics

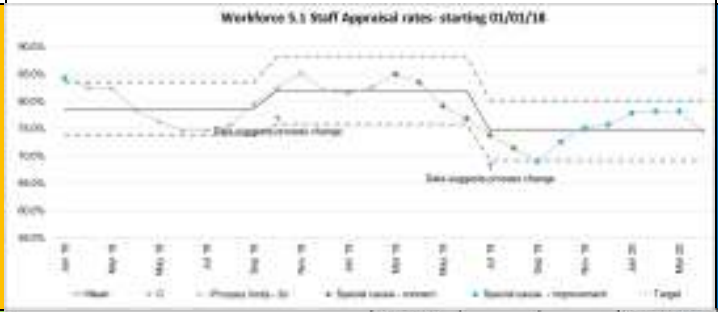
4.22	OPEL level - Community Care Teams		4.23	Community Care Teams - patient contacts	

Narrative

The Children's Services and Adult Community Services metrics are currently showing no adverse variance.

Harrogate and District NHS Foundation Trust

Section 5 - Workforce - April 2020

Indicator number	Indicator name / data quality assessment	Trend chart	Interpretation
5.1	Staff appraisal rates		Appraisals have been put on hold due to COVID19 and consequently the completion rate has slightly decreased.
5.2	Mandatory training rates		Mandatory % Report – Trust exc HIF 01.05.20 The data shown is for the end of April 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 90% which is just higher than the last reporting cycle where we scored 89%. Please note, that the report percentages include all the Mandatory training that the Trust usually includes each month. However at the moment staff are not required to complete all MEST training, only a subset that have been deemed high priority. From June 2020 until further notice, training reports will only include training requirements deemed a priority at this point in time.
5.3	Sickness rates		COVID19 reasons for absence are not being included within our general sickness absence and there has been a 0.17% decrease.

Competence Name	Renewal Period	Required	Achieved	Compliance %
421|LOCAL|Fire Safety - Level 1|	Annual	4083	3659	90%
421|LOCAL|Fire Safety Facilitator Led Training	2 yeary	4083	2426	59%
421|LOCAL|Risk Awareness eLearning|	Once Only	4083	3952	97%
421|LOCAL|Safer Manual Handling eLearning	3 Yearly	4083	3609	88%
NHS|CSTF|Equality, Diversity and Human Righ	3 Yearly	4083	3868	95%
NHS|CSTF|Health, Safety and Welfare - 5 Year	5 Yearly	4083	3974	97%
NHS|CSTF|Information Governance and Data	Annual	4083	3717	91%
NHS|CSTF|Safeguarding Children (Version 2) -	3 Yearly	4083	3818	94%
NHS|MAND|Infection Control - No Renewal|	Once Only	4083	4030	99%

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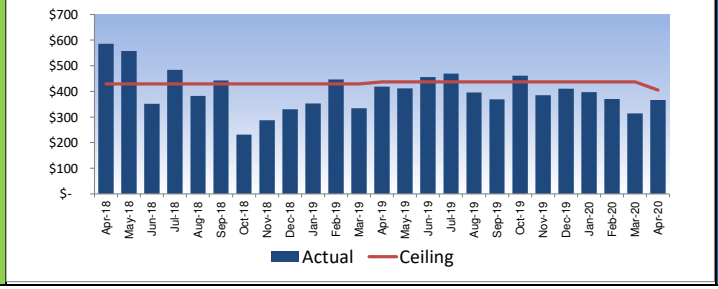
Harrogate and District NHS Foundation Trust

Section 5 - Workforce - April 2020

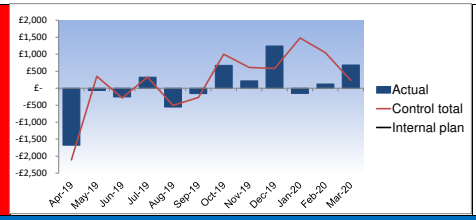
Indicator number	Indicator name / data quality assessment	Trend chart	Interpretation
5.4	Staff turnover rate		Turnover has remained fairly static through this period.
5.5	Agency spend in relation to pay spend		Trust agency spend in month one equated to £367k, a favourable position compared to plan.

8

Section 6 - Efficiency and Finance - April 2020

Finance

6.1 **Surplus / deficit and variance to plan**



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

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

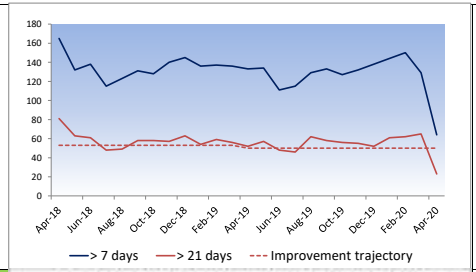
6.3 **Capital spend**

Narrative

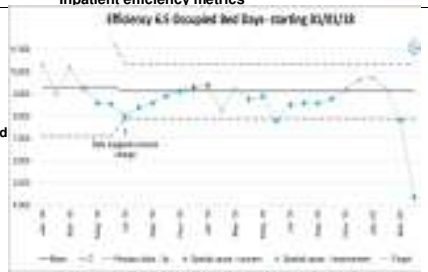
The Trust reported a balanced position in month 1, in line with the national expectation for providers. This position is supported by a £2,050k top up payment, supporting the costs of Covid19 and some underlying variances as a result of the plan.
Currently reported as a 1, however, the Trust awaits further guidance on this monitoring during the response to Covid 19.
Capital reporting will be updated from month 2 onwards.

Inpatient efficiency metrics

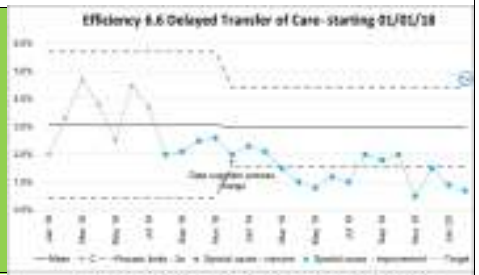
6.4 **Long stay patients**



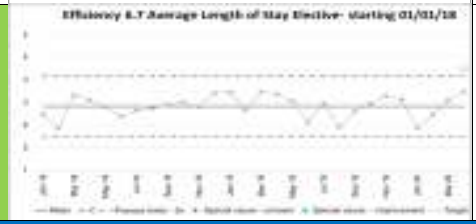
6.5 **Occupied bed days**



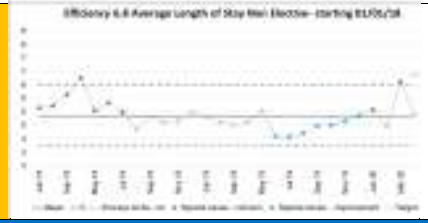
6.6 **Delayed transfers of care**



6.7 **Length of stay - elective**



6.8 **Length of stay - non-elective**



6.9 **Avoidable admissions**

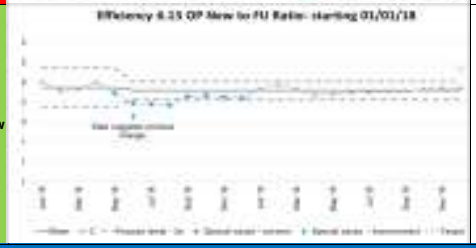
Narrative

Long stay patient numbers and occupied bed days reduced significantly in April, this will have been impacted by the Trust dealing with COVID19. Occupied bed daysElective length of stay increased this month, remaining above the Trust mean, while non elective length of stay decreased to just below the Trust mean. Long stay patients decreased significantly this month. Avoidable admissions decreased further, remaining below the Trust mean.

8

Section 6 - Efficiency and Finance - April 2020

Productivity metrics

6.10	Theatre utilisation		6.11	Day case rate		6.12	Outpatient DNA rate	
6.13	Outpatient new to follow up ratio							

Narrative

Theatre utilisation decreased further in April and remains below the target and Trust mean position. This will have been impacted by the cancellation of elective operations following the stepping down of elective services as a result of COVID19.

Day case rates have increased significantly this month however the number of elective day cases and inpatients have both dropped significantly. Outpatient DNA rates and new to follow up ratios remain consistent.

8

Harrogate and District

Section 7 - Activity - April 2020

Narrative

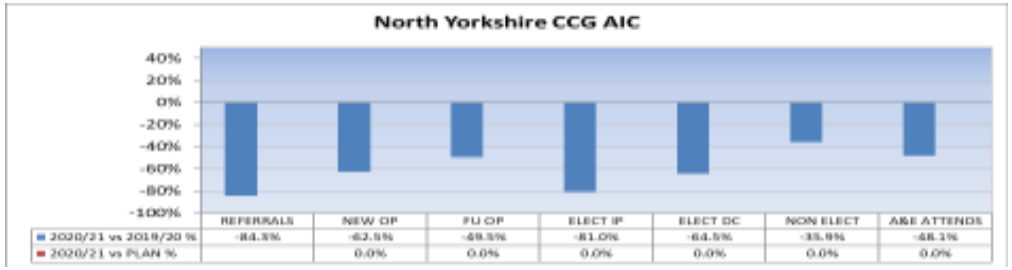
The tables below show activity by Point of Delivery by Contract Type: North Yorkshire AIC; All Other CCGs (PbR); NHSE, Yorkshire Hub Cost per Case.

All activity types are below the levels experienced in 2019/20 as a result of COVID 19. The Trust is actively working on the plan for the recovery phase to improve this position and incrementally increase the levels seen between now and October.

Activity Summary

North Yorkshire CCG AIC

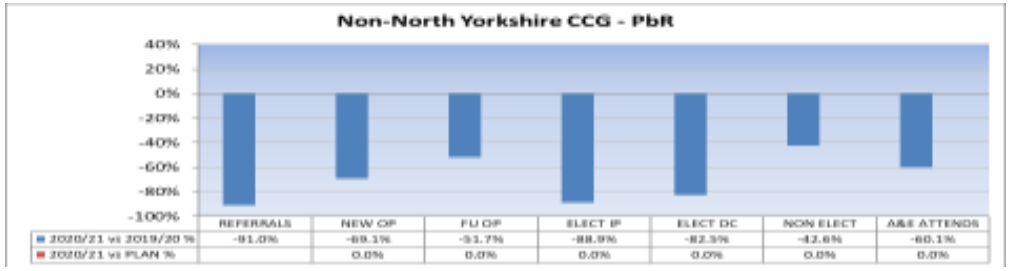
GROUP	2019/20 APR	2020/21 APR ACTUAL	2019/20 YTD	2020/21 YTD ACTUAL	2020/21 vs 2019/20	2020/21 vs 2019/20 %
REFERRALS	3,208	505	3,208	505	**-2,703**	**-84.3%**
NEW OP	5,452	2,042	5,452	2,042	**-3,410**	**-62.5%**
FU OP	11,062	5,587	11,062	5,587	**-5,475**	**-49.5%**
ELECT IP	153	29	153	29	**-124**	**-81.0%**
ELECT DC	1,802	640	1,802	640	**-1,162**	**-64.5%**
NON ELECT	1,495	958	1,495	958	**-537**	**-35.9%**
A&E ATTENDS	3,241	1,682	3,241	1,682	**-1,559**	**-48.1%**



Non-North Yorkshire CCG - PbR*

GROUP	2019/20 APR	2020/21 APR ACTUAL	2019/20 YTD	2020/21 YTD ACTUAL	2020/21 vs 2019/20	2020/21 vs 2019/20 %
REFERRALS	1,511	136	1,511	136	**-1,375**	**-91.0%**
NEW OP	2,020	625	2,020	625	**-1,395**	**-69.1%**
FU OP	3,834	1,852	3,834	1,852	**-1,982**	**-51.7%**
ELECT IP	99	11	99	11	**-88**	**-88.9%**
ELECT DC	727	127	727	127	**-600**	**-82.5%**
NON ELECT	470	270	470	270	**-200**	**-42.6%**
A&E ATTENDS	1,174	468	1,174	468	**-706**	**-60.1%**

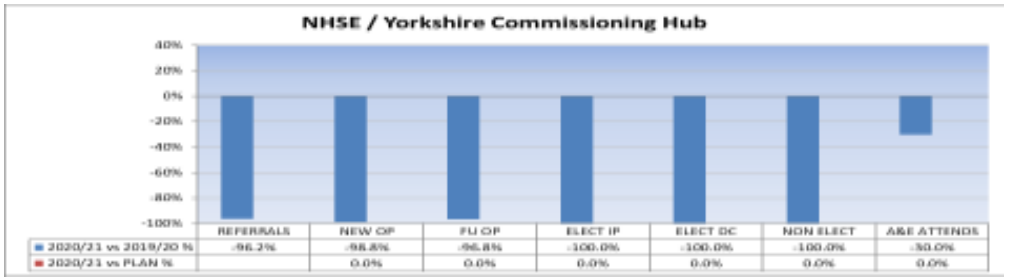
**Non-HaRD CCGs: Leeds CCG, Vale of York CCG, All Other CCGs*



Harrogate and District

NHSE / Yorkshire Commissioning Hub

GROUP	2019/20 APR	2020/21 APR ACTUAL	2019/20 YTD	2020/21 YTD ACTUAL	2020/21 vs 2019/20	2020/21 vs 2019/20 %
REFERRALS	234	9	234	9	**-225**	**-96.2%**
NEW OP	252	3	252	3	**-249**	**-98.8%**
FU OP	468	15	468	15	**-453**	**-96.8%**
ELECT IP	1	0	1	0	**-1**	**-100.0%**
ELECT DC	367	0	367	0	**-367**	**-100.0%**
NON ELECT	2	0	2	0	**-2**	**-100.0%**
A&E ATTENDS	10	7	10	7	**-3**	**-30.0%**



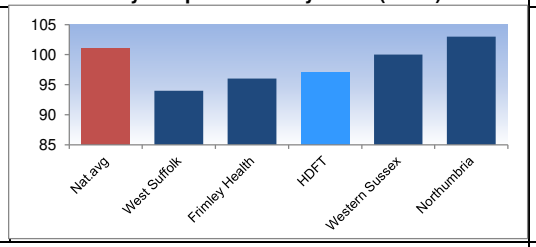
Trust Total

GROUP	2019/20 APR	2020/21 APR ACTUAL	2019/20 YTD	2020/21 YTD ACTUAL	2020/21 vs 2019/20	2020/21 vs 2019/20 %
REFERRALS	4,953	650	4,953	650	**-4,303**	**-86.9%**
NEW OP	7,724	2,670	7,724	2,670	**-5,054**	**-65.4%**
FU OP	15,364	7,454	15,364	7,454	**-7,910**	**-51.5%**
ELECT IP	253	40	253	40	**-213**	**-84.2%**
ELECT DC	2,896	2,708	2,896	767	**-2,129**	**-73.5%**
NON ELECT	1,967	1,228	1,967	1,228	**-739**	**-37.6%**
A&E ATTENDS	4,425	2,157	4,425	2,157	**-2,268**	**-51.3%**

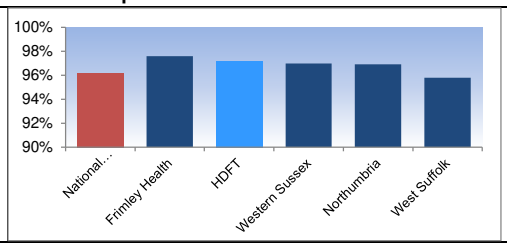
8

Section 8 - Benchmarking - April 2020

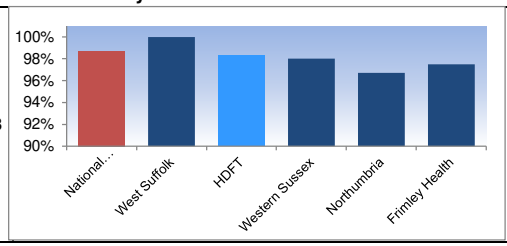
8.1 Summary Hospital Mortality Index (SHMI)



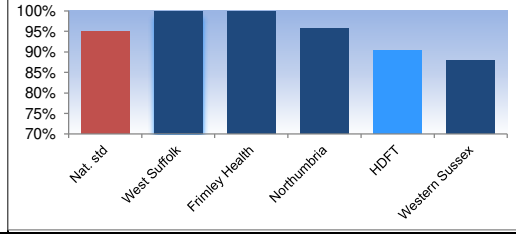
8.2 Inpatient FFT - % recommend



8.3 Maternity FFT - Q2 Birth - % recommend

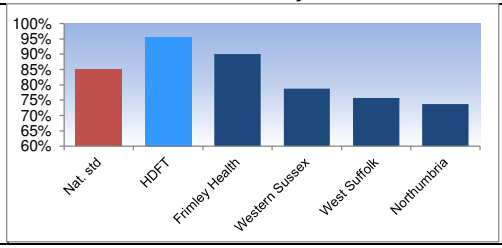


8.4 Emergency Department 4 hour standard

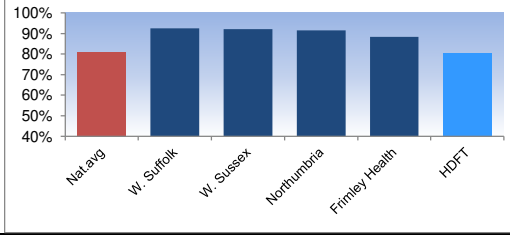


8.5 RTT incomplete pathways

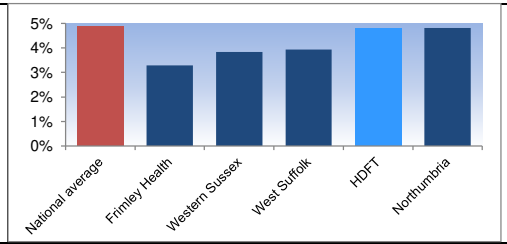
8.6 Cancer 62 days



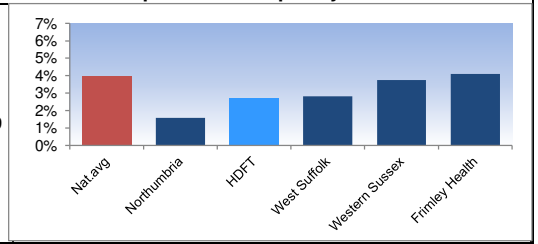
8.7 Staff FFT - % recommend (place to work)



8.8 Sickness absence



8.9 Proportion of temporary staff



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.

Harrogate and District NHS Foundation Trust

Integrated board report - March 2020

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

8

NHS
Harrogate and District
NHS Foundation Trust

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.

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Indicator traffic light criteria

Indicator number	Domain	Indicator	Description	Traffic light criteria	Rationale/source of traffic light criteria
1.1	Safe	Pressure ulcers - hospital acquired	The chart shows the number of category 2, category 3, category 4 or unstageable hospital acquired pressure ulcers in 2018/19. The Trust has set a local trajectory for 2018/19 to reduce the number of avoidable category 3, category 4 or unstageable pressure ulcers. The data includes hospital teams only.	tbc	tbc
1.1	Safe	Pressure ulcers - hospital acquired	The chart shows the number of category 2, category 3, category 4, unstageable and DTI hospital acquired pressure ulcers, including device related and device related mucosal for 2019/20. The data includes hospital teams only.		
1.2	Safe	Pressure ulcers - community acquired	The chart shows the number of category 2, category 3, category 4 or unstageable community acquired pressure ulcers in 2018/19. This metric includes all pressure ulcers identified by community teams including pressure ulcers already present at the first point of contact. The Trust has set a local trajectory for 2018/19 to reduce the number of avoidable category 3, category 4 or unstageable pressure ulcers. The data includes community teams only.	tbc	tbc
1.2	Safe	Pressure ulcers - community acquired	The chart shows the number of category 2, category 3, category 4, unstageable and DTI community acquired pressure ulcers, including device related and device related mucosal for 2019/20. The data includes community teams only.		
1.3	Safe	Safety thermometer - harm free care	Measures the percentage of patients receiving harm free care (defined as the absence of pressure ulcers, harm from a fall, urine infection in patients with a catheter and new VTE) in the Safety Thermometer audits conducted once a month. The data includes hospital and community teams. A high score is good. Whilst there is no nationally defined target for this measure, a score of 95% or above is considered best practice.	Blue if latest month >=97%, Green if >=95% but <97%, red if latest month <95%	National best practice guidance suggests that 95% is the standard that Trusts should achieve. In addition, HDFT have set a local stretch target of 97%.
1.4	Safe	Safety thermometer - harm free care - community care teams	As above but including data for community teams only.		
1.5	Safe	Falls	The number of inpatient falls expressed as a rate per 1,000 bed days. The data includes falls causing harm and those not causing harm. A low rate is good.	Blue if YTD position is a reduction of >=50% of HDFT average for 2018/19, Green if YTD position is a reduction of between 20% and 50% of HDFT average for 2018/19, Amber if YTD position is a reduction of up to 20% of HDFT average for 2018/19, Red if YTD position is on or above HDFT average for 2018/19.	Locally agreed improvement trajectory based on comparison with HDFT performance last year.
1.6	Safe	Infection control	HDFT's C. difficile trajectory for 2019/20 is 19 cases, an increase of 8 on last year's trajectory. This increase takes into account the new case assignment definitions. Cases where a lapse in care has been deemed to have occurred would count towards this. Hospital apportioned MRSA cases will be reported on an exception basis. HDFT has a trajectory of 0 MRSA cases for 2019/20. The last reported case of hospital acquired MRSA at HDFT was in Oct-12.	Green if below trajectory YTD, Amber if above trajectory YTD, Red if above trajectory at end year or more than 10% above trajectory in year.	NHS England, NHS Improvement and contractual requirement
1.7	Safe	Incidents - all	The number of incidents reported within the Trust each month. It includes all categories of incidents, including those that were categorised as "no harm". The data includes hospital and community services. A large number of reported incidents but with a low proportion classified as causing significant harm is indicative of a good incident reporting culture	Blue if latest month ratio places HDFT in the top 10% of acute trusts nationally, Green if in top 25%, Amber if within the middle 50%, Red if in bottom 25%	Comparison of HDFT performance against most recently published national average ratio of low to high incidents.
1.8	Safe	Incidents - comprehensive SIRIs and never events	The number of Serious Incidents Requiring Investigation (SIRIs) and Never Events reported within the Trust each month. The data includes hospital and community services. Only comprehensive SIRIs are included in this indicator, as concise SIRIs are reported within the presure ulcer / falls indicators above.	Green if none reported in current month; Red if 1 or more never event or comprehensive reported in the current month.	
1.9	Safe	Safer staffing levels	Trusts are required to publish information about staffing levels for registered nurses/midwives (RN) and care support workers (CSW) for each inpatient ward. The chart shows the overall fill rate at HDFT for RN and CSW for day and night shifts. The fill rate is calculated by comparing planned staffing with actual levels achieved. A ward level breakdown of this data is provided in the narrative section and published on the Trust website.	Green if latest month overall staffing >=100%, amber if between 95% and 100%, red if below 95%.	The Trusts aims for 100% staffing overall.
2.1	Effective	Mortality - HSMR	The Hospital Standardised Mortality Ratio (HSMR) looks at the mortality rates for 56 common diagnosis groups that account for around 80% of in-hospital deaths and standardises against various criteria including age, sex and comorbidities. The measure also makes an adjustment for palliative care. A low figure is good.	Blue = better than expected (95% confidence interval), Green = as expected, Amber = worse than expected (95% confidence interval), Red = worse than expected (99% confidence interval).	Comparison with national average performance.
2.2	Effective	Mortality - SHMI	The Summary Hospital Mortality Index (SHMI) looks at the mortality rates for all diagnoses and standardises against various criteria including age, sex and comorbidities. The measure does not make an adjustment for palliative care. A low figure is good.		
2.3	Effective	Readmissions	% of patients readmitted to hospital as an emergency within 30 days of discharge (PbR exclusions applied). To ensure that we are not discharging patients inappropriately early and to assess our overall surgical success rates, we monitor the numbers of patients readmitted. A low number is good performance.	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		
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

Indicator number	Domain	Indicator	Description	Traffic light criteria	Rationale/source of traffic light criteria
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.	Target to be reviewed by CCC Directorate	tbc
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.	Target to be reviewed by CCC Directorate	tbc
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.	Target to be reviewed by CCC Directorate	tbc
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
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.		
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.	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.
6.9	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.		

Indicator number	Domain	Indicator	Description	Traffic light criteria	Rationale/source of traffic light criteria
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.	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.
6.13	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	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

Harrogate and District NHS Foundation Trust

Date of Meeting:	27 May 2020	**Agenda item:**	7.1
Report to:	Board of Directors		
Title:	Covid-19 Assurance Report		
Sponsoring Director:	Mr Robert Harrison, Chief Operating Officer		
Author(s):	Mrs Megan Matthewman, Governance & EPRR Officer Mr Robert Harrison, Chief Operating Officer		
Report Purpose:	**Decision** ✓ **Discussion/ Consultation** ✓ **Assurance** ✓ **Information** ✓		
Executive Summary:	This report provides the Board with an update on the management of the current Incident relating to Covid-19. It provides information on the overall activity related to the virus and the stage of the response. The presentation attached to the report, sets out the draft proposals for the recovery 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:	**Risks are included in the Corporate Risk Register**
Legal / regulatory:	NHSE/I This remains a national level 4 incident and our response is in line with the guidance provided
Resource:	This is currently being fully assessed
Impact Assessment:	Considered as part of the Incident
Conflicts of Interest:	N/A
Reference documents:	N/A
Assurance:	Plans are being developed in line with national guidance

Action Required by the Board of Directors:

It is recommended that the Board of Directors:

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

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You matter most

Board of Directors

27 May 2020

COVID-19 ASSURANCE REPORT

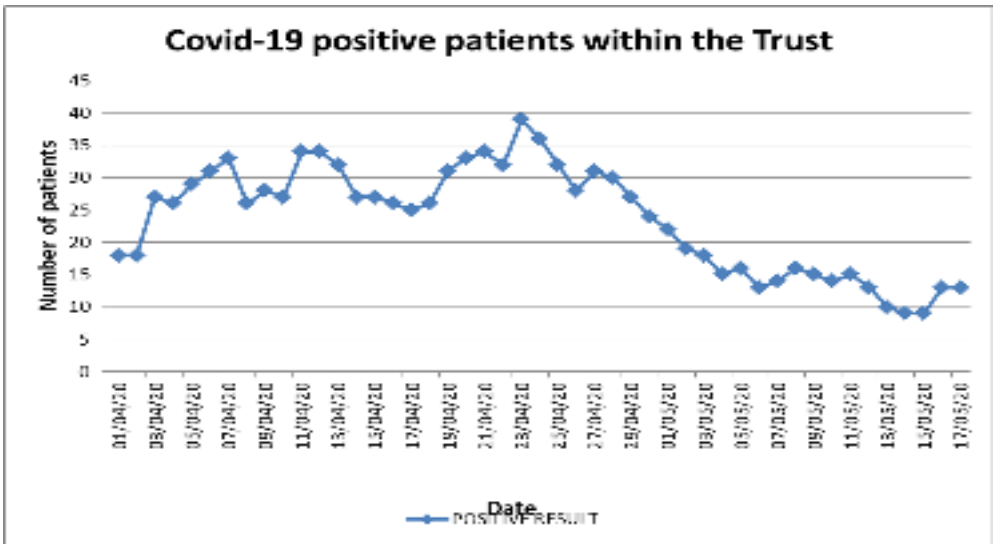
1. Overview

The response to the Coronavirus pandemic is now moving into the longer term management phase of the response. Nationally there has been work to support Trusts in the procurement of resources to provide a different model of care to patients and relatives. Within the West Yorkshire and Harrogate region we have been working with other Trusts to formulate a model of care that enables a high standard of care to be provided to all patients whilst moving forward into the 'new normal' for the National Health Service.

2. Covid-19 within the Trust

As of Thursday 14th May, 97 inpatients have recovered from covid-19 and been discharged. This figure includes patients who have been ventilated and non-ventilated. The below infographic is included in the daily communications bulletin each Thursday to provide an update to staff.

The chart below shows the number of covid-19 positive patients in Harrogate hospital since the beginning on April 2020. Since the peak on the 23rd April, there has been an almost consistent decline in the number of positive cases. To date (17/05/2020), there have been 230 confirmed positive results. Of these, 170 were admitted to hospital (73.9%). There are currently no members of NHS staff admitted who have tested positive.



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To date (17/05/2020) 57 patients with positive Covid-19 results have died in the hospital. All deaths have been notified to NHS England so that they may be included within the national reporting.

3. Hospital Response

In line with the national guidance, the Trust remains coordinating the incident response through the incident command centre (ICC) which is available 8am – 8pm, 7 days a week. This is providing support to all the Trust functions to ensure the smooth running of services during these unusual times. Guidance is still being received centrally by the ICC from the national incident response teams, and this is being reviewed by the incident command centre and disseminated to teams as appropriate. The Gold ICC meetings are held on a Monday, Wednesday, Friday and weekends to coordinate the ongoing works at directorate level.

The configuration of the bed base has been adapted to accommodate the new cohorting models for patients, and to enabling staffing to be adapted to ensure a robust skill mix across the wards. The Silver cell is meeting as part of the daily flow meetings to ensure that the tactical response to the incident is implemented as appropriate.

4. Recovery planning

To move forward with the recovery planning, a new governance structure has been initiated to with sub groups created to design and implement the new ways of working across the Trust. The work of each sub group is overseen by the Recovery Planning Cell, which is led by Mike Forster, Operational Director and discussed at the daily Operational Recovery Group.

The new ways of working are moving towards having a ‘zoned’ hospital, with a covid-19 free ‘green’ zone, a covid-19 positive ‘blue’ zone, and a further ‘yellow’ zone for patients with a low risk for covid-19 however there will be diligence regarding patient symptoms when attending in these zones. The zoning of the hospital will support in the standing up of elective procedures.

To compliment the zoning, a staffing model is being worked up to ensure that non clinical and clinical staff, are not crossing between green and Blue/Yellow zones during their working day – thus lowering the risk of cross transmission. To support with this work, all patients and clinicians will be screened for covid-19 prior to any elective activity.

There is also a clear focus on supporting vulnerable groups as part of our re-establishment of 0-19 services across the different locations we serve, ensuring there is resilient capacity to support safeguarding and continuation of online methods to manage social distancing measures.

Adult community teams are working closely with Primary Care Networks and the Local Authority through the Harrogate and Rural Alliance to ensure patients are cared for at home as much as possible and supported for early discharge from Hospital. In addition, specific teams are providing additional Infection Control Advice and training with PPE for Care homes across the district.

The restarting of Elective activity has to be done safely, taking into account PPE supply, Social Distancing measures, Infection Prevention and Control Measures to minimise the potential for hospital transmission. This will impact significantly on productivity levels and it will therefore be challenging to resume pre Covid-19 activity levels.

Harrogate and District NHS Foundation Trust

HDFT

COVID19 - Recovery Plan Draft Outline

May 2020

You matter most

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Introduction and Context

NHS
Harrogate and District
NHS Foundation Trust

- Work to develop the plan during May is ongoing
- Demand for services currently remains well below pre-CoVid levels
- Bed occupancy remains low
- Staff sickness stabilised at around 8%, but managing given bed occupancy/activity
- PPE remains a concern, in hospital and the community
- Work to 'switch on' services more complex than closing down

- Lots of operational detail behind this plan

You matter most

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Introduction and Context

Harrogate and District NHS Foundation Trust

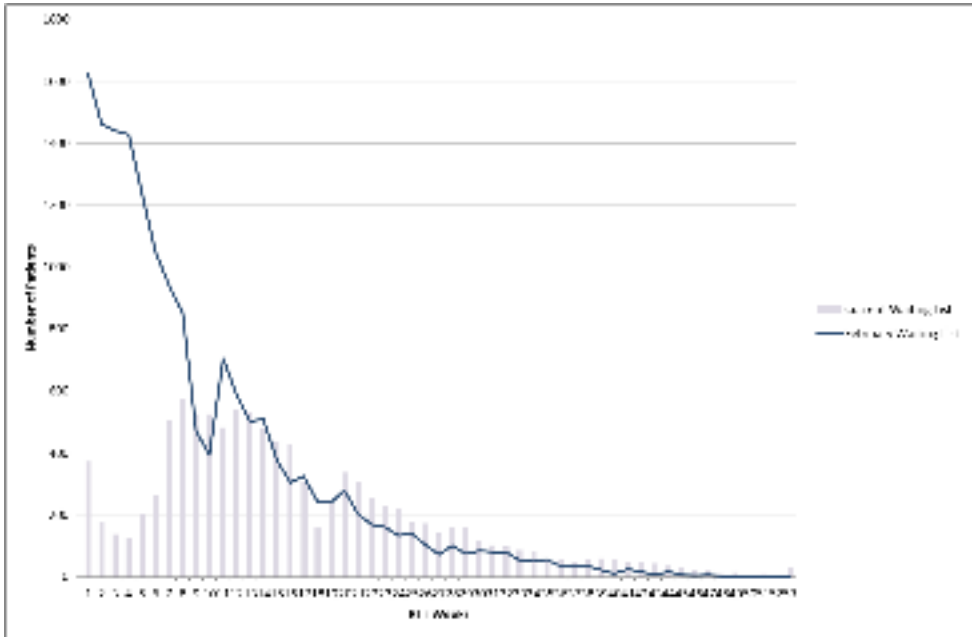
Below shows the impact of the COVID19 incident on the activity at HDFT and the current waiting list :

Main PODs for period 1st April to 30th April 2019 and 2020

1st April to 30th April			
POD	**2019**	**2020**	**% Apr20 vs Apr19**
Primary Care Referrals	4953	650	**13%**
New OP Attendances	7724	2647	**34%**
FU OP Attendances	15364	7319	**48%**
Elective IP	253	40	**16%**
Elective Daycases	2896	767	**26%**
Non Elective	1967	1228	**62%**
A&E Attendances	4425	2157	**49%**

NEW OP activity (inc Ward Attenders) UPDATE 12th May			
Clinic type	**2019**	**2020**	**% Apr20 vs Apr19**
FACE TO FACE COMMUNICATION	7708	1564	**20%**
TELEPHONE	16	1080	**6750%**
TELEMEDICINE WEB CAMERA	0	3	-
Total	**7724**	**2647**	**34%**
% FACE TO FACE COMMUNICATION	99.8%	59.1%	
TELEPHONE	0.2%	40.8%	
TELEMEDICINE WEB CAMERA	0.0%	0.1%	

RTT Waiting list position



You matter most

Creating a 'Green' area

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Hospital site to be **reconfigured** to provide the following:

- 3 main theatres (with ability to flip one back to blue if needed)
- Dedicated Elective Ward with separate external entrance
- 3 Day surgery theatres
- Endoscopy unit
- CT scanning
- Critical care beds, if needed

Logistics includes:

- Testing for patients and staff
- Staff facilities
- Car parking
- Access controls

Additional off-site capacity:

- 2 laminar flow theatres at BMI Duchy, Harrogate
- Exploring additional off-site locations for Radiology.

You matter most

10

Delivering Outpatients

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This will be achieved by:

- activity to be delivered non face to face where possible
- maximum possible Social Distancing through one-way flow (where possible) and reduced waiting area occupancy
- Utilisation of maximum possible capacity off Main Hospital Site (utilising Alwoodley, Ripon, Yeadon, & Wetherby clinics)
- Minimising the potential for Vulnerable patients to access Higher Risk areas on Hospital Site
- Minimising number of attendances to the site through one stop approach where possible

You matter most

Urgent care

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As part of realigning the **hospital site**:

- Streaming ED
- Ward reconfiguration
- Critical care resilience
- Moving coronary care unit out of 'green' area

Adult community service resilience:

- Community Care Teams
- Supported Discharge service
- Discharge centre on HDH site

Assumption is that we will have non-elective activity at the same level as 2019/20 from September onwards but delivered through increased out of hospital capacity

You matter most

10

Community children's services

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- Vaccination and Immunisation service - Catch up programme (June) and increased demand re Flu (October)
- Health Visitor / School Nurse – home visit risk assessment and assessment of face:face requirements
- Safeguarding – virtual 6-day service, limited face:face where required, supervision undertaken virtually

Issues:

Premises – often in GP practices and schools, so will require support re distancing and access

PPE supply

Vaccine supply

You matter most

Key dependencies

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- Retention of independent sector capacity
- Availability of PPE
- Availability and timeliness of equipment
- Availability of staff
- GP referral patterns
- Productivity impact from PPE and IPC
- Patient compliance with isolation requirements for Pre and post operative periods

You matter most

10

What we will deliver

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TRUST TOTAL ACTIVITY			
POD	2019/20 Actual	2020/21 Fcst	2020/21 vs 2019/20 %
Primary Care Referrals	55,492	40,231	72%
New Outpatients	82,243	47,241	57%
Follow Up Outpatients	180,448	113,095	63%
Elective Inpatients	3,293	1,441	44%
Elective Day cases	22,611	14,344	63%
Elective Day cases Endoscopy	11,633	6,472	56%
Non Electives	23,987	18,590	78%
A&E Attendances	52,637	41,126	78%

- This is based on a significant set of assumptions in relation to A&E attendances and non-elective admissions.
- Through the continued use of clinical triage, advice and guidance and appointments it is anticipated we will be able to continue to meet demand for 2WW urgent cancer referrals based on predicted activity.
- To maintain social distancing and IPC measures delivery of direct access diagnostic capacity for Radiology can only be delivered with access to additional off site capacity.
- Further work is required to expand the outpatient capacity (all contact types – telephone, video, f2f).
- Further work is required to finalise the arrangements for access to Endoscopy to support safe patient care in this high volume setting.

You matter most

10

Work-streams – next steps

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Children's and Community Care

Confirm assurance on Safeguarding resilience

Review risk assessment for home visiting from 0-19 teams

Consider consolidation of sites for podiatry across North Yorkshire

Frailty / CCT / SDS / Therapies /Discharge

Confirm review to remove any duplication

Review overall resource requirements

Confirm Ambulatory Frailty is included

ED

Review resource requirements and confirm costs

Wards

Review and confirm costs of all the establishments and then map against the bed model

Theatres & Day Surgery

Review and confirm costs

Forecast activity per month based on new theatre schedule and compare to 2019/20

Outpatients

Review and confirm the clinical model

Confirm activity split by contact type (telephone/video/face2face)

Confirm clinic space required for face to face contacts

Confirm Estates plan to support face to face requirements

Diagnostics

Endoscopy

Confirm Endoscopy- capacity and demand

Confirm clearance time of 12-weeks for Cancer and Urgent work.

Radiology

Review and confirm plan

Planning to arrange meeting wc 18.05.2020

Infrastructure

ED changes to go at risk

Critical Care to go at risk

CCU to go at risk

Main theatre plan to go at risk

Access controls for Green agreed

CT enabling works to go at risk

Rapid reviews of: Wards inc Rowan move; Radiology plan; Outpatients plan; Community bundle

Include overall staffing requirements and financial implications.

Initial outpatient areas that can open to be agreed and then a plan for all the areas once we have a confirmed activity plan.

You matter most

10

Harrogate and District NHS Foundation Trust

Date of Meeting:	27 May 2020	**Agenda item:**	7.2
Report to:	Board of Directors		
Title:	Operational Performance Report		
Sponsoring Director:	Mr Robert Harrison, Chief Operating Officer		
Author(s):	Mr Paul Nicholas, Deputy Director of Performance and Informatics		
Report Purpose:	**Decision** ✓ **Discussion/ Consultation** ✓ **Assurance** ✓ **Information** ✓		
Executive Summary:	• Provisional data indicates that 4 of the 7 applicable Cancer Waiting Times standards were achieved for April, with the 14-day Suspected Cancer, 62-day Screening, and 31-day Surgical subsequent treatment standards below the operational standard. • HDFT's performance against A&E 4-hour standard was 92.6% in April. This is below the 95% standard and trajectory. • Pre-validated provisional data shows that there were a total of 9,931 patients waiting on the list at the end of April. There were 18 patients waiting over 52 weeks at the end of the month.		

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:	SMT

Action Required by the Board of Directors:

It is recommended that the Board notes items included in the report.

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OPERATIONAL PERFORMANCE REPORT

1.0 SERVICE ACTIVITY

Trust total activity in April for all contact types is below the levels experienced in 2019/20 as a result of COVID 19. The Trust is actively working on the plan for the recovery phase to improve this position and incrementally increase and improve all activity levels between now and the end of the year.

2.0 RTT WAITS

Pre-validation provisional data shows that there were a total of 9,934 patients on the RTT waiting list at the end of April. There were 18 patients waiting over 52 weeks at the end of the month. All 52 week patients will be reviewed to identify any clinical harm.

The large reduction in the total number of patients waiting is linked to the reduction in elective referrals received following the stepping down of elective services in response to COVID19. Longer waiting times have continued to increase during this period and reducing these will be part of the planning process.

3.0 EMERGENCY DEPARTMENT PERFORMANCE

HDFT's Trust level performance against the 4-hour standard was 92.2% in April, below the required 95% standard. This includes data for the Emergency Department at Harrogate and Ripon MIU.

The department is now starting to experience an increase in attendances following the initial reduction owing to the coronavirus outbreak. The department has been split into two clear areas, one for COVID patients (Red ED) and one for Non COVID patients (Green ED). This is now live with clear process and procedure in place for the two separate areas.

4.0 CANCER WAITING TIMES

Provisional data indicates that 4 of the 7 applicable cancer waiting times standards were achieved in April, with 14 day suspected cancer, 31 day surgical subsequents, and 62 day Screening performance below the operational standards.

There has been a significant reduction in the number of 2WW referrals received by the Trust since the outbreak of Covid-19, resulting in more than a 50% reduction in first attendances. This, combined with various Covid-related delays (i.e. patients shielding, isolation, staff sickness, patients choosing to postpone their appointments), have also led to longer waits, meaning 14 day suspected cancer performance was just below the operational standard at 92.9% (provisional data).

In order to minimise the number of delays, telephone consultations have taken place where appropriate in order to assess and manage the risks associated with deferring diagnostics and treatment for suspected cancer patients. The number of referrals has been gradually increasing in May, and current expected performance is above 93% for both 14 day standards.

Covid-19 has also affected delivery of diagnostics for cancer patients as all non-emergency endoscopic procedures were suspended in April and early May. The Trust is working with the West Yorkshire Cancer Alliance in order to understand the volume of patients affected, the risk level of these patients, and the capacity available regionally. Alongside the Trust's own recovery plans, the aim is to optimise all available capacity so that diagnostics and treatments can be safely delivered for patients on a cancer pathway.

62 day standard performance is expected to be delivered in April. Provisionally there were 50.0 accountable treatments in April with 5.0 accountable over 62 days, meaning performance was at 90.0%. Of the 11 tumour sites treated in April, performance was above 85% for all but 2 (Head and Neck – 1 treatments and 1 breach; Lung – 5 treatments and 4 breaches). No patients waited over 104 days for treatment in April.

Provisional data indicates that 60% (6/10) of tertiary patients treated in April were transferred by day 38.

Delivery of the 62 day Screening standard for bowel patients continues to be a significant challenge as outlined above. Provisional data indicates that 3 breast patients and 2 bowel patients were treated in April, with the 2 bowel patients treated outside 62 days (1 Leeds and 1 York). This translates to an accountable denominator of 2.5 with 1.0 outside 62 days (60%).

1 skin patient received their surgical subsequent treatment on day 39 due to patient choice - with a total of 10 patients treated, this means performance was below the 94% standard at 90%.

Harrogate and District NHS Foundation Trust

Date of Meeting:	27 May 2020	**Agenda item:**	7.3
Report to:	Trust Board		
Title:	Chief Nurse Report		
Sponsoring Director:	Jill Foster, Chief Nurse		
Author(s):	Jill Foster, Chief Nurse		

Report Purpose:

Decision		Discussion/ Consultation	✓	Assurance	✓	Information	✓

Executive Summary:

This paper is to provide the Trust Board with assurance regarding patient safety and quality of care during the response to the COVID-19 pandemic. The paper specifically refers to

- Changes to Visiting Times
- Information regarding Complaints 2019/20
- Pressure Ulcer Prevention 2019/20
- Falls Prevention 2019/20
- Incident Reporting in relation to COVID -19 Issues
- Infection Prevention and Control Board Assurance Framework for COVID – 19

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 BAF 13: risk of insufficient focus on quality in the Trust.
Legal / regulatory:	None identified.
Resource:	None identified.
Impact Assessment:	Not applicable.
Conflicts of Interest:	None identified.

Action Required by the Board of Directors:

This paper requires the Trust Board to be informed and assured about quality of care in relation to

- Changes to Visiting Times
- Information regarding Complaints 2019/20
- Pressure Ulcer Prevention 2019/20
- Falls Prevention 2019/20
- Incident Reporting in relation to COVID -19 Issues
- Infection Prevention and Control Board Assurance Framework for COVID – 19

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Chief Nurse Report – May 2020

Harrogate and District NHS Foundation Trust

This Chief Nurse report provides an overview and assurance of care quality during the response to challenging and evolving COVID-19 pandemic. More details on key performance metrics are provided in the Integrated Board Report.

1.0 Visiting

1.1 At the beginning of the emergency response to the threat of COVID -19 viral infection our visiting arrangements were, under national instruction, severely restricted to one person to visit in the following circumstances

- A patient receiving end of life care
- A patient who has needs which require them to be accompanied
- A birthing partner
- An adult accompanying a child in the paediatric and neonatal departments

1.2 There has been subsequent national guidance regarding visiting but even in advance of this, we reviewed our stance with regard to supporting more considered and compassionate visiting arrangement. We have, so far, eased restrictions on

- End of life visiting including frequency of visits, the number of people able to visit and have included 'red' aerosol generating procedure areas
- Visiting patients experiencing longer lengths of stay
- Visiting patients with mental capacity issues
- Increasing the length of time a birthing partner can be present
- Increasing the number of adults accompanying a child in the paediatric and neonatal departments

1.3 There is detailed guidance for patients, relatives and staff for how the easing of restrictions can be safely managed.

2.0 Complaints

2.1 In 2019/20 there was a total of 234 complaints.

2.2 In the last 5 years, the average number of complaints per year is 225.

2.3 In 2019/20 we improved our response time for completing complaint responses to deadline to 49%

2.4 In April 2020 the Trust received 5 complaints, all graded yellow. None was COVID -19 related.

3.0 Pressure Ulcer Prevention

3.1 HDFT's dual aims are to reduce the total of hospital and community acquired pressure ulcers and, when pressure ulcers occur, reduce the number of omissions in care for category 3, 4 and unstageable pressure ulcers.

3.2 Hospital Acquired Pressure Ulcers

Year	Total no. Pressure Ulcers	Category 2	Category 3	Unstageable
2018/19	250	181	34	34
2019/20	305	252	23	28
	18% ↑	28% ↑	33% ↓	18% ↓

There has been an 18% increase in the total number of hospital acquired pressure ulcers in 2019/20, which is disappointing. It is encouraging, however, that the total number of category 3 and unstageable pressure ulcers have reduced with largest increase being seen in the number of category 2 pressure ulcers. This indicates there is earlier recognition, improved risk assessment and earlier appropriate interventions to prevent further loss of skin integrity.

3.3 Community Acquired Pressure Ulcers

Year	Total no. Pressure Ulcers	Category 2	Category 3	Unstageable
2018/19	332	197	94	37
2019/20	288	190	45	48
	13%↓	3%↓	48%↓	33%↑

The total number of community acquired pressure ulcers in 2019/20 has reduced by 13%. This is reflective of the significant effort of the community care teams to prevent skin damage.

3.4 All category 3 and unstageable pressure ulcers have a Root Cause Analysis (RCA) to learn if there has been any omissions in care. From 2019/20 there are 8 RCA's still to be completed. Once finished I will be able to provide information regarding omission of care and lessons learnt.

3.5 in 2019/20 we were asked to collect information regarding the number of pressure ulcers present on admission (POA) but not attributable to HDFT care. The total was 564. There has been no further

instruction regarding this information but the high number does indicate significant unmet need, which requires further analysis and a health economy wide response.

4.0 Falls Prevention

4.1 Inpatient Falls 2019/20

Month	No Harm	Low	Moderate	Severe	Death	Totals
April	39	11	0	0	0	50
May	42	16	0	0	0	58
June	37	10	2#	0	0	49
July	50	14	1#	1#	0	66
August	46	18	1 (Dislocated hip)	0	0	65
September	41	9	3#	0	0	53
October	52	12	2 (x1#) (x1 Haem)	0	0	66
November	42	11	0	1#	0	54
December	50	10	1#	2#	0	63
January	64	11	0	1#	0	76
February	30	15	0	0	0	45
March	37	12	0	0	0	49
Total	**530**	**149**	**10**	**5**	**0**	**694**

4.2 2019/20 has seen a 3% rise in the total number of falls. This compares to a 4% reduction in falls in the previous year (2018/19).

4.3 In 2019/20 the number of falls resulting in a fracture has reduced by 30%.

4.4 All falls resulting in moderate or severe harm are analysed by a RCA. There is 1 RCA remaining for completion in 2019/20.

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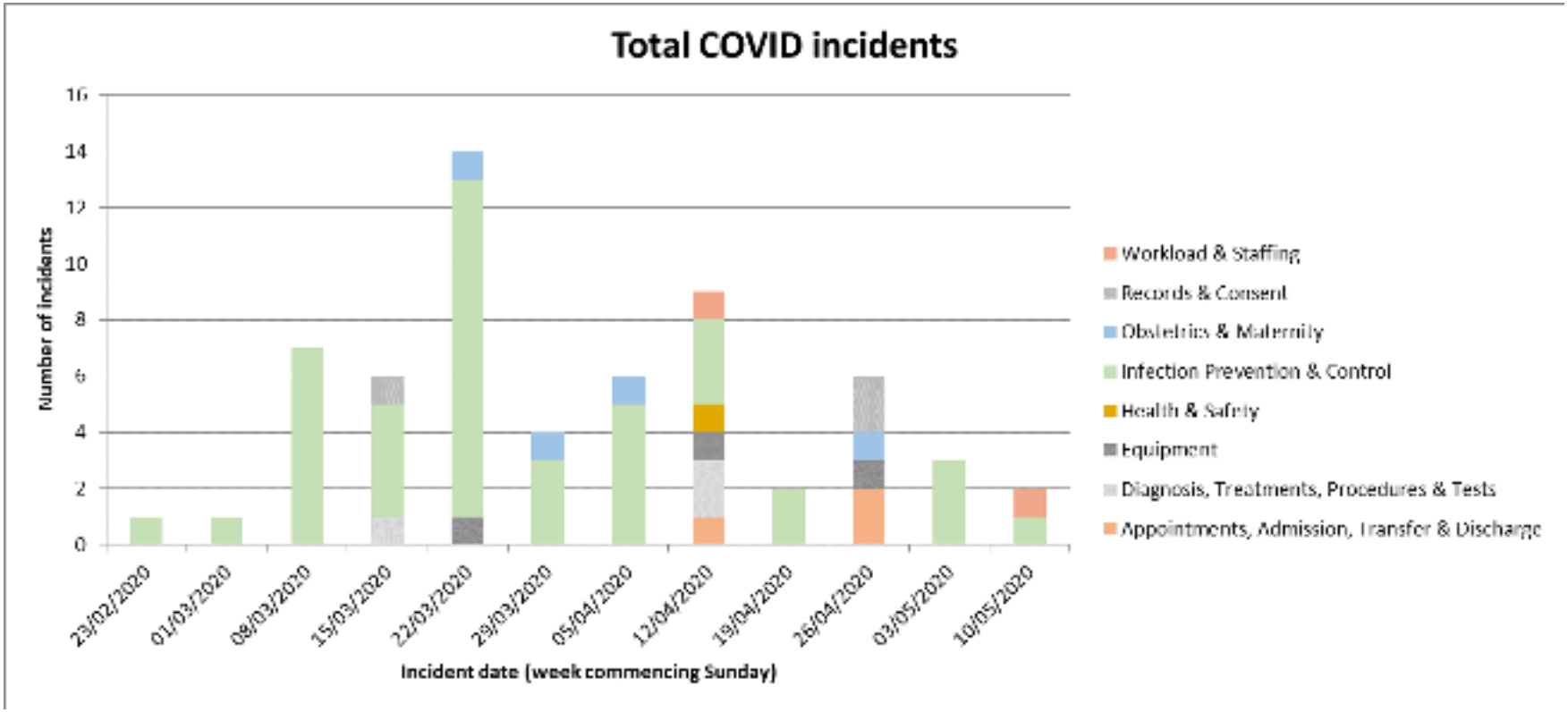
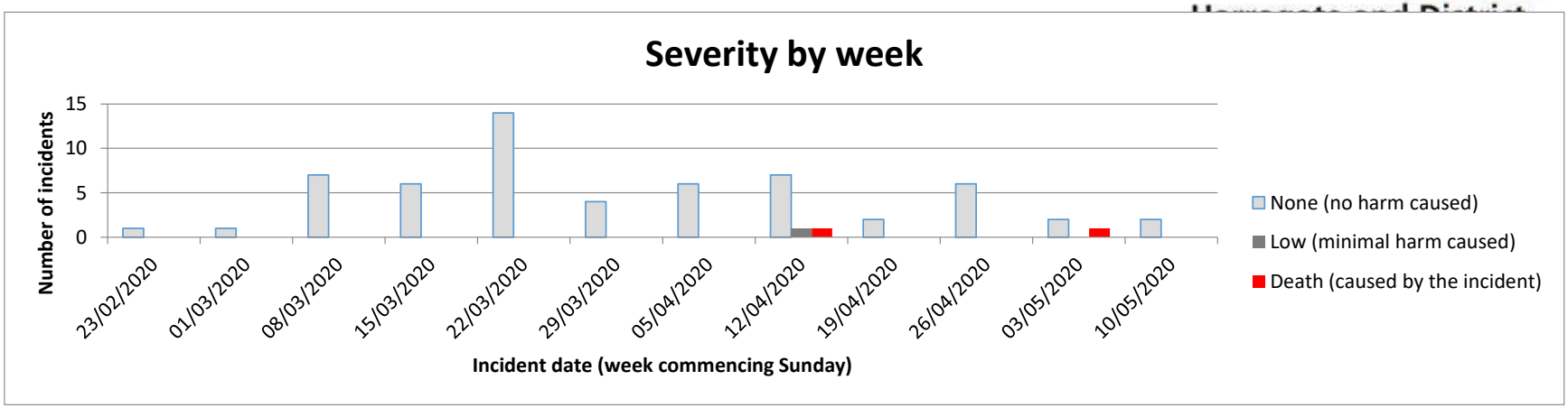
5.0 Incident reporting related to COVID – 19 Issues

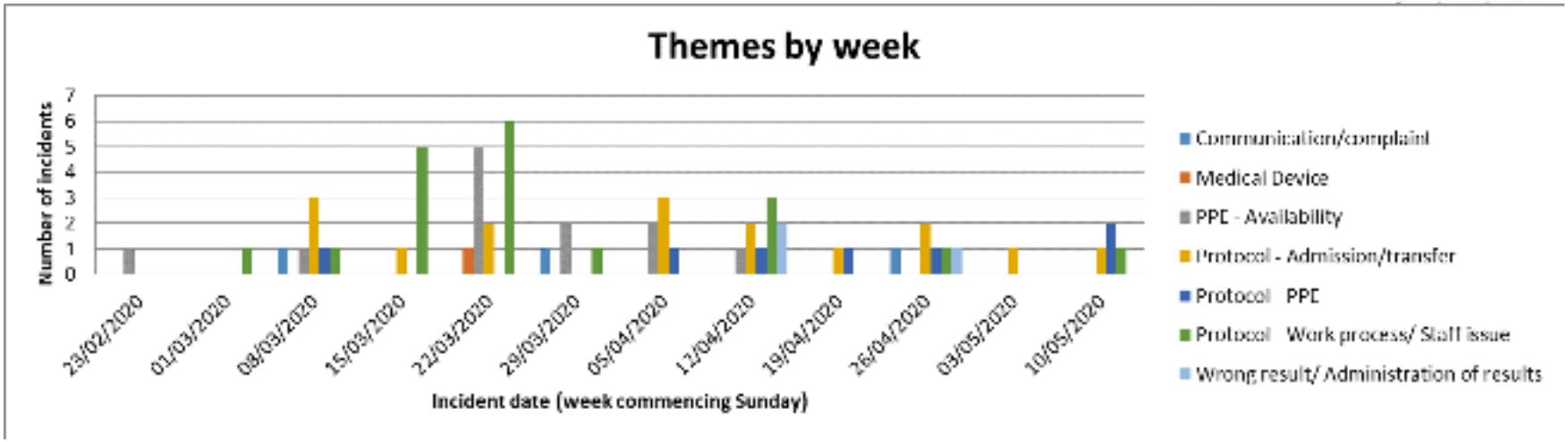
5.1 Total COVID Incidents



You matter most



You matter most



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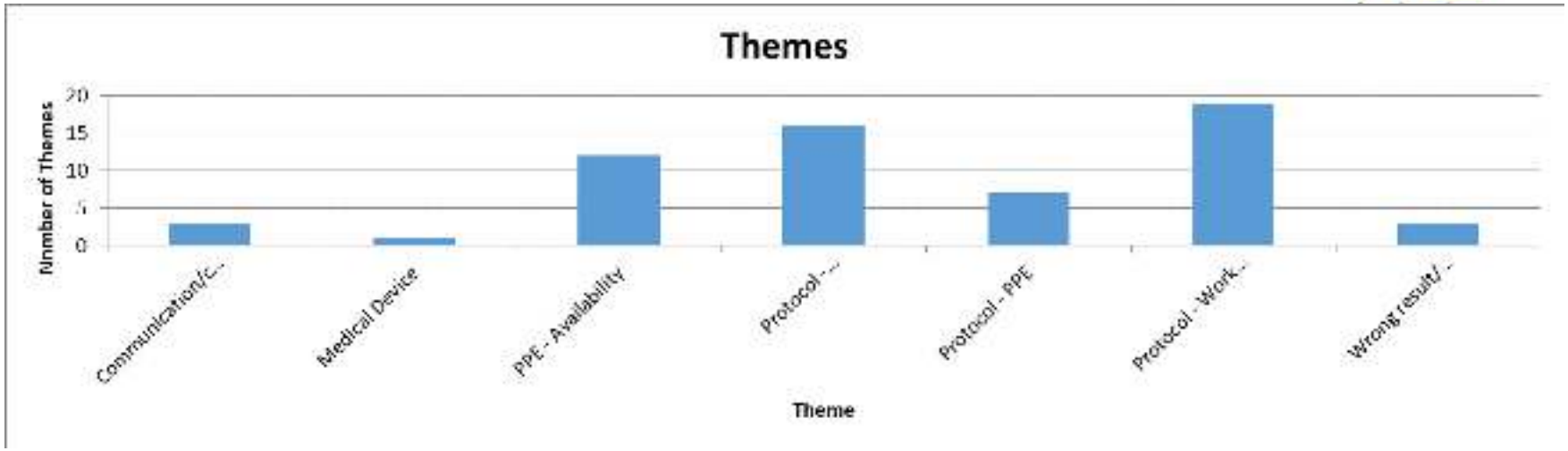

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6.0 Infection Prevention and Control Board Assurance Framework – COVID – 19

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • infection risk is assessed at the front door and this is documented in patient notes • patients with possible or confirmed COVID-19 are not moved unless this is essential to their care or reduces the risk of transmission • compliance with the national guidance around discharge or transfer of COVID-19 positive patients	• There is a Trust mandated pathway for both walk in and admitted patients within the Trust. This includes emergency admissions and outpatient appointments. • Guidance has been compiled by the IPC and Microbiology team to support in the placement of patients following receipt of their swab result. Where possible all patients are admitted to the most appropriate location so that they do not require transfer later in their admission. • As a Trust, we are adhering to the national guidelines in terms of discharge of patients. This includes ensuring that care homes and primary care have all relevant patient information to maintain	• The gaps in assurance are in relation to ensuring that the rapidly changing information is noted by the teams within the Trust. Due to increased staff pressures there is reduced management time and availability for some teams to review emails and attend meetings to discuss. • The current enhanced discharge support services are dependent on several redeployed	• Daily bulletins are being drafted for staff and shared with Matrons and managers for implementation at a ward/team level during huddles. This reduces the need for individual staff to check their emails. Comms Boards have also been erected and maintained for all wards and departments. • Currently under consideration as part of the recovery planning process

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• patients and staff are protected with PPE, as per the PHE national guidance • national IPC guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way	safety. A Discharge Centre was introduced March 2020 and is open 8 – 8, 7 days a week. This comprises: □ Discharge Liaison team □ NYCC/ HDFT Discharge Command □ Integrated therapy in-reach model □ Discharge nursing team The role is to enable timely patient discharge, transfer from ward within 1 hour of patient being deemed medically fit and discharge from hospital 2 hours from arrival in the Discharge Centre. • Appropriate PPE has been provided to all teams within the Trust with reference materials to promote the safe donning and doffing of the PPE. The Trust has provided PPE photos and checklists to support this. Patients are provided with the appropriate PPE for use within the hospital site. • IPC national guidance is received via the Trust Incident Command Centre (ICC). The guidance is reviewed and cascaded to hospitals teams as appropriate using the covid-19 response command	staff. To retain the 8-8 7 day a week model a workforce uplift is required	

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• changes to guidance are brought to the attention of boards and any risks and mitigating actions are highlighted • risks are reflected in risk registers and the Board Assurance Framework where appropriate • robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens	structure. Any changes to guidance are reviewed centrally by the IPC and ICC to ensure they are robust and provide the Trust mandated levels of protection. • Risks and mitigating actions associated with the new guidance are discussed and raised with the Board as appropriate. • Risks in relation to the covid-19 response are logged centrally via the ICC. These risks are discussed as part of the regular risk review process. This includes escalating any risks as appropriate onto the board assurance framework. • Normal IPC processes are still in place in reference to non covid-19 infections and pathogens. These are detailed as part of the existing IPC policy. IPC risk assessments have been stood down temporarily during the covid-19 response, however there will be a Trust wide audit of IPC processes in response to the covid-19 outbreak to assess the effectiveness of the Trust response.		

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2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • designated teams with appropriate training are assigned to care for and treat patients in COVID-19 isolation or cohort areas • designated cleaning teams with appropriate training in required techniques and use of PPE, are assigned to COVID-19 isolation or cohort areas. • decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE and other national guidance	• Teams based in all patient facing areas have been provided with the appropriate training for them to undertake the appropriate tasks. The skills matrix of each team has been reviewed and staff allocated as appropriate to maintain patient safety. • Designated cleaning teams have been allocated to ensure that any cleaning requirements can be fulfilled as soon as possible. These staff have been trained in the appropriate IPC and PPE techniques to maintain staff and patient safety. • Decontamination of patient areas are carried out in line with PHE IPC guidelines as per the IPC policy/protocol.	• There were concerns that there was not a big enough establishment of domestics to support the need in cleaning.	• Business case submitted by HIF to bring in additional staffing to bolster the domestic service.

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• increased frequency of cleaning in areas that have higher environmental contamination rates as set out in the PHE and other national guidance	• Decontamination of the hospital environments is carried out in line with standard IPC procedures as detailed in the IPC policy.		
• linen from possible and confirmed COVID-19 patients is managed in line with PHE and other national guidance and the appropriate precautions are taken	• Linen used in patient areas is processed in line with IPC guidance and adherence to Trust linen requirements as set out in HCN04.		
• single use items are used where possible and according to Single Use Policy	• Single used items are used as per the Trust decontamination policy and disposed of in line with Trust waste guidelines.		
• reusable equipment is appropriately decontaminated in line with local and PHE and other national policy	• Reusable equipment is decontaminated in line with Trust IPC procedures. Any PPE that is available for reuse (i.e. visors) have had a SOP for cleaning created.		

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3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and process are in place to ensure: • arrangements around antimicrobial stewardship are maintained • mandatory reporting requirements are adhered to and boards continue to maintain oversight	• Antimicrobial stewardship continues in line with the HDFT Antimicrobial Medicines Code. New Trust guidelines have been produced for the antimicrobial treatment of COVID-19-associated secondary bacterial pneumonia, available on the intranet. Weekly MDT continues for patients on out-patient parenteral antibiotic therapy (OPAT). Ongoing education where possible e.g. microbiology induction session for FiY1s. • Continued laboratory reporting to SGSS (regional antimicrobial resistance surveillance application). Continued reporting of alert organisms to PHE data capture service (DCS).	• Temporary suspension of daily ITU ward round and twice weekly antibiotics ward round, to avoid non-essential ward visits and help to conserve PPE.	• Ward rounds conducted via telephone.

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4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • implementation of national guidance on visiting patients in a care setting • areas in which suspected or confirmed COVID-19 patients are where possible being treated in areas clearly marked with appropriate signage and have restricted access • information and guidance on COVID-19 is available on all Trust websites with easy read versions	• The Trust visitor guidance has been made available on the Trust intranet and internet so that it is available to the public. The Trust guidance has been created in line with the national guidance. • Signage has been placed at the entrances to all wards with notification of the level of PPE required for each area. These areas have restricted access and clearly identified donning and doffing areas. The ward configurations are being regularly shared with Trust staff via the daily bulletins. • There is a covid-19 specific intranet page that has been set up with all the relevant information for Trust staff. Information for patients and visitors is also available on the internet. An easy read version of this	• There have been issues with staff having access to their emails to view this information.	• Information being shared with Matrons at the bed management meetings so that they are able to feed this information back at huddles in their wards/areas. All wards and departments also have Comms Boards.

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• infection status is communicated to the receiving organisation or department when a possible or confirmed COVID-19 patient needs to be moved	information has been made available. • Relevant information is being given to the receiving unit when a patient is discharged from the Trust.		

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5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms to minimise the risk of cross-infection • patients with suspected COVID-19 are tested promptly • patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-	• Front door services such as MIUs, GPOOH, outpatients and ED have appropriate triaging in place to ensure that any high risk patients are identified. A SOP has been put in place to guide staff through the screening questions that need to be asked when a patient attends. Waiting areas have been revised to ensure that social distancing procedures can be adhered to by staff and patients. • Currently, only inpatients are being swabbed for covid-19. When elective care is stood up, there will be a process for swabbing all patients implemented prior to them attending the hospital for their procedure. • Patients who test negative but are	• There were concerns from the CSM team that the results for NTAP patients were not	• A flow cart to support with the testing and moving of patients was pulled together by the

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tested • patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately	presenting with clinical symptoms of covid-19 are regularly tested throughout their inpatient stay. A protocol for the placement of negative but treat as positive patients (NTAPs) has been drafted by the Clinical Director and Microbiology to support the bed management team in the placement of these patients. • Patients are being asked not to attend their appointments if they are displaying covid-19 symptoms. If a patient attends with symptoms, they are given a facemask and asked to go home or if severely unwell present through the covid-19 ED stream.	coming back soon enough to support with the flow of patients through the hospital.	clinical director to support the clinicians on the wards.

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6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • all staff (clinical and non- clinical) have appropriate training, in line with latest PHE and other guidance, to ensure their personal safety and working environment is safe	• Staff are provided with the appropriate guidance and training to ensure that they are able to undertake their duties. Reference pictures and guidance on donning and doffing has been produced in line with the PHE guidance.		
• all staff providing patient care are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely don and doff it	• As above.		
• a record of staff training is maintained	• Staff training in relation to FIT testing of FFP3 masks is recorded on the Trust ESR module. A report of staff compliance and ward/department can be provided by the Learning & Development		

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	team as required.		
• appropriate arrangements are in place that any reuse of PPE in line with the CAS alert is properly monitored and managed	• An SOP has been drafted by the Trust to support in the reuse of visors. The gowns are laundered and repackaged for use in line with the Trust's laundering contract with Synergy (a copy of this is available from the Facilities Manager if required).		
• any incidents relating to the re-use of PPE are monitored and appropriate action taken	• Any incidents in relation to the use of PPE are recorded using the DATIX software. A report of all DATIXs referencing PPE or the Covid-19 response is provided to the ICC on a regular basis. This ensures that oversight of the incidents can be maintained and the issues picked up by the appropriate members of staff.		
• adherence to PHE national guidance on the use of PPE is regularly audited	• Although there is no formal audit of the use of PPE, DATIX and staff feedback is regularly monitored to identify any areas of concern. The IPC team provided drop in services to areas to provide guidance on the correct donning and doffing of PPE.		
• staff regularly undertake hand hygiene and observe standard			

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infection control precautions • staff understand the requirements for uniform laundering where this is not provided for on site • all staff understand the symptoms of COVID-19 and take appropriate action in line with PHE and other national guidance if they or a member of their household display any of the symptoms.	• The promotion of good hand hygiene is present throughout the Trust as part of the Trust's business as usual IPC approach. Posters are located in the key hand washing areas. • Guidance regarding the laundering of uniforms has been placed in the staff bulletins to support staff in the safe use of uniform. Uniform/laundering bags have also been provided to staff so use to transport their uniform home. • Clear guidance regarding the symptoms of covid-19 and what to do if they or a member of their family becomes symptomatic has been provided on the daily communication briefing and on the communications boards around the Trust. There is also a link to the government self-assessment tool on the intranet and guidance within the HR toolkit.	• There were concerns from some members of staff that they are not able to launder their uniforms appropriately.	• The offer of scrubs has been made to certain members of staff as these can be laundered thought the Trust linen contract.

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7. Provide or secure adequate isolation facilities			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • patients with suspected or confirmed COVID-19 are isolated in appropriate facilities or designated areas where appropriate • areas used to cohort patients with suspected or confirmed COVID-19 are compliant with the environmental requirements set out in the current PHE national guidance • patients with resistant/alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement	• Guidance for the placement of covid-19 positive or suspected patients has been provided to Trust teams. The Clinical Site Managers have oversight of these pathways and are clear on the isolation procedures for these patients. Individual teams such as maternity and pediatrics have developed their own SOPS to support this work. • Areas used to cohort covid-19 positive or suspected patients conform to the standard IPC environmental guidelines as outlines in the IPC policy. The domestic teams have been trained to undertake the cleaning processes on the higher risk areas. • Patients with resistant/alert organisms are managed according to IPC guidelines as set out in the Trust IPC policy.		

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8. Secure adequate access to laboratory support as appropriate			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
There are systems and processes in place to ensure: • testing is undertaken by competent and trained individuals • patient and staff COVID-19 testing is undertaken promptly and in line with PHE and other national guidance • screening for other potential infections takes place	• Swabbing is undertaken by appropriately trained staff. These staff have been trained both in the swabbing process and the appropriate donning and doffing of PPE. The following guidance for swabbing was drafted by IPC. • Patients are swabbed at the point of admittance into the Trust. Staff testing can be booked by any member of staff who are symptomatic or have a symptomatic household member. Currently, there is a waiting time of 24 hours or less for this service which is currently run out of Ripon. • Patients are still screened for other potential infections whilst admitted in the Trust and these are being managed as per normal IPC guidelines.		

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9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure that: • staff are supported in adhering to all IPC policies, including those for other alert organisms	• Staff receive IPC training as part of their induction process. The IPC team are available for advice throughout the day and are available to deliver team based training as and when required.		
• any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff	• Any changes to the PHE guidance are reviewed by the IPC team and Microbiology to ensure this is robust and agreed by the Trust. This is then disseminated to staff via the communications bulletin and communication boards.		
• all clinical waste related to confirmed or suspected COVID-19 cases is handled, stored and managed in accordance with current national guidance	• All clinical waste is handled in accordance with the Trust waste guidelines which have been agreed in line with the current national guidance. This guidance in available on the intranet.		
• PPE stock is appropriately			

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stored and accessible to staff who require it	• PPE supplies are managed centrally by the supplies team. A Trust sitrep of stock levels is provided to the ICC each day and supplies provided to wards/departments as appropriate. There is a dedicated number for wards to call if there is a shortage of supplies.		

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10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Appropriate systems and processes are in place to ensure: • staff in 'at-risk' groups are identified and managed appropriately including ensuring their physical and psychological wellbeing is supported	• Staff in at risk groups have been identified and the appropriate mitigations put in place. Support network and wellbeing information is regularly circulated on the daily communications and there is a dedicated HR covid-19 email address to provide ease of access for staff with any HR related queries and support for line managers.		
• staff required to wear FFP reusable respirators undergo training that is compliant with PHE national guidance and a record of this training is maintained	• Staff who require the use of FFP respirators have undergone training. There is a dedicated training team who are able to support staff with training. All training is logged via the ESR portal so that compliance can be monitored.		
• staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing	• Staff absence and wellbeing is monitored through the covid-19 HR inbox and wellbeing advice is regularly circulated. Those who are self-isolating have access		

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• staff that test positive have adequate information and support to aid their recovery and return to work.	to the staff testing service hosted at Ripon Minor Injuries unit. • Staff are provided with a guidance leaflet once they have received their swab. Their line managers are asked to make contact as per the HR sickness policy and maintain contact with the member of staff during their period of sickness.		

Jill Foster
Chief Nurse
May 2020

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Date of Meeting:	27 May 2020	**Agenda item:**	7.4
Report to:	Board of Directors		
Title:	Medical Director Update Report		
Sponsoring Director:	Dr David Scullion, Medical Director		
Author(s):	Dr David Scullion, Medical Director		
Report Purpose:	**Decision** ☐ **Discussion/ Consultation** ☐ **Assurance** ✓ **Information** ✓		
Executive Summary:	This report provides and update on key points and activities from the Medical Director.		

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 are escalated from ward to Board through the Corporate Risk Register and Board Assurance Framework.
Legal / regulatory:	NHSE/I CQC Fundamental Standards
Resource:	Not applicable
Impact Assessment:	Not applicable
Conflicts of Interest:	None identified
Reference documents:	Not applicable
Assurance:	Senior Management Team Directors Team

Action Required by the Board of Directors:

The Board is asked to note the content of this report.

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Board of Directors Meeting

27 May 2020

Medical Director's Report

1. GIRFT (Getting it Right First Time) update

In order to assist in releasing clinicians onto the front line to manage the Covid pandemic, GIRFT have officially announced that they will be suspending visits to Trusts and specialty specific data collection for the foreseeable future. Should any data packs in preparation become available during the pandemic, the intention is for GIRFT to release these to interested parties. In the interim, GIRFT are contributing to central work streams in both the acute and community sectors.

There is little doubt the GIRFT programme of data collection and deep dive visits will continue at pace once he pandemic has passed.

2. Chaplaincy matters

Having announced his attention to retire, I am delighted to report the appointment of Rev Darren McClintock to the post of lead for Chaplaincy services in the Trust. Darren is currently assistant Chaplain at LTHT and has a proposed start date towards the end of June in order to facilitate a handover. Darren's appointment is welcomed though comes at a challenging time for the chaplaincy services not least due to the background pandemic pressures and challenges within the chaplaincy workforce generally. I would like to welcome Darren to the Trust and formally thank the Reve David Payne for his insights, diligence, exceptional professionalism and support to me in the last 5 years. I wish him a long and happy retirement.

3. Medical student placement/trainee update

One of the many challenges we face as we emerge from the Covid pandemic is to ensure those in medical training graduate on schedule with sufficient training experience to satisfy GMC requirements. Work is beginning to ensure this takes place and that, whilst a number of factors are taken into consideration, priority is given to ensuring appropriate clinical placements o ahead to ensure the future medical workforce is maintained. The pandemic has forced medical schools to rethink learning opportunities for students and it is essential that the best of these are maintained post-Covid. Whilst it is accepted that clinical placements will not return to normal levels for some time, both Medial Schools and provider organisations will be asked to prioritise final year medical students. This prioritisation will have to balance the value of clinical placements for those at different stages of their medical training.

The Trust has always highly valued clinical placements and the sustained positive experience of students in Harrogate is testament to the hard work of our many clinical and educational supervisors. The Trust has recently received correspondence from the Dean of

Medicine in Leeds with a view to agreeing funding arrangements and working in partnership with the Trust to re-establish clinical placements with priority given to specific clinical areas:

- Acute and Critical Care
- Acute Medicine
- Emergency medicine
- Anaesthesia
- Continuing care and Cancer
- Obstetrics, Gynaecology and Sexual Health
- Paediatrics
- Psychiatry

Communication has been received from HEE regarding the induction of the new set of FY1 doctors. The expectation is that all new FY1's should receive a "Wellness Induction" and that Trusts will be expected to appoint wellness champions from outside the normal clinical team to exercise this function. Take up is not obligatory. Support ids already o offer for trainees from HEE and wellness webinars are arranged (dates confirmed). Trusts are advised not to duplicate effort. Other support strategies are already in place through the Deanery such as peer mentoring and coaching services. It is important that all Doctors are well supported in very difficult times.

4. Training Post expansion in Intensive Care Medicine

It is no coincidence that future workface adjustments in the light of the Covid pandemic, have focused of Intensive Care Medicine expansion. HEE YH has been provided with additional funding for 14 new training posts in ICM from august 2020 onwards. In principal, our Department in Harrogate could support this expansion by 1 training post. Discussions are ongoing regarding funding arrangements. The Trust would meet 50% of the cost plus any additional on call payments. The remainder would be met by HEE YH.

5. Medical Examiner update

The formal process for recruitment of ME roles paused to take into account the Covid pandemic, but this in of itself presented opportunities for a "trial run" with a group of "Interim Medical Examiners". This initiative came about from a group of pathologists who were deprived of their normal workload and keen to contribute positively. The initiative was also facilitated by temporary relaxation of the legislative requirements around death certification arising from the Corona virus Act 2020. Our Pathologists were expertly assisted by Dr Richard Hobson, Consultant microbiologist. All had previously expressed some interest in the substantive ME role. The process is ongoing and is providing useful insights into how the permanent appointments might function post-Covid. Re-invigorating the appointment process will be a task for my successor. The cremation fees generating from all certified in patient deaths have been donated to the Hospital charity.

6. National Flu immunisation programme 2020/21

Trusts are already being urged to prepare for what could be a challenging winter with co-circulating Covid and flu virus. The clinical groups eligible remain the same as last year,

although this may change depending on how the winter develops. There is a central expectation for universal vaccination of frontline health care workers. Quite how this will be achieved has yet to be detailed, though central guidance is promised in due course. Where possible, vaccination of healthcare workers and those vulnerable should be completed by the end of November

7. Research and service innovation

The Covid pandemic is proving a fertile opportunity for research and service innovation. Our staff has embraced this, the first patient already having been recruited into the Recovery Trial.

Clinical teams are also involved in other opportunities for service innovation, or benchmarking against current non-Covid treatment pathways. Examples include:

- HAREM: management of appendicitis in over 18's
- Covid surgery/Covid cancer surgery. Participation in national clinical effectiveness studies.

The CRN Yorkshire and Humber are developing a funding working group to inform the distribution of research funding across the network for 2020/21. This was originally paused due to Covid but has now been resurrected. Terms of reference have been circulated and representation requested. I will be liaising with my MD successor and the clinical lead for research to ensure we are properly represented.

8. Covid reflections

The past few months have seen a fundamental change in how we live and work. This has been a very difficult journey for many and there is some way to go before the Covid pandemic is truly behind us. The manner in which staff have met the challenge and coped with change, anxiety and tragedy has been truly inspirational and I am proud to have contributed in a small way worked with them. The positives have far outweighed the negatives, and the manner in which colleagues have rallied, often in the face of inconsistent advice, ever changing guidance and personal anxieties has been a joy to behold. I wish all of them the very best for the future as I hand over the Medical Director reins. I also send my very best wishes to Jackie Andrews in her role as the next Medical Director of the Trust.

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Date of Meeting:	27 May 2020	**Agenda item:**	7.5
Report to:	Board of Directors		
Title:	Workforce & Organisational Development Up-date		
Sponsoring Director:	Ms Angela Wilkinson, Director of Workforce and Organisational Development		
Author(s):	Mrs Shirley Silvester, Deputy Director, Workforce & Organisational Development Ms Angela Wilkinson, Director of Workforce and Organisational Development		
Report Purpose:	**Decision**	**Discussion/ Consultation**	**Assurance**	**Information** ✓		
Executive Summary:	The paper highlights the areas of current importance and focus in relation to workforce issues; • Providing Positive Support to BAME Colleagues through COVID-19 • Impact of pension tax - Scheme pays • Death in Service – new benefits • Doctors in Training – August Rotations • Local Clinical Excellence Awards		

- **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 HR Directorate and Corporate Risk Registers.
Legal / regulatory:	None identified
Resource:	None identified.
Impact Assessment:	Impact assessments for individual initiatives would be required in addition to considerations around recruitment practices to tackle recognised underrepresentation of protected groups.
Conflicts of Interest:	None identified.
Reference documents:	None identified.

Action Required by the Board of Directors:

The Board is asked to note the updates which are provided for information and to note progress with the BAME risk assessment process.

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Introduction	The Workforce and OD team continue with provision of services to HDFT for 'business as usual' and our response to COVID. Support to COVID activity continues at the same levels during Phase 2 recovery as it did during Phase 1 Emergency with the COVID HR team averaging 600 transactions a week handling queries and concerns and questions from managers and staff as the complexities and anxieties caused by working through and leading staff through the pandemic have not notably subsided and continue. National guidance is still being produced in response to the new and emerging issues – some of the key elements of which are included in this report.
Providing Positive Support to BAME Colleagues through COVID-19	**BAME staff Risk Assessment** Emerging evidence that is currently being reviewed by Public Health England shows that black, Asian and minority ethnic (BAME) communities are disproportionately affected by COVID19, with high rates of infection and higher rates of mortality. The reasons for this are not yet fully understood, but the health inequalities present for BAME communities have long been recognised. Within the NHS 40 percent of doctors and 20 per cent of nurses are from BAME backgrounds, as are a substantial number of health care support workers and ancillary staff. At HDFT 8.33% (409) staff are BAME and 8.77% (431) are 'not stated'. Work is underway to aim to establish the ethnicity in the 'not stated' category. On 30 April Simon Stevens CEO of the NHS advised employers that, on a precautionary basis, they should conduct risk assessments for BAME colleagues and act accordingly. In response to this request, the following resulting actions have been taken within HDFT: • An **Individual Risk Assessment** has been developed by HR colleagues – a copy of this is shown in **Appendix A.** At the time of writing 198 out of 445 BAME staff (44% completion rate) has been achieved. • **Manager support** - Appx 70 Line Managers attended a webinar hosted by Angela Wilkinson, Shirley Silvester and OH colleagues to provide guidance in the completion of the risk assessment. The Frequently Asked Questions and a recording of the webinar are available on the COVID19 section of the HDFT intranet. • Line managers have been provided with a **list of all BAME colleagues** in their teams. This has provided a useful opportunity to accuracy check and update our records. This process has resulted in at least another 100 staff previously recording their ethnicity as 'not stated' to indicating it specifically on ESR. • **Individual Contact with colleagues**- All BAME colleagues have been sent a letter to their home address and their work email address

	advising them that a risk assessment will be conducted with either their line manager or with another colleague should they so wish. • A **BAME Taskforce** has been established to provide governance and organisational oversight of this important issue. The Taskforce will report into SMT. The first meeting of the Taskforce was held on Wednesday 13 May. • 2 **Listening Events** for BAME colleagues have been held – hosted by Steve Russell, Angela Wilkinson and Jill Foster to provide our BAME colleagues with the opportunity to discuss their views and any concerns they have. The key themes that emerged from these are; a. Concerns about the safety of the general environment (Not clinical areas requiring PPE). These are generally regarded as safe however not all staff feel safe in communal areas where standards of social distancing and safety may be less clear and not as regulated b. PPE and ongoing concerns about appropriate use and level of PPE provided c. Impact of housing and community deprivation on staff health d. Concerns about the resumption of surgery – plans and safety e. Feedback about the risk assessment process – positive experiences and also feedback on who/how it can be best conducted. • **Agency and Bank workers –** significant work has been done to ensure the safety of colleagues who work on our premises who are supplied via agencies or bank suppliers. Agreements are now in place with all suppliers of Medical, Nursing, AHP and HIF staff to ensure we have risk assessment in place for Bank only workers and those who are multipostholders.
Impact of pension tax - Scheme pays	The Board will be aware that this has been a key concern for medical staff over the last 12 months. The voluntary 'scheme pays' election deadline for members of the NHS Pension Scheme has been extended to 31 October 2020 for tax bills relating to 2018-19. This has been extended by three months to help staff avoid missing the annual deadline during the COVID-19 response. If a member elects to use scheme pays, the NHS Pension Scheme will pay their annual allowance tax bill to HMRC on their behalf, with the member's benefits in retirement being reduced by a corresponding amount. This option means that members do not need to settle any pension tax bills with cash upfront.
Doctors in Training – August Rotations	The Board will be aware that the April rotation was paused in light of COVID 19.

	Health Education England (HEE) has announced that rotations for doctors in training are to restart in August. Planned rotations were cancelled for May, June and July as a result of COVID-19. All trainees in Foundation and Core posts will rotate as usual at the start of August. However, not all specialties rotate in August and, as a result of COVID-19, there will be more programmes with start dates later than August.
Death in Service – new benefits	The Secretary of State announced on 27th April, a new death in service benefits for NHS staff providing vital work during the COVID-19 pandemic - **The NHS and social care coronavirus life assurance scheme** This new scheme is to provide life assurance benefits for eligible NHS and social care staff who are performing frontline work during the COVID-19 pandemic. This is in recognition of the increased risks that staff are currently facing, and will be particularly welcomed by those who are not members of the NHS Pension Scheme. In the event of a staff member dying in the course of COVID-19 work, a lump sum payment of £60,000 will be made to their estate. The scheme will be administered by the NHS Business Services Authority (NHS BSA) however further details and guidance are still awaited.
Local Clinical Excellence Awards	Local Clinical Excellence Awards (LCEA) have been halted as a result of the COVID-19 pandemic, with a proposal that the award money due be distributed equally among eligible consultants. NHS Employers, the British Medical Association (BMA) and HCSA, who represent senior doctors and their employers, have agreed a joint statement which acknowledges the current exceptional circumstances, and the significant operational pressures services are currently under. The rationale for this nationally was as follows. The LCEA award round was due to start this month (April 2020) for the year 2020-21.The halt to the forthcoming round and related work will enable clinicians and managers to focus on immediate priorities. The existing funding (including any money rolled over from the last two years or from award rounds that may not yet have been run or completed) will be redistributed equally among eligible consultants as a one-off, non-consolidated payment in place of normal LCEA rounds. At HDFT however, we are proposing to complete the 19/20 round which was already well underway pre- COVID. The proposal for the 20/21 round is that we distribute it across all consultants, not just those who would have been eligible to apply for a CEA award. This is

	being discussed with LNC colleagues on 21st May.

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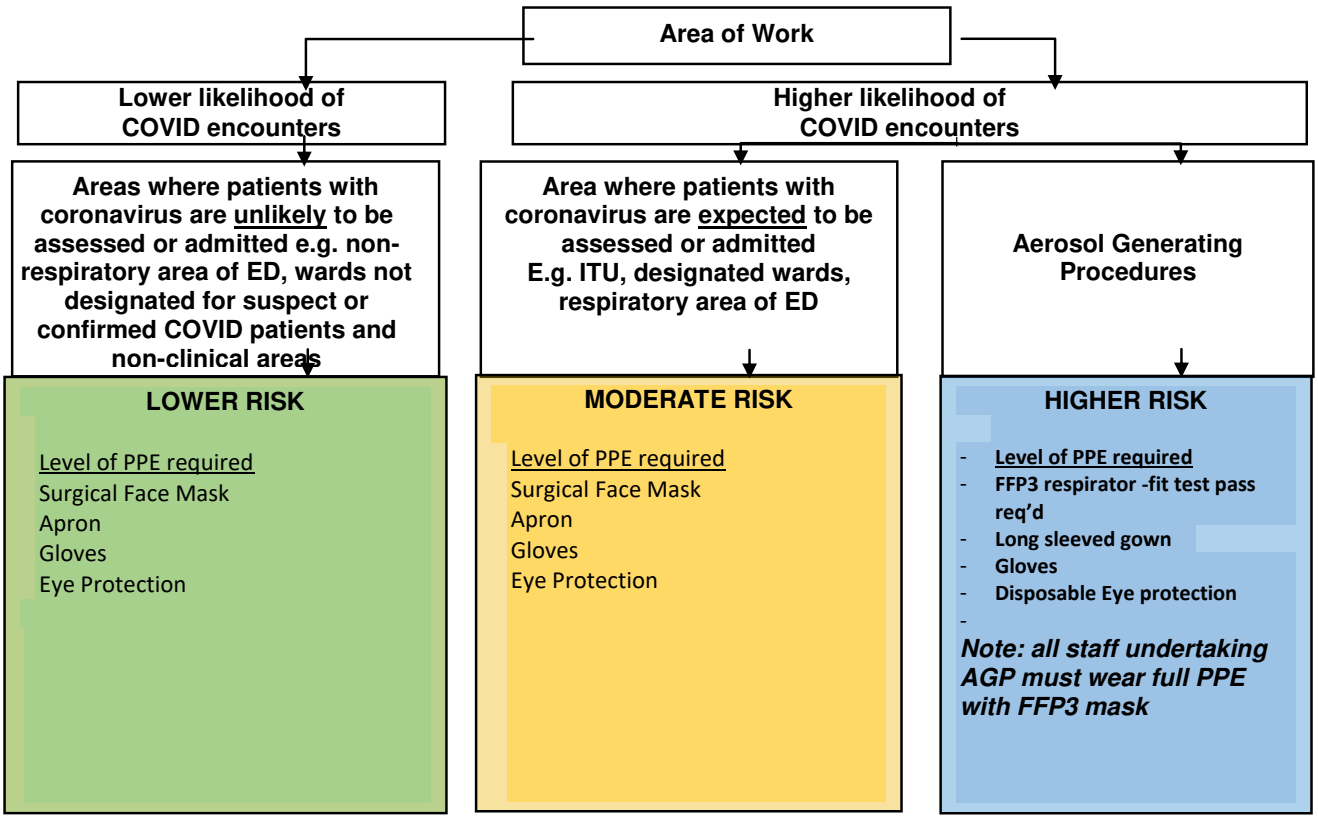
Appendix A - Individual Risk Assessment

Risk assessment for Black Asian and Minority Ethnic (BAME) Group Staff with potential work related exposure to COVID-19

Completing the Risk Assessment

1. This assessment can be undertaken by the line manager, or if the employee does not wish to discuss/disclose health related information to their manager they may instead want to contact Occupational Health. Other parties who are able to carry out the risk assessment are: Freedom to Speak up Guardian and Human Resources COVID 19 Team.
2. Involve the employee in the risk assessment in the most appropriate way – face to face/telephone or virtual meeting, e.g., MS Teams
3. Consider actions to minimise the risk of potential work related exposure to COVID-19
4. Record the risk assessment and actions agreed.
5. Agree a review date if required
6. Both Line Manager and employee to sign the document, copy to be provided to employee, original to held on their personnel file and copy to be sent to HDFTcovidhr.@nhs.net

Employee Name:		**Date of Assessment:**	
Employee Role:			
Work Location:		**Date of Review (if applicable):**	



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The employees' work area is:	☐ LOW RISK	☐ MODERATE RISK	☐ HIGH RISK
The employee is:	☐ Clinically extremely vulnerable as defined by Public Health England :		☐ BAME employee without severe clinical risk
	Employees in clinically extremely vulnerable groups should not attend the workplace. Working from home is permitted if possible in their role		Use the form below, in consultation with the employee and undertake individual risk assessment

Wellbeing Questions	Current Position	Possible Actions
1. Does the employee have an underlying health condition	YES ☐ NO ☐ Comments/Action:	See next question and take appropriate action
2. If yes, have they received advice from Occupational Health during the pandemic in relation to their condition(s)	YES ☐ NO ☐ N/A ☐ Comments/Action:	If NO you should refer employee to Occupational Health If YES and Occupational Health have already reviewed employee check that recommendations and/or modifications have been implemented
3. Does the employee have any concerns about travelling to and from work?	YES ☐ NO ☐ Comments/Action:	If YES Can public transport/rush hour be avoided through adjustments to work hours/shift patterns if required to accommodate changes to timetabling and where social distancing is difficult to maintain to reduce risk?
4. Does the employee have any other anxieties about attending work?	YES ☐ NO ☐ Comments/Action:	Ask if the employee if there are measures they can suggest that would ease their anxieties Check that the employee is aware of and able to

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		access the Health & Wellbeing support available. Provide paper copy if intranet access limited.
Role Specific Questions	**Current Position**	**Possible Actions**
5. Is the employee still attending the workplace \?	YES ☐ NO ☐ Comments/Action:	Managers should document the reason for non attendance e.g. shielding, isolating, absence due to other reasons and what steps have been taken to manage this absence e.g. referral to OH.
6. Has the employee been redeployed into another role?	YES ☐ NO ☐ Comments/Action:	Managers should state reasons for redeployment, e.g. advice from OH, failed fit test, or request from employee which they could support due to child care or other personal reasons
7. Is the employee working in moderate or high risk areas?	YES ☐ NO ☐ Comments/Action: Duration / Frequency	If YES record the frequency and duration of time spent in moderate or high risk areas Where possible limit duration of close patient interactions e.g., prepare in advance away from patient If YES, consider redeploying the individual to a low risk area or modifications that can be made to reduce risk
Role Specific Questions	**Current Position**	**Possible Actions**

8. Is the employee receiving adequate breaks at work?	YES ☐ NO ☐ Comments/Action:	If NO document any actions needed to ensure that breaks can be taken
9. Does the employee have any concerns in relation to their working hours or shift pattern?	YES ☐ NO ☐ Comments/Action:	Document any actions agreed to address any concerns where this is possible, i.e., temporary changes to hours or work or days worked, etc.
10. Can the employee maintain >2m distance from the patient and/or maintain social distancing in non-patient facing scenarios?	YES ☐ NO ☐ Comments/Action:	Can face to face interactions be limited? Look at things like working environment – desk space, meeting room space, use of communal facilities such as changing rooms or places where employees can eat or get a drink
11. Could the employees work be done from home?	YES ☐ NO ☐ Comments/Action:	Managers should document any reasons/barriers preventing working from home
12. Could alternative work be undertaken elsewhere in the Trust or at home?	YES ☐ NO ☐ Comments/Action:	Managers should record what would need to be in place to enable this to happen – identification of alternative role, provision of IT equipment, necessary training, etc,
PPE Questions	**Current Position**	**Possible Actions**
13. **Are patients being asked to wear masks for staff member interactions?**	YES ☐ NO ☐ Comments/Action:	

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14. Is the employee trained to use appropriate PPE?	YES ☐ NO ☐ Comments/Action:	If NO employee must not undertake further patient contact facing role until training has been received. In the meantime move to a low risk non-patient facing area or arrange to work from home
15. Is the employee confident and competent in using appropriate PPE?	YES ☐ NO ☐ Comments/Action:	If NO employee must not undertake further patient contact facing role until further training has been received and personal support when Donning and Doffing arranged until employee feels confident and competent in the use of appropriate PPE. In the meantime move to a low risk non-patient facing area or arrange to work from home
PPE Questions	**Current Position**	**Possible Actions**
16. Has the employee been fit tested if required?	YES ☐ NO ☐ Comments/Action:	If NO employee must not undertake activities requiring fit test to be passed.
17. If employee has undertaken fit test please provide details: **NB If passing fit test not possible the employee must be moved to role in lower risk area not requiring this**	Date: | Test type: | Portacount ☐ Taste test ☐	Respiratory Protective Equipment (RPE) Mask Type tested: | Pass ☐ Fail ☐
18. Is appropriate PPE available to the employee at all times?	YES ☐ NO ☐ Comments/Action:	Managers should ensure the employee does not undertake patient facing activities unless wearing the appropriate level of PPE

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19. Does the employee have any concerns about the availability or suitability of PPE / RPE?	YES ☐ NO ☐ Comments/Action:	Managers should record the level of PPE required in the employees' work area, its accessibility, training provided re donning and doffing.
Personal Circumstances		
20. Is there anything else that the employee feels we should know about them working through the pandemic?	YES ☐ NO ☐ Comments/Action:	For example: -does their household include someone in the extremely vulnerable group - are they experiencing financial difficulties -are there issues of overcrowding due to lockdown -have they suffered any bereavement and loss due to COVID-19 which may heighten anxiety
Summary of Risk Assessment actions agreed:		
If you need advice from OH please contact us by email indicating "Covid-19 Referral" in your enquiry/e-mail subject header attaching the completed risk assessment along with your COVID-19 Management Referral document.		

Signed:

Manager:	Employee:
Name	Name:
Date:	Date:
Position:	Position:

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Date of Meeting:	27 May 2020	**Agenda item:**	7.5.1
Report to:	Board of Directors		
Title:	Diverse representation in decision making and workforce equality		
Sponsoring Director:	Ms Angela Wilkinson, Director of Workforce and Organisational Development		
Author(s):	Ms Angela Wilkinson, Director of Workforce and Organisational Development		

Report Purpose:

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

Executive Summary:

On 29 April, Sir Simon Stevens and Amanda Pritchard wrote to Trusts regarding the second phase of the NHS response to COVID-19. As noted in that letter, there is emerging evidence that the virus is having a disproportionate impact on our black, Asian and minority ethnic (BAME) colleagues. The Board will be aware that significant action is already been underway in response these concerns for colleagues.

On 19th May 2020, all Trusts received a follow up letter from Prerana Issar Chief People Officer for the NHS and Dido Harding Chair of NHS Improvement (Appendix A) explaining that one of the areas they are focusing on is representation in decision making, which will ensure that BAME and disabled staff have influence over decisions that affect them.

In the letter, organisations are being asked to review COVID-19 command and governance structures, for levels of diversity representation in leadership and decision-making with a very strong encouragement for chairs and non-executive directors to tap into the talent and resource that exists within organisations.

This paper outlines an overview of the Trusts position in relation to this issue.

- **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 HR Directorate and Corporate Risk Registers
Legal / regulatory:	NHSE/I
Resource:	None identified
Impact Assessment:	Impact assessments for individual initiatives would be required in addition to considerations around recruitment practices to tackle recognised underrepresentation of protected groups.
Conflicts of Interest:	None identified

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Reference documents:	None identified
Action Required by the Board of Directors:	
The Board is asked to note this report including the plans in place to continually embed in the Trust.	

Board of Directors Meeting

27 May 2020

Diverse Representation in Decision Making and Workforce Equality

Introduction	On 29 April, Sir Simon Stevens and Amanda Pritchard wrote to Trusts regarding the second phase of the NHS response to COVID-19. As noted in that letter, there is emerging evidence that the virus is having a disproportionate impact on our black, Asian and minority ethnic (BAME) colleagues. The Board will be aware that significant action is already been underway in response these concerns for colleagues. On 19th May 2020, all Trusts received a follow up letter from Prerana Issar Chief People Officer for the NHS and Dido Harding Chair of NHS Improvement (Appendix A) explaining that one of the areas they are focusing on is representation in decision making, which will ensure that BAME and disabled staff have influence over decisions that affect them. In the letter, organisations are being asked to review COVID-19 command and governance structures, for levels of diversity representation in leadership and decision-making with a very strong encouragement for chairs and non-executive directors to tap into the talent and resource that exists within organisations. This paper outlines an overview of the Trusts position in relation to this issue.
Equality Diversity and Inclusion ('EDI') lead	The Director of Workforce and OD created a new role in December 2019 for a lead for the Trust which is positioned in the HR senior management team which brings opportunity to inform and influence through the management arrangements within the Directorate in response to COVID. We have ensured that Angie Colvin is active in the arenas suggested in the attached letter in order to strengthen and deepen our understanding of the issues. • currently undertaking NHS England WRES Expert programme • Angie is a member of the Yorkshire and Humber Regional EDI Leads Network and the West Yorkshire and Harrogate BAME Network
Governance and Decision Making – COVID 19	Since the outset of the COVID 19 emergency/incident phase, the Trusts decision making process was aligned to our organisational structure which is overseen by the CEO and Executive team. The governance then channels through our ICC (which incorporates Gold/Silver/Bronze) is embedded under the leadership of the Executive team and aligned to the Directorate management teams. In making decision through that structure Bronze teams are engaging with Directorate Colleagues which seeks to ensure a wide reflection of the colleagues within the organisation. The Trust also set up a Clinical Advisory Group (CAG) which is at the heart of advising on changes in practice which affect patents and staff. This has regular BAME representation (approximately 90% of meetings).

	As CAG and the Workforce Cells advise the ICC (Gold) on policy matters relating to staff and service users, the diversity of involvement in those two groups is key to enabling good inclusive decision making by the ICC.
Staff Networks	The Trust fully endorses the view in the letter which promotes engaging and using the 'wisdom' that networks and BAME colleagues can offer. • HDFT recently launched Staff Networks – BME, Disability and Long-term illness and LGBT+ • The Trust has Fairness Champions with BME representation Whilst in their early stages of operation, the BAME network has already played an active role in helping co-create our response to the emerging concerns.
Response to Impact upon BAME colleagues of COVID 19	In reviewing our 'command and governance' structures and how we have ensured we are listening to the voice and feedback from colleagues to influence and inform decision making, we have put the following in place or taken the following actions; • Created a new BAME Taskforce which met for the first time on 14th May which comprises senior leaders and Trust Decision makers and representatives from the BAME staff network. • Created a risk assessment tool to form the basis of a conversation with every BAME member of staff to explore concerns and risks and to agree actions. This was discussed and considered at the Taskforce. A representative from the BAME staff network was part of the discussions in creating this. • In order to reach out directly, a letter and email was sent to BAME colleagues from the Chief Executive and Director of Workforce and OD expressing how seriously the Trust is taking this issue and encouraging them to raise concerns and participate in the Risk assessment process. Concerns and feedback that emerges from this will be fed into the Taskforce so decisions can be made in response. • We have held 2 BAME staff Listening Events – hosted by the Chief Executive, the Director of Workforce and OD and the Chief Nurse. These events raised issues of importance that are now being taken forward; e.g. Staff safety in non-clinical/non PPE wearing areas, understanding impact of deprivation on health, review and reinforcement of PPE standards. • There is representation from the BAME Staff Network on the Trusts Health and Wellbeing Group which is the leading group on putting together and implementing our health and wellbeing offer for staff.
Conclusion and Next steps	The infrastructure is relatively new regarding EDI, but it has worked well during the time of crisis in leading the focus on these issues and ensuring to date BAME colleagues are involved. CAG is working well and is a good example of an inclusive group where significant decisions are made.

	We will look to ensure representation within the general decision making arrangements (particularly Bronze command which is currently aligned to Directorate and Trust governance) and have representation where this is not currently in place as part of the established existing management teams. We will continue with the current arrangements in line national guidance until we are informed of any required change.

Classification: Official

Publications approval reference: 001559

To: Chief executives of NHS trusts and foundation trusts
Chairs of NHS trusts and foundation trusts and CCG Accountable Officers
Chairs of ICSs and STPs

NHS England and NHS Improvement
Skipton House
80 London Road
London
SE1 6LH

Copy to: NHS Regional Directors

19 May 2020

Dear colleagues

Diverse representation in decision making and workforce equality

Firstly, we would like to thank you for all that you and your colleagues are doing to respond to COVID-19 in these incredibly challenging times – we sincerely appreciate the continued dedication and commitment of all **our NHS people** working in organisations across the country.

On Wednesday 29 April, Sir Simon Stevens and Amanda Pritchard wrote to you regarding the second phase of the NHS response to COVID-19. As noted in that letter, there is emerging evidence that the virus is having a disproportionate impact on our black, Asian and minority ethnic (BAME) colleagues.

One of the areas we are focusing on is representation in decision making, which will ensure that BAME and disabled staff have influence over decisions that affect them. Data collections, including those which contribute to the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES), had to be paused as part of the initial response to COVID19, however, **WRES and WDES implementation** including associated data collections is now resuming

Organisations are also being asked to **review COVID-19 command** and governance structures, for levels of diversity representation in leadership and decision-making.

We know that chairs and non-executive directors are expected to lead internal scrutiny and assurance at all levels, but we would strongly encourage you to tap into the immense talent and resource that already exists within our organisations. This includes equality, diversity and inclusion leads and, where they exist, trained WRES experts.

Classification: Official

On Thursday 30 April, we hosted a webinar for more than 240 **BAME staff network leads** from across the NHS. Key themes included:

- **better resourcing of staff networks**
- **giving more power to the networks**
- **ensuring robust connections between staff networks and their boards**

We also hosted a virtual meeting of over 200 disabled staff network chairs and disabled leaders. We will be following up with attendees as a priority to identify what we can all do – both individually and as a collective. Annex A summarises some of the actions that are being taken following this session.

These networks, along with others, are critical to our organisational and system-wide response to the virus. We encourage you to engage and fully utilise the vast wisdom that they hold – and to develop such forums where they do not exist.

By embracing and implementing the key recommendations cited above – as well as our collective passion and commitment to health equality for all, we will be better able to respond to the virus – now and in the months to come.

Over the coming days, the WRES and WDES Implementation teams will be in touch with your organisations regarding the collection of this years' data, as well as obtaining data for your virus response structures.

In the meantime, please accept once again our personal thanks and support for the remarkable way in which you and all **our NHS people** have risen to this exceptional health challenge.

Best wishes,

Prerana Issar

Dido Harding

Prerana Issar
Chief People Officer for the NHS

Dido Harding
Chair of NHS Improvement

Classification: Official

Annex A

Actions arising from the BAME staff network webinar 30.04.20	
Theme	**Actions** (undertaken or planned)
Health and wellbeing of BAME Staff	• Webinar reaching out to over 1000 staff to explore health and wellbeing needs was hosted - data will be used to tailor and improve the current offer. • A tailored bereavement service for colleagues in the Filipino community will be established within next 10 days.
Disproportionate impact of COVID-19 on BAME community	• Liaising with multidisciplinary group of experts on practical risk assessment tool; considering ethnicity as a factor in conjunction with other conditions (w/c 4 May) • PHE's review of COVID-19's impact on BAME communities commission by Chief Medical Officer (ongoing) • Work is underway to bring together race and health work, research and practice (ongoing) • Webinar with academics on the impact on BAME community scheduled (12/5)
Staff networks and support	• Letter from NHS England and NHS Improvement to NHS organisations highlighting the importance of staff networks (w/c 4 May) • Sharing of resources from the staff network webinar and generally about staff networks, with NHS organisations (w/c 4 May) • NHS England and NHS Improvement to link with Equality and Diversity Council (EDC) to focus on regional BAME staff networks for the purpose of sharing good practice (w/c 4 May)
Data, research and evidence	• Work is underway to bring together race and health work, research and practice (ongoing)
Diversity in decision making	• WRES and WDES implementation (including data submission and publication) will continue in 2020 – letter to the system outlining this (w/c 4 May)

Classification: Official

	• Extension of WRES and WDES data collections to include data on the make-up of COVID-19 response structures (goal command and Nightingale hospitals) – letter to the system outlining this (w/c 4 May)
Board diversity	• WRES implementation (including data submission and publication, and implementation of the Model Employer strategy) will continue in 2020 – letter to the system outlining this (w/c 4 May)
Protection of BAME Staff	• NHS Employers risk assessment guidance published (29/4) • Liaising with multidisciplinary group of experts on practical risk assessment tool (w/c 4 May) • Examining evidence from 2 trusts on fit testing processes to inform how to update risk guidance further (w/c 4 May) • Will continue to update guidance as further evidence emerges including PHE's review of COVID-19's impact on BAME communities (ongoing)
Listening and engaging with BAME staff	• Importance of BAME staff networks – letter to the system (w/c 4 May) • Sharing of staff network resources to attendees of the webinar (w/c 4 May) • Collaborative work between WRES team and the FTSU Guardians Office (5 May)
Board leadership and advocacy	• NHS England and NHS Improvement to link with ongoing NHS Confederation and NHS Providers work re: the role of boards, leadership and advocacy (w/c 4 May)
Comms and media	• Comms and media strategy developed • Proactive pieces now on social media, BAME leaders, influencers, radio, television and communication channels • Thank-you video to our BAME workforce, blogs by senior BAME leaders and a range of webinars.

Harrogate and District NHS Foundation Trust

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Finance Report

Board of Directors – 27 May 2020

Operational plan 2020/21

Operational priorities 2020/21

- During the autumn and winter period of 2019/20, discussions in relation to planning for 2020/21 continued as per the usual process
- Draft priorities were identified for discussion, alongside a financial, activity and workforce plan for the year
- The CoVid outbreak and necessary response cancelled the planning process nationally and deferred the process locally
- A revised plan is required to be agreed, reflecting the new financial arrangements, the capital requirements, and the response to the CoVid outbreak
- Whilst we are rightly focused on the CoVid response and recovery, we need to not lose sight of the operational priorities that we were discussing

Operational priorities 2020/21

Below are the areas we previously identified, alongside comment in relation to current status:

area	comment
Sufficient access to computers/devices across the Trust	Additional investment as part of CoVid response, this can continue as part of 20/21 planning
Implement a rostering system and recruitment tracker	Can continue – external funding identified for rostering
Health & Wellbeing – an employee assistance programme	Continue – has been introduced as part of CoVid response
Develop community children's services to ensure retention and further growth	Process in relation to NY agreed but paused, mobilisation of Durham to continue. Our relationships with Commissioners can continue to be developed this year and a development plan identified
Outpatient transformation	Significant change through CoVid response. Part of our Recovery Plan for 2020/21.

area	comment
Transform consultant based care to team based care	Significant work changes as a result of CoVid response. Can be developed as part of Recovery plan, and retain the learning.
Review theatre staffing strategy, including alignment of job plans and scheduling to improve productivity	Part of Recovery planning, but acknowledged challenges in relation to theatre productivity currently. Priority to continue as we undertake elective work, and consider job plans, staffing, capacity and WLI approach
Develop an acute frailty model	A high priority and part of the work with the CCG. Need to continue with this work
Improve care outside of hospital for our older population	As above, and part of developing our working with local authority (through HARA) and PCNs. Priority enhanced due to impact of CoVid and impact on Care Homes.

Revised financial plan

National financial regime:

- Moving to block contract payments, paid on account, for all Trusts, with the suspension of the PbR payment mechanism and associated processes. This arrangement has been extended until the end of October but anticipated to be the arrangement for the full year
- Payments from Commissioners are not dependent upon performance or activity levels, and all contract sanctions suspended
- Payments values to be determined centrally based upon recent runrate of costs uplifted for inflation of 2.83%
- The tariff efficiency requirement is removed, and there will no funding for growth. Effectively the value will be 19/20 costs uplifted to 20/21 rates
- Top-up payments made to ensure that Trusts breakeven this year
- Additional funding available to cover the additional costs (capital and revenue) of responding to CoVid

Revised financial plan

Internal principles

In response to the national financial regime, the financial plan for the Trust needs to be updated and agreed. As part of this process the following principles apply:

- We need to continue to manage and govern our financial expenditure appropriately
- The budget set for this year is not the recurrent budget for the future, as we will see a necessary return to delivering efficiency and productivity in future years
- Expenditure budgets have been based upon outturn from 2019/20 plus inflation
- No CIP has been applied
- No underspends have been brought forward
- The only developments funded will relate to CoVid response and recovery
- The CoVid recovery plan, when agreed, may necessitate movement of budgets between and within Directorates

Revised financial plan

The proposed budget for 2020/21 is summarised below:

Directorate	2019/20 Outturn £'000s	Budget Book incl. CIP £'000s	Proposed Covid Budgets £'000s
CCCC	- 53,455	- 53,229	- 54,208
Corporate	- 36,369	- 36,534	- 37,585
LTUC	- 71,467	- 70,800	- 73,683
PSC	- 70,092	- 70,072	- 72,562
Capital Charges	- 4,057	- 5,495	- 5,495
Central	7,617	5,643	- 1,785
Total Non Commissioner Revenue	- 227,822	- 230,487	- 245,318
Commissioner Income	228,185	231,761	230,421
Underlying Surplus/Deficit Position	**363**	**1,274**	**- 14,896**
FYE of Nationally Calculated "Top Up"			3,804
Surplus/Deficit Position	**363**	**1,274**	**- 11,092**

There are two key issues to further explain:

- The resulting £11m planning shortfall – see next slide
- The reconciliation of the increased budget from £230.5m to £245.3m – see later slide

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Revised financial plan

The planning gap of £11m is due to the following items:

Issue	Potential annual financial impact (£m)
Depreciation – NHSI assumption based upon runrate in months 8,9,10 of 2019/20. This was the period we transacted our asset lives review impact.	2.9
TEWV income for Briary Wing – NHSI assumption based upon income received in 2019/20	1.0
Local Authority pay award funding – NHSI assumption that this is fully funded from LAs. Currently, a number of commissioners haven't committed to the funding	1.5
Local authority contract reductions – NHSI assumption that all income is as per 2019/20. This is consistent across the NHS commissioners but not with local authorities, where we have some contract reductions	0.5
Calculation of CNST premium – Unclear how the calculation has been made but is inconsistent with nationally notified premium	0.8
Business Rates – cost pressure in 20/21 over and above runrate in 2019/20	0.8
Reconciliation with HaRD / NY CCG – clarity required to ensure that income assumption from NY CCG reflects the year end agreements reached across the ICS	3.0
ICS transformation funding – payment of £0.5m due from HDFT in 2020/21, which will not be part of NHSI runrate for 2019/20	0.5
total	**11.0**

These issues are being discussed with NHSI to correct their planning assumptions.

This should result in a revised income assessment that we will then receive.

Until this is corrected, we will request additional funds each month through the 'true-up' process to ensure we deliver a break-even position.

Revised financial plan

The increase in planned budget from £230.5m to £245.3m is due to:

Issue	**£m**
CIP removed from budget	8.0
National reclassification of our MRET income – it is now part of our top-up to get to breakeven rather than paid as part of our income	2.5
Business rates impact	0.8
Reduction in income from TEWV following vacation of Briary Wing	1.0
Requirement to repay funding to WY&H ICS	0.5
Funding for Local Authority pay award	1.5
Capital charges increase	0.2
Other minor changes	0.3
total	**14.8**

The revised plan has been discussed with Directorates through Resource Review meetings last week, and at SMT. The budgets have been agreed with Directorates, subject to final Board approval.

Capital

The resources available for the capital programme are based upon the following:

- Cash is available from depreciation and surplus, less any loan repayments
- Assumed that the cash available from our original planned surplus will be available (£1.3m) despite the new regime targeting a breakeven only position
- CoVid capital is funded separately, but all schemes now require pre-approval by NHSI. This is new requirement from 19.5.2020.
- National funding available for schemes such as digital, or ICS agreed bids (eg Scan for Safety)
- Our 'allowable spend' that fits within the overall ICS capital limit, is £8.4m. This provides us with sufficient headroom if we had additional cash available

- The following slide outlines the current position in relation to the programme for 2020/21.

Capital

	Proposed Plan - not finalised			Post Covid			
	Resource £'000s	Expenditure £'000s	Net Impact £'000s	Resource £'000s	Expenditure £'000s	Net Impact £'000s	Notes
Internally Generated Resource							
Depreciation	6,382		6,382	6,382		6,382	
Surplus	1,274		1,274	0		0	National Planning now break even
cash				1,274		1,274	assumed for planning that cash available in lieu of surplus
Loan Repayments		2,125	-2,125		2,125	-2,125	Normal Course of Business Loans
Internally Generated Resource	6,606	2,125	4,481	6,606	2,125	4,481	
Externally Generated							
CT capacity	2,600	2,600	0	0	0	0	timescale to be clarified
Mammography	390	450	-60	390	450	-60	
Rostering	370	370	0	370	370	0	Unclear on position of this
WebV	1,000	1,000	0	600	600	0	Assume staff (£400k) and small amount of non pay (£100k)
Scan for Safety	200	200	0	200	200	0	Unclear on position of this
Externally Generated Resource and Schemes	4,460	4,520	-60	1,460	1,520	-60	
Covid 19 related expenses							
IT - VDI				391	391	0	
IT - attend anywhere				43	43	0	
IT - wifi				130	130	0	
IT - other				12	12	0	
Equipment - critical care				2,165	2,165	0	
equipment - pathology				183	183	0	
equipment ED room				283	283	0	
equipment - C-Arm				119	119	0	
site - MAU/medical gases				556	556	0	
site - infrastructure (DSU/ED)				323	323	0	
site - briary wing				289	289	0	
Nightingale recharge				128	128	0	
ITU				670	670	0	
Externally Generated Resource and Schemes	0	0	0	5,241	5,241	0	
Internal Schemes							
2019/20 C/F		1,500	-1,500		1,207	-1,207	includes Cath Lab
Windows 7 to 10		1,100	-1,100		600	-600	£500k brought into 2019/20
PSC		739	-739		991	-991	£700k c/f/ppe
LTUC		1,267	-1,267		1,338	-1,338	Mortuary / radiology kit
CCCC		100	-100		100	-100	
Backlog Maintenance and Estate		600	-600		600	-600	Full backlog £2.7m
Improvements to the Hospital Environment		0	0		50	-50	Current value approved
IT infrastructure		0	0		250	-250	
Mannequins		150	-150		150	-150	
Future Site Strategy		150	-150		150	-150	
Contingency		500	-500		500	-500	
Internal Schemes	0	6,006	-6,006	0	5,816	-5,816	
Total	11,066	12,645	-1,579	13,307	14,702	-1,395	

The current list of proposed commitments exceeds expected cash by £1.4m.

Priorities will need to be reassessed over the next few weeks to deliver a programme within the resources available.

The areas to focus on are the Directorate priorities and c/f schemes.

These total £3.6m, and we will need to generate slippage / defer / cancel £1.4m.

A proposal will be discussed at SMT in June.

This remains a significant capital programme given the CoVid response expenditure.

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Other comments

This revised plan proposal covers in particular the new **financial** arrangements that impact upon our budgets and our capital programme.

The original **activity** plan and performance trajectories are clearly completely irrelevant currently, and will need to be agreed as part of our CoVid Recovery Plan for the remainder of 2020/21

Our original **workforce** plan remains relevant, and the establishments have been agreed and used to build up the budgets for each area. As part of the CoVid Recovery Plan, establishments might need to be amended or transferred between areas – these will need to be signed off with the recovery plan and any increase in establishment approved alongside any financial impact.

We need to ensure that we consider our **Quality** priorities alongside this plan and the Covid Recovery plan. This will also be informed by the 'lessons learned' exercise currently being undertaken in respect of the Phase 1 CoVid response.

Month 1 Position

The Table below outlines the position for Month 1 against the NHSEI plan for the Trust.

	NHSI Plan £m	Trust Actual £m	Covid Costs £m	Top-Up £m	Var to Plan £m
Income (Exc Top-Up)	21.55	19.596			1.96
Cost	-21.65	-20.33	-1.07		-0.25
EBITDA	**-0.09**	**-0.73**	**-1.07**	**0.00**	**1.71**
Dep/Int	-0.22	-0.56			0.34
Net I & E (Exc Top-Up)	**-0.31**	**-1.30**	**-1.07**	**0.00**	**2.05**
Pre-Notified Top-Up	0.31			0.31	0.00
Retrospective Top-Up				2.05	-2.05
Bottom Line	**0.00**	**-1.30**	**-1.07**	**2.36**	**0.00**

As outlined the Trust reported a balanced position, which was achieved by £2.05m of retrospective top up funding.

The current planning assumptions from the NHSI plan has a number of issues within it. The impact of these issues equated to £1.08m. If these issues were addressed, and the costs of Covid-19 accounted for the Trust would have reported an underlying underspend of £103k. Clearly as we enter the next phase of the response to Covid-19, monitoring this underlying position will be significant.

Month 1 Position

Harrogate and District NHS Foundation Trust

The costs associated with Covid 19 for HDFT are summarised below.

Expanding medical / nursing / other workforce	Sick pay at full pay (all staff types)	COVID-19 virus testing (NHS laboratories)	Plans to release bed capacity	Increase ITU capacity (incl Increase hospital assisted respiratory support capacity, particularly mechanical ventilation)	Segregation of patient pathways	Existing workforce additional shifts	Decontamination	Other	COVID-19 Nightingale Set up cost total
101	478	17	4	22	34	40	9	145	216

The total CoVid revenue cost of £1.07m equates to 4.9% of revenue, which is broadly aligned with the costs reported by providers in WYAAT and HCV ICS.

Board approval

The Board is asked to:

- **Note** the revised financial framework for 2020/21
- **Approve** the revised budgets for 2020/21
- **Note** the current position in relation to the capital programme for 2020/21
- **Note** the Month One financial position of breakeven, and the ongoing dialogue with NHSI in relation to the financial plan for 2020/21

Harrogate and District NHS Foundation Trust

Date of Meeting:	27 May 2020	**Agenda item:**	8.0
Report to:	Board of Directors		
Title:	Learning from Deaths Report Q4 2019/20		
Sponsoring Director:	Dr David Scullion, Medical Director		
Author(s):	Dr Sylvia Wood, Deputy Director of Governance		
Report Purpose:	**Decision** ☐ **Discussion/ Consultation** ✓ **Assurance** ✓ **Information** ✓		
Executive Summary:	During Q4 2019/20 seven structured judgement reviews (SJRs) were completed. 86% (6/7) patients reviewed had good or excellent overall care. 28/32 (88%) phases of care were rated as good or excellent. There were three deaths of patients with learning disabilities reviewed by SJR during Q4. The overall care was rated as good for all of these. All appropriate deaths are referred to the national Learning Disabilities Mortality Review (LeDeR) programme. We have received feedback from four LeDeR reviews.		

Related Trust Objectives

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

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

Action Required by the Board of Directors:

It is recommended that the Board:

- Notes items included within the report and the current processes for ensuring learning from deaths.

Harrogate and District NHS Foundation Trust

Introduction

For those patient deaths meeting the criteria for a detailed review of case notes, the Medical Director appoints a clinician with appropriate expertise to undertake a structured judgement review (SJR). Whenever possible, the clinician will not have been involved in the care of the patient who died. A case note review is to determine not only examples of good practice, but also whether there were any problems in the care provided to the patient who died in order to learn from what happened.

The Trust has adopted the RCP National Mortality Review Tool which is hosted on Datix. This enables easy access to the information gathered but is not an easy tool for reporting and there is some potential for error when historic cases are being reviewed at the same time as current cases.

All structured case note reviews undertaken during Q4 2019/20 have been included in this report.

All hospital cardiac arrests are reported to the National Cardiac Arrest Audit (NCAA) to monitor and report on the incidence of, and outcome from, in-hospital cardiac arrest in order to foster improvements in the prevention, care delivery and outcomes from cardiac arrest. It is a joint initiative between the Resuscitation Council (UK) and ICNARC (Intensive Care National Audit & Research Centre) and is included in the Department of Health Quality Accounts. In addition, the Resuscitation Committee undertakes case notes reviews of all in-hospital cardiac arrests to determine whether the resuscitation is deemed appropriate or inappropriate, and to identify any areas of learning to share. The data for Q4 is not available because the resuscitation team have been supporting the work to respond to the COVID-19 pandemic.

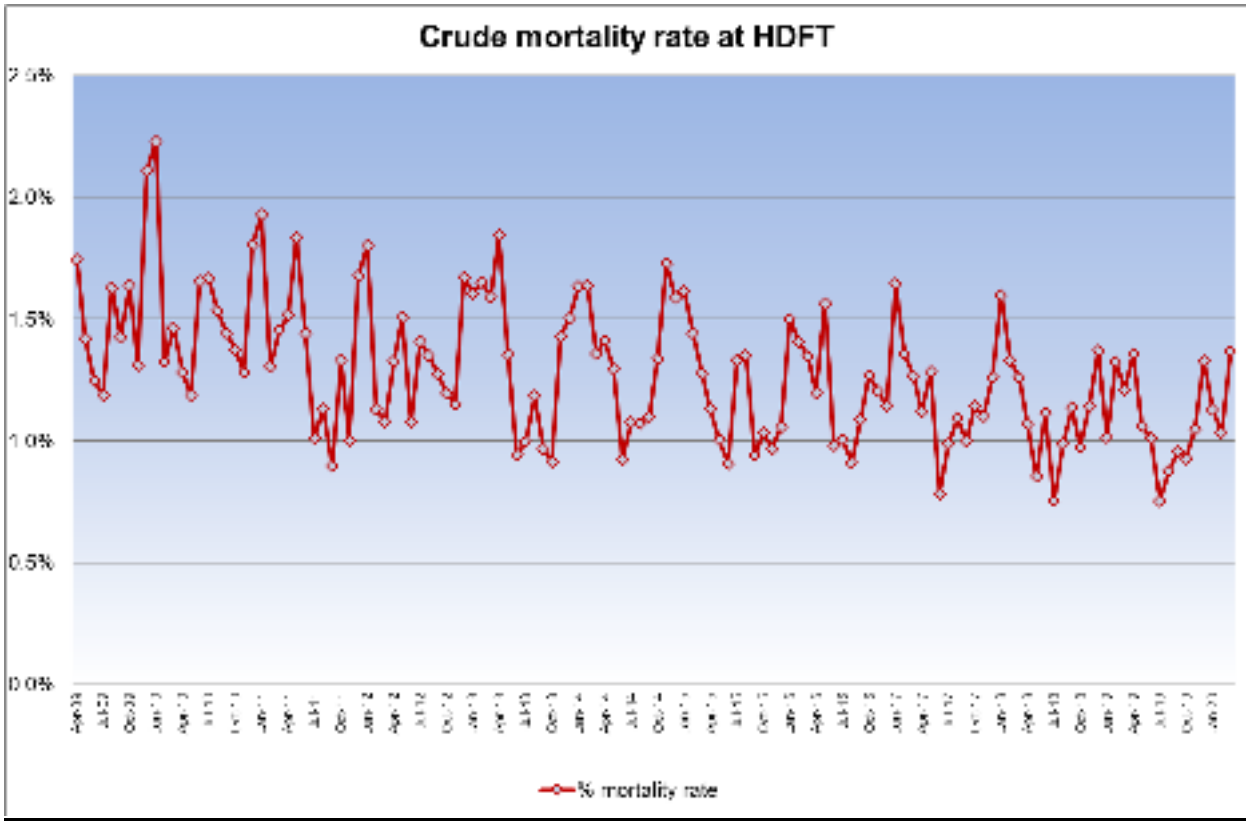
The report also includes updated information about the LeDeR Programme and the outcome of reviews.

Information has been included this quarter about the processes for using external reports of mortality to ensure appropriate review of cases where appropriate and learning.

Crude mortality data

The crude mortality data is given to give some content to the number of the deaths reviewed quarterly.

Inpatient deaths - quarterly trend									
Q1 2016/17	167		**Q1 2017/18**	145		**Q1 2018/19**	142		**Q1 2019/20**	177
Q2 2016/17	133		**Q2 2017/18**	140		**Q2 2018/19**	140		**Q2 2019/20**	139
Q3 2016/17	167		**Q3 2017/18**	167		**Q3 2018/19**	177		**Q3 2019/20**	177
Q4 2016/17	199		**Q4 2017/18**	205		**Q4 2018/19**	182		**Q4 2019/20**	172
Total	666			657			641			665



Structured case reviews

Summary of inpatient deaths and structured case note reviews

The table below shows the number of inpatient deaths by quarter since 2017/18, and the number of structured judgement reviews (SJRs) undertaken since 2014/15, by the year in which the review was undertaken and the year and quarter in which the death occurred. During 2018/19 60 SJRs were undertaken, 31 related to deaths during 2017/18 and 29 related to deaths during 2018/19.

During Q1 2019/20 11 SJRs were undertaken, nine related to deaths during 2018/19 and two related to deaths during Q1 2019/20. During Q2 2019/20 seven SJRs were undertaken, three related to deaths during 2018/19 and four to deaths in 2019/20. During Q3 2019/20, five SJRs were undertaken, all related to deaths during this year. During Q4 2019/20, seven SJRs were undertaken, all related to deaths during this year.

In summary, during 2019/20 30 SJRs were undertaken, 18 related to deaths in 2019/20 and 12 to deaths in 2018/19.

Please note that the data has to be collected and described in this way for the Quality Report NHS foundation trust quality reports: 2019/20 requirements | NHS Improvement

		Quarter or year in which the death occurred																	
					2017/18					2018/19					2019/20					
		2014/15	2015/16	2016/17	Q1	Q2	Q3	Q4	2017/18	Q1	Q2	Q3	Q4	2018/19	Q1	Q2	Q3	Q4	2019/20	
	No of inpatient deaths				145	140	167	205	657	142	140	177	182	641	177	139	177	172	665	
																				Total undertaken
Number of structured judgement reviews (SJRs)	SJRs previously reported	4	27	40	3	8	14	6	31	N/a	N/a	N/a	N/a	N/a	N/a	N/a	N/a	N/a	N/a	102
	Total SJRs undertaken during 2018/19 by year of death								31					29	N/a	N/a	N/a	N/a	N/a	60
	Total SJRs undertaken during Q1 2019/20 by year and Q of death										2	3	4	9	2	N/a	N/a	N/a	2	11
	Total SJRs undertaken during Q2 2019/20 by year and Q of death											1	2	3	2	2	N/a	N/a	4	7
	Total SJRs undertaken during Q3 2019/20 by year and Q of death													0	0	1	4	N/a	5	5
	Total SJRs undertaken during Q4 2019/20 by year and Q of death													0	0	1	1	5	7	7
	Total SJRs undertaken during 2019/20 by year of death													12					18	30
	Total number of SJRs undertaken relating to deaths in the period	4	27	40					62					41					18	192

Assessment of care

The table below shows the assessment of care for the identified stages of care provision for each of the seven case reviews completed during Q4. 86% (6/7) patients reviewed had good or excellent overall care. The care is rated for each of up to seven phases or elements of care. Out of 49 possible phases or elements of care, 17 were not applicable, and 28/32 (88%) phases of care were rated as good or excellent.

Care scores summary 2019/20 Q4					
	Good or excellent care (score 4-5)	Average care (score 3)	Poor care (score 1-2)	N/a	Total
Admission and initial management	6	0	1	0	7
On-going care	2	1	1	3	7
Care during procedure	0	0	0	7	7
Peri-operative care	0	0	0	7	7
End of life care	7	0	0	0	7
Overall assessment of care received	6	0	1	0	7
Overall assessment of patient record	7	0	0	0	7

Problems with care

The SJR proforma has a section that enables the identification of problems in care.

Problems with care: 2019/20 Q4				
	Degree of harm if problems identified			Total
	No harm	Uncertain harm	Harm	
No problems with care identified				5
Problems in care identified	0	1	1	2
Total				7

The death where harm was identified was also investigated as a serious incident and the .

Deaths of patients with learning disabilities

Three patients with learning disabilities who died during Q4 2019/20 had SJRs completed. The overall assessment of care was good in all cases. LeDeR notifications were sent for all three.

During Q4 we received feedback from four LeDeR reviews

Two patients who died in 2017/18:

1. The SJR done at the time identified good overall care. The LeDeR report identified:

One area of good practice to feedback:

- Compassionate end of life care. Decision made to not transfer to ITU from theatre as she would die during the transfer. Family were called in to the theatres department to spend time

Some areas of identified learning for the Trust:

- There was a 3 to 4 hour delay in reporting of the CT scan results. The Surgical Team should have followed up the scan results more assiduously or could have contacted the on call Consultant Radiologist for escalation. This delay related to an external agency and has been investigated by the radiology department.

2. The LeDeR report identified:

Some areas of good practice to feedback:

- Prompt diagnosis and relevant care pathways followed.
- Evidence of relevant professionals making key decisions in best interests when she was too ill to make them herself.
- Comprehensive intensive treatment following Sepsis Pathway and treatment for pneumonia.

<u>One patient who died in 2018/19.</u>

3. The SJR done at the time identified poor overall care and this was reported to the Board. The LeDeR report identified:

One area of good practice to feedback:

- The Trust paid for the patient to be supported by his existing care team whilst on the ward to support compliance and behaviour.

Some areas of identified learning for the Trust:

- To review training around DNACPR for medical staff so autism/learning disability are not recorded as the reason for someone not to be resuscitated. This has been addressed and added to resuscitation training.
- To review the knowledge and understanding of the Mental Capacity Act to ensure capacity assessments are completed and bests interests recorded. This has started and new electronic documentation is in development that should lead to improvements in documentation.
- To review the training provision for staff regarding autism and how it affects individuals. The Supporting Vulnerable People Steering Group has considered mandatory autism training and how this could be implemented.
- To review the internal medical records and consider appropriate actions to improve quality of documentation. Any actions?

<u>One patient who died in 2019/20</u>

4. The SJR done at the time identified poor overall care and this was reported to the Board. The LeDeR report identified:

Some areas of identified learning for the Trust:

- Two internal structured judgement reviews expressed concerns about the care received by the patient during her arrival to ED on 22 June 2019 and rated the care as 2 (poor). The Trust must act on the internal recommendations made following the findings of the structured judgment reviews undertaken as part of the internal mortality review process.
- The patient self- discharged without her PE medication. Hospital staff must be responsible for exploring all safety netting options including out of hours services to ensure that a patient gets their critical medication as prescribed.
- The patient was not registered as a known person with a learning disability to hospital services. The Trust must review their current system and process for registering a patients learning disability into their hospital records when that patient has attended hospital.

We have some concerns about two of the recommendations in this final report:

- The team that saw the patient at the time in question made reasonable adjustments to support her own decision making
- The patient had a very mild LD (if at all). She was known to TEWV mental health services who did not refer on to TEWV LD team.

External reviews of mortality

The Trust receives detailed mortality date from a number of sources:

- Hospital Episode Statistics (HES)
- Healthcare Evaluation Data (HED)
- Dr Foster

This data is also reflected in the CQC Insight dashboard. The March 2020 CQC Insight dashboard shows that:

- Deaths in Low-Risk Diagnosis Groups had improved
- The SHMI and HSMR for the 12-month period from Jul 18 - Jun 19 were within expected range.
- There were no active mortality alerts for the Trust.

Reflection and learning identified

The numbers of deaths in hospital that can be unequivocally shown to be truly avoidable are fortunately rare. The mortality review process however provides a rich seam of learning which, albeit not necessarily affecting outcomes, will allow us to improve end of life care for many patients. The SJRs continue to emphasise the frailty and complexity of medical elderly patients in particular, and confirm the excellent care received by the great majority of patients whose death in hospital is expected. The key learning points were to:

- Improve oncology documentation and sharing of palliative care advance plans with the hospital.
- Address delays with death certification and documentation following unsuccessful resuscitation.
- Promote the need to gain collateral information and ascertain relatives' difficulties with home circumstances quicker.
- Promote clear documentation in medical records of roles and designation of clinical staff, and dates and times of entries.
- Implement the requirement for all patients returning after discharge (or self-discharge) to be seen by an ED doctor, and if being considered for direct return to a ward there must be a doctor to doctor handover prior to patient moving.
- Ensure reflection by individual staff members on any identified lack of documentation and deficiencies in clinical management.
- Highlight the importance of good medical handover, completion of investigations planned on post take ward rounds and senior review.
- Continue to promote better communication with patients about treatment escalation and resuscitation alongside an infrastructure to make it easy to share information appropriately. This has highlighted the need for dedicated staff training regarding treatment escalation and DNACPR discussions.
- Undertake an audit of patients with learning disabilities and DNACPR decisions which identified a number of inappropriately documented DNACPR decisions.

The number of deaths being reviewed by SJR has reduced. It is hoped that the introduction of the Medical Examiner role during 2020 will result in more deaths being reviewed, which would provide a larger sample of cases to ensure learning.

Actions taken

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

- A poster has been developed for all wards and department to share learning from the LeDeR report and a summary communicated to all medical staff;
- Staff training clarifies that learning disabilities including autism are never an acceptable rationale for a DNACPR order, acknowledging and addressing any unconscious bias.
- Items identified from our learning from deaths processes are shared in the staff Chatter Matters newsletter

- An RPIW is planned this year to progress better communication with patients and their families about treatment escalation and resuscitation, and a tool to make it easy to share information with patients, colleagues at HDFT and across primary and secondary care.

The impact has been to continue to share and embed the learning identified from ongoing review of deaths, including people with learning disabilities and therefore improve patient care.

Harrogate and District NHS Foundation Trust

19

Date of Meeting:	27 May 2020	**Agenda item:**	9.0
Report to:	Board of Directors		
Title:	NHS Provider Licence Annual Self-assessment		
Sponsoring Director:	S Russell, Chief Executive		
Author(s):	L Hughes, Interim Company Secretary J Coulter, Deputy Chief Executive/Director of Finance		

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

Executive Summary:	Each year, the Board of Directors is required to self-certify compliance with certain conditions against its licence as issued by "Monitor". ("Monitor" was the independent regulator of NHS Foundation Trusts whose functions are now undertaken by NHS Improvement). The specific conditions we are required to self-certify against are: General Condition G6, Foundation Trust Condition FT4, and Continuity of Services Condition CoS7. In addition, the Board is required to self-certify that it has met its legal (Section 151(2) of the Health and Social Care Act 2012) and Constitutional (paragraph 14.2) obligation to "…take steps to secure that the governors are equipped with the skills and knowledge they require in their capacity as such." This report aims to provide information to enable the Board to determine whether it can confirm compliance against these conditions.

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:	Updated Corporate Risk Register to reflect Covid-19 is included within the report.
Legal / regulatory:	Trust Licence NHSE/I NHS 2006 Act as amended by the 2012 Health and Social Care Act
Resource:	Not applicable
Impact Assessment:	Not applicable
Conflicts of Interest:	None identified
Reference documents:	Not applicable

Assurance:	-

Action Required by the Board of Directors:

The Board is asked to:

1. Certify compliance against condition G6 (3) that the Trust has taken all precautions to comply with the licence, NHS Acts and NHS Constitution;
2. Certify compliance against Condition FT4(8) required governance arrangements;
3. Certify compliance against Continuity of Services Condition 7 (3) that required resources will be available for acute services for 12 months from the date of the statement;
4. Certify compliance against the Training of Governors obligation; and
5. Publish compliance against condition G6 (3) on the Trust's website by 30 June 2020.

Board of Directors Meeting

29 May 2020

NHS Provider Licence Annual Self-assessment

1. Background

Each year, the Board of Directors is required to self-certify compliance with certain conditions against its licence as issued by "Monitor". ("Monitor" was the independent regulator of NHS Foundation Trusts whose functions are now undertaken by NHS Improvement).

The specific conditions we are required to self-certify against are: General Condition G6, Foundation Trust Condition FT4, and Continuity of Services Condition CoS7.

In addition, the Board is required to self-certify that it has met its legal (Section 151(2) of the Health and Social Care Act 2012) and Constitutional (paragraph 14.2) obligation to "…take steps to secure that the governors are equipped with the skills and knowledge they require in their capacity as such."

This report aims to provide information to enable the Board to determine whether it can confirm compliance against these conditions.

2.0 The Timetable for Board Sign-off

The table below provides a description of each condition and the deadline date for sign-off by the Board:

NHS provider licence conditions

Condition G6(3)	The Trust has taken all precautions to comply with the licence, NHS acts and NHS Constitution	By 31 May
Condition G6(4)	Publication of condition G6(3) self-certification	By 30 June
Condition FT4(8)	The Trust has complied with required governance arrangements	By 30 June
Condition CoS7(3)	The Trust a reasonable expectation that required resources will be available to deliver the designate services for the 12 months from the date of the statement.	By 30 June

NHS Improvement provides a template to assist the recording of self-certifications, should the Trust be audited by NHS Improvement. This template is no longer mandatory but it can be used to illustrate compliance with the process and maintained for record keeping purposes should the Trust be audited by NHS Improvement.

3.0 Condition G6(3)

Condition G6(3) requires NHS providers to confirm or not confirm that they have processes and systems that:

- Identify risks to compliance with their licence, NHS Acts and the NHS Constitution
- Guard against those risks occurring.

3.1 The Board's determination of compliance with General Condition G6

The question that this condition asks is whether the Trust has identified the risks to compliance and whether it has taken steps to mitigate such risks.

Evidence to support compliance against this condition is provided in Appendix A.

4.0 Condition FT4(8)

Condition FT4(8) is regarding systems and processes for good governance and if the Trust has governance systems and processes in place to achieve compliance against condition FT4.

Having taken into account the well-led framework for governance reviews, NHS Foundation Trust Code of Governance and the Single Oversight Framework, Appendix A references evidence to support the Board's determination of compliance against FT4(8).

5.0 Continuity of Services Condition 7

Only NHS Foundation Trusts that are designated as providing Commissioner Requested Services (CRS) are required to self-certify under condition CoS7(3).

What is CRS designation?

CRS are services commissioners consider should continue to be provided locally even if the provider is at risk of failing financially and, as such, are subject to closer regulation by NHS Improvement. Providers can be designated as providing CRS because:

- There is no alternative provider close enough
- Removing the services would increase health inequalities
- Removing the services would make other related services unviable

The Trust has received confirmation that its acute services have been confirmed as CRS by our commissioners as part of the annual contract review process.

Under this requirement the Trust is required to confirm only one of three statements below and provide supporting narrative explaining the reasons for the chosen statement:

a. The required resources will be available for 12 months from the date of the statement;
b. The required resources will be available over the next 12 months, but specific factors may cast doubt on this; or
c. The required resources will not be available over the next 12 months.

The Trust would like to confirm against (a) above that as part of its annual planning process and the revised planning arrangements introduced nationally in response to the Covd-19 outbreak, we are assured that that required resources will be available for acute services for 12 months from the date of the statement.

6.0 Other Self-certifications

6.1 Training of Governors

NHS Foundation Trusts are required to review whether their governors have received enough training and guidance to carry out their roles.

Governors are provided with induction training, opportunities to join local and national network events and are provided with presentations and information by directors and officers throughout the year.

During the year Governors attended workshops regarding membership and governor engagement, holding Non-Executive Directors to account, the financial governance regime including understanding financial statements and the development of the annual plan and the planning regime.

7.0 Recommendation

The Board is asked to:

6. Certify compliance against condition G6 (3) that the Trust has taken all precautions to comply with the licence, NHS Acts and NHS Constitution;
7. Certify compliance against Condition FT4(8) required governance arrangements;
8. Certify compliance against Continuity of Services Condition 7 (3) that required resources will be available for acute services for 12 months from the date of the statement;
9. Certify compliance against the Training of Governors obligation; and
10. Publish compliance against condition G6 (3) on the Trust's website by 30 June 2020.

Appendix A

G6 (3) - Systems for compliance with licence (deadline for Board sign off - 31 May 2020			
The Board is required to respond 'Confirmed' or 'Not confirmed' to the following statement. Explanatory information should be provided where required.			
	Statement	**Response (and supporting information/ assurance)**	**Risks and Mitigations**
	Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution	**Confirmed** At Audit Committee on 5 May 2020 the draft annual accounts and the draft charitable accounts were received. The Trust's Internal Audit progress report highlighted that they believe that the Head of Internal Audit Opinion would confirm that "there is a good system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently". The Head of Internal Assurance Report is planned to be presented to the Audit Committee at its 19 June 2020 meeting. This is a key piece of evidence to support compliance with this condition of the provider licence. Further evidence to support this condition is the Board Workshop discussions on the Annual Operational Plan 2020/21, including all known risks to compliance, Risk Reports presented to each Audit Committee, Board and Board Committee meetings, the Board Assurance Framework supported by the Annual Assurance Framework Opinion from Internal Audit, Resource Committee reports, Quality Committee reports and the Integrated Board Reporting arrangements in place. The Trust's information processes provide the opportunity to review performance data across multiple domains across the organisation, thereby improving the availability and accuracy of data and the flow of information and assurance through the governance structure.	No risks identified

FT4 Declaration - Corporate Governance Statement & Training of Governors (deadline for Board sign off - 30 June 2020)			
The Board are required to respond 'Confirmed' or 'Not confirmed' to the following statements, setting out any risks and mitigating actions planned for each one.			
	Statement	**Response (and supporting information/ assurance)**	**Risks and Mitigations**
1.	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	**Confirmed** The Annual Governance Statement 2019-20 (to be approved by the Audit Committee on 19 June 2019) outlines the main arrangements in place to ensure the Trust applies the principles, systems and standards of good corporate governance expected of it as a provider of health and social care services. There is an internal audit programme in place, under the direction of the Audit Committee to ensure systems and processes are appropriately tested. The external auditors deliver a robust annual audit plan reporting to the Audit Committee.	No risks identified
2.	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time.	**Confirmed** Declaration of compliance included in Annual Report; NHSI segmentation as per its Single Oversight Framework; Well Led assessment by CQC last rated as "Good	No risks identified
3.	The Board is satisfied that the Licensee implements: (a) Effective Board and Committee structures (b) Clear responsibilities for its Board, for Committees reporting to the Board and for staff reporting to the Board and those	**Confirmed** The Board Committee structures reporting to the Board are defined and supported through a review of Committee Terms of Reference and reporting arrangements. The Board has formally delegated specific responsibilities to the Committees listed below, summary Chair's reports and formal minutes are provided to Board.	No risks identified

	Committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	• Quality Committee • Resource Committee • Remuneration Committee • Audit Committee The Trust's governance structure ensures the appropriate flow and review of information at service level and up through the divisions to Senior Management Team (SMT) and SMT supporting groups, providing assurance to the Board and its Committees. The monthly SMT provides scrutiny and monitoring of operational performance which supports the working of the Board's Committees and reports directly to the Board of Directors. An internal audit review of governance through the working of the Board Assurance Framework and conflict of interest policy and processes was carried out during 2019/20. Findings of this audit was paused due to the response to COVID-19 but the outcome is now planned to be presented to the 19 June 2020 Audit Committee meeting.	
	The Board is satisfied that the Licensee effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality	**Confirmed** The Board's infrastructure including Committees of the Board together with various operational groups, ensure that the Board of Directors is assured that the organisation's decisions and business are monitored effectively and efficiently. There are clear escalation routes up to the Board of Directors (as described above). b) SMT and supporting groups scrutinise key areas of performance including quality, workforce, finance, operational and contractual. The Committees review performance and risk by exception (and in accordance with ToR) at each meeting and subsequently provide assurance to the Board of Directors through the Chair's reports highlighting any key recommendations or key risks identified. c) The Quality Committee reviews the patient experience and quality	No risks identified

	Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence (g) To generate and monitor NHS Improvement delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.	report, with quality performance data available and the Trust's compliance with CQC fundamental standards using an on-line tool to support service self-assessments against the CQC domains. An approved Quality Improvement and Audit Programme is in place, overseen by the Audit Committee. The approval of the Quality Improvement and Audit Programme for 2020-21 has been delayed due to COVID-19 but this was agreed with the Audit Committee. The requirement for the Trust to produce an Annual Quality Report for 2018-19 have been revised nationally due to COVID-19; the Trust will however produce an Annual Report in accordance with the revised ARM and it is anticipated that this will include a summary on quality performance during 2018-19. d) The Trust reviewed its Standing Financial Instructions (SFIs) and Scheme of Reservation and Delegation of Powers (SoRD) in 2019-20 to reflect current procurement practices and to respond to Covid; this determines the agreed framework for financial decision making, management and control. Systems of internal control are in place and are subject to regular audit on an annual basis through the Trust's internal audit programme and by external auditors. The Resource Committee and Audit Committee are the principal Committees that maintain oversight. There are robust systems and processes in place to monitor and oversee all CIP schemes; The Trust has a good track record of effective financial management and of achieving its statutory financial duties. e) The Board and Committee meeting dates are scheduled to allow the most up-to-date information to be provided to meetings for scrutiny and assurance. The Standing Orders for the Practice and Procedure of the Board of Directors also provide for the Chairman to call a meeting of the Board at any time. f) The Trust has an approved Risk Policy in place, the Board Assurance Framework and Corporate Risk Register provide the framework through which risks are considered, reviewed and managed. SMT tracks corporate risks and receives an overall organisational risk update to determine the robust management of risks. The Board receives a summary of the Corporate Risk Register at each of its meeting and a summary of the Board	

		Assurance Framework. g) The Trust has an annual planning process that ensures future business plans are developed and supported by appropriate engagement and approvals. h) The governance, risk and control processes in place ensure that the Trust remains compliant with all the legal requirements.	
5.	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	**Confirmed** a) There are effective appraisal processes in place to support the Board members individually and collectively. b) There are QIA and EIA processes in place to support decision making processes for any service development or changes and any impact on the quality of care is carefully considered. c) The Quality Committee supports the monitoring of information on quality of care; the monthly SMT receives a quality performance report from the Chief Nurse and the Quality Committee considers a detailed patient experience and quality report. The Committee chair reports any key decisions and recommendations to the next meeting of the Board. d) As above - the Board receives a report from the Quality Committee. The board also receives the Quality annual Quality Account. e) Members of the Board are engaged in service visits and the Freedom to Speak Up Guardian is supported by Fairness Champions across the organisation. One of the Non-executive Directors (NED) is nominated as a NED lead to support 'Freedom to Speak up' for the Trust and the Chief Nurse and Director of Workforce and OD also support the assurance arraignments in place providing advice and support to the Board as necessary. The members of the Board, particularly NEDs meet with the Council of Governors to take account of views from outside the organisation. The CoG has established a Membership and Engagement Committee which has been put on hold due to Covid but plans to meet at least quarterly to actively engage with members. f) There is clear accountability for quality of care through the Chief Nurse and Medical Director.	No risks identified

6.	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	**Confirmed** All members of the Board, Clinical Directors, Assistant Medical Directors and those that carrying out a role to provide advice to the Board comply with the requirements of the Fit and Proper Persons Regulation and all members of the Board and senior decision makers are required to complete declaration of interests. The annual appraisal process supports effective succession planning through talent conversations and a number of senior managers are engaged in national programmes to support their development to Director level, as appropriate. The Board of Directors has a development programme in place through its Board Workshops and due to commence with external facilitation in March 2020; this was paused to allow the priority focus on the Trust's response to COVID-19.	No risks identified

Harrogate and District NHS Foundation Trust

Board Committee Report to the Board of Directors

Committee Name:	Quality Committee
Committee Chair:	Laura Robson, Non-executive Director
Date of meeting:	1 April 2020
Date of Board meeting this report is to be presented	27 May 2020

Summary of key issues

- This was the first Quality Committee following new guidelines. The agenda was significantly reduced with suspension of some of the routine reports and reduced attendance. The meeting was not quorate under previous terms of reference but the meeting was agreed to continue due to no items requiring approval.
- Previous discussions regarding Non Invasive Ventilation had been overtaken by the new approach in light of Covid-19. Anaesthetic department now managing the Trust approach.
- We are still awaiting guidance regarding the need for a Quality Account for this year. Dr Wood will keep this under review and the Quality Committee will undertake the work if and when it is required.
- The Quality Committee received a detailed briefing on the management of Covid-19 patients in the hospital and the impact on staff, from the Chief Nurse. The Board should note that Dr Childs had resumed in the role of Director of Infection Prevention and Control (DIPC) whilst managing the critical situation.
- Dr Shepherd raised his concerns about patients with Non Covid-19 related conditions and significant reduction in attendance at ED and the hospital in general.
- The Clinical Advisory Group is meeting daily and Dr Wood or Dr Hall will report significant issues and decisions to the Quality Committee at future meetings.
- The corporate risk register is under review in light of the current significant changes in the hospital and the pressures in community teams and 0-19 services.

Any significant risks for noting by Board? (list if appropriate)
The Board is clearly sighted on the current risks.
Any matters of escalation to Board for decision or noting (list if appropriate)
To note the reappointment of Dr Childs to DIPC.

Harrogate and District NHS Foundation Trust

Board Committee Report to the Board of Directors

Committee Name:	Quality Committee
Committee Chair:	Laura Robson, Non-executive Director
Date of meeting:	6 May 2020
Date of Board meeting this report is to be presented	27 May 2020

Summary of key issues

- The Quality Committee met via teleconference and the Trust Chair plus all Non-Executive Directors were in attendance.
- Mrs Foster presented the Hot Spots to the committee which were reduced compared to previous meetings. Availability of PPE was currently not causing concern but it was under constant review. The staff were working well together under pressure and absence had reduced.
- Previous concern regarding a rise in the number of safeguarding children referrals was becoming a reality with a rise in the number of cases reported. There was no reported increase in safeguarding adults cases.
- The Committee was presented with the notes from the Clinical Advisory Group established to advise Gold Command of clinical decisions requiring urgent change as a result of the COVID -19 pandemic.
- The committee noted the exceptional work of Dr Clare Hall and Dr Sylvia Wood managing the group with significant skill when the decisions required were complex and little national guidance was available.
- Initially the attendance of clinicians was also notable, with senior staff undertaking a considerable amount of work, searching available evidence and advising the group. However of late the attendance had reduced and a discussion took place that illustrated the difficulties of making informed decisions if the right people were not around the table.
- The notes were very detailed and a large number of topics were included. It was noted that there was to be an increase in 'normal work' which will impact on decisions made at the committee.
- The IBR quality indicators were considered with a number of issues raised for clarity. The Committee requested more detail of the specific indicators being monitored in response to the pandemic.
- The Quality Dashboard for February was considered. A rise in medication errors was noted, for further review, also improvement in the sepsis screening scores was evident. This may be due to a change in

recording but clarity will be provided.

- The Chief Nurse of the CCG commented on the support being provided by the Trust to the Care home sector and wished to ensure that the Board was aware of the significance of this contribution.

Any significant risks for noting by Board? (list if appropriate)

The Board is clearly sighted on the current risks however we would commend the work of CAG and the leadership of Dr Clare Hall and Dr Sylvia Wood.
Note the thanks from the CCG for the Trust assistance with the Care Home sector.
Note the increasing numbers of child safeguarding cases.

Any matters of escalation to Board for decision or noting (list if appropriate)

None required.

Harrogate and District NHS Foundation Trust

Board Committee Report to the Board of Directors

Committee Name:	Audit Committee
Committee Chair:	Richard Stiff, Non-executive Director
Date of meeting:	24 April and 5 May 2020
Date of Board meeting this report is to be presented	27 May 2020

Summary of key issues

24 April 2020

The committee met informally via Microsoft Teams and was briefed on the draft 2019-20 accounts prior to their submission on 27 April 2020.

5 May 2020

The committee met via Microsoft Teams, all committee members were present. The meeting was observed by a governor (Doug Masterman). The main items considered were –

- Corporate Risk Review Group minutes and the Corporate Risk Register – the revised approach resulting from Covid – 19 considerations was noted
- The Audit Committee draft annual report – some small amendments/additions were requested
- The annual Local Security Management Specialist's annual report on 2019/20 and work programme for 2020/21 – an increase in the number of incidents of violence and aggression towards staff was noted as was an increase in the number of absconding patients and whether the proposed work programme adequately reflected the likely HDFT operating environment during and post Covid – 19 were discussed – clarifications to be sought from the security team
- The committee received and noted the draft Trust annual accounts and the draft charitable accounts - a further sign off meeting is to be held in June prior to the June Board
- Internal Audit progress report and Annual Report on work done in 2019/20 – the response to recommendations and the approach to following up to unactioned recommendations were discussed and some small amendments/additions were made to the draft annual report
- The external auditor's healthcare sector technical update was received

- A single tender action relating to a pharmacy procurement was noted and the need to maintain clear audit trails in relation to procurement was agreed

Any significant risks for noting by Board? (list if appropriate)

- The need to keep risk management processes and assumptions under review in recognition of an altered operating environment both currently and over the next 12 to 18 months
- The possible need to develop some new approaches to security and related issues in recognition of the altered operating environment

Any matters of escalation to Board for decision or noting (list if appropriate)

None.