NHS
Harrogate and District
NHS Foundation Trust

Board of Directors Meeting (to be held in Public)
will be held on Wednesday, 30 September 2020 from 9.00am to 12noon
in the Boardroom, Trust Headquarters, Harrogate District Hospital, Harrogate
via virtual arrangement

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 July 2020**	Chairman	**Approve**	**Attached**
4.0	**Matters Arising and Action Log**	Chairman	Discuss	Verbal **Attached**
5.0	**Overview by the Chairman**	Chairman	Discuss/ Note	Verbal
6.0	**Chief Executive Report**	Chief Executive	Discuss/ Note	**Attached**
6.1	**Board Assurance Framework/Corporate Risk Register**	Chief Executive	Discuss/ Note/ **Approve**	**Attached**
6.2	**Senior Management Team Chair's Report**		Note	**Attached**
7.0	**People and Culture Committee Chair's Report**	People and Culture Committee Chair	Discuss/ Note	**To follow**
7.1	**Conflict of Interest including Relationships at Work Policy**	Director of Workforce and Organisational Development	Note	**Attached**
7.2	**People Plan**	Director of Workforce and Organisational Development	**Approve**	**Attached**
7.3	**Director of Workforce and Organisational Development Report**	Director of Workforce and Organisational Development	Discuss/ Note	**Attached**
8.0	**Audit Committee Chair's Report**	Audit Committee Chair	Note	**Attached**
8.1	**Resource Committee Chair's Report**	Resource Committee Chair	Note	**To follow**

8.2	**Recovery Plan Update**	Interim Chief Operating Officer	Note/ Discuss	**Attached**
8.3	**Finance Report**	Deputy Chief Executive/Director of Finance	Note/ Discuss	**Attached**
9.0	**Integrated Board Report**	Executive Directors	Note/ Discuss	**Attached**
10.0	**Quality Committee Chair's Report**	Quality Committee Chair	Note	**Attached**
10.1	**Chief Nurse Report** - Equality Delivery System (EDS)2 Updated Report - CQC Engagement and Support Call Summary - IPC BAF (September 2020) - Lessons Learnt from 2019/20 Flu Programme	Chief Nurse	Discuss/ Note	**Attached**
10.2	**Flu Campaign 2020/21**	Chief Nurse	Discuss/ Note	**Attached**
10.3	**Quality Report 2019/20**	Chief Nurse	Approve	**Attached**
10.4	**Medical Director Report**	Medical Director	Discuss/ Note	**Attached**
10.4.1	**Guardian of Safe Working Hours Report (Q1)**	Medical Director Chief Nurse/	Note Discuss/	**Attached**
11.0	**Any other Business** *By permission of the Chairman*	Chairman	Note/ Discuss/ **Approve**	Verbal
12.0	**Board Evaluation**	Chairman	Discuss	Verbal
13.0	**Date and Time of next meeting** Wednesday, 25 November 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. A small representative from the Trust's Council of Governors will have the opportunity to observe this meeting if they wish to do so.

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

Harrogate and District NHS Foundation Trust

Board of Directors Register of Interest

Board Member	Position	Relevant Dates From	To	Declaration Details
Angela Schofield	Chairman	2018	Date	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 5. Member of Humber Coast and Vale ICS Partnership
Jacqueline Andrews	Medical Director	June 2020	Date	Familial relationship with managing parterner of Priory Medical Group, York
Sarah Armstrong	Non-executive Director	October 2018	Date	1. 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
Jonathan Coulter	Deputy Chief Executive/ Finance Director	November 2017	Date	(Interim Chief 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)
Jeremy Cross	Non-executive Director	January 2020	Date	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
Jill Foster	Chief Nurse	July 2020	Date	Director of Harrogate Healthcare Facilities Management Limited t/a Harrogate Integrated Facilities (a wholly owned subsidiary company of Harrogate and District NHS Foundation Trust)
Dr Kat Johnson	Clinical Director (Planned and Surgical Care)			No interests declared
Dr Natalie Lyth	Clinical Director (Children's and County Wide Community Care)			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.
Andrew Papworth	Non-executive Director	March 2020	Date	Director of People Insight and Cost at Lloyds Banking Group
Laura Robson	Non-executive Director	September 2017	Date	Familial relationship with Alzheimer's Society
Steve Russell	Chief Executive	March 2020	Date	Chief Executive of NHS Nightingale Hospital Yorkshire and Humber
Wallace Sampson OBE	Non-executive Director	March 2020	Date	1. Chief Executive of Harrogate Borough Council 2. Director of Bracewell Homes – wholly owned Harrogate Borough Council housing company. 3. Chief Executive of Harrogate Borough Council 4. Chair of Harrogate Public Services Leadership Board 5. Member of North Yorkshire Safeguarding Children Partnership Executive 6. Member of Society of Local Authority Chief Executives
Dr Matthew Shepherd	Clinical Director (Long Term & Unscheduled Care)	April 2017	Date	Director of Shepherd Property Ltd

Richard Stiff	Non-executive Director	May 2018	Date	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
Maureen Taylor	Non-executive Director			No interests declared
Angela Wilkinson	Director of Workforce and Organisational Development	October 2019	Date	Director of ILS and IPS Pathology Joint Venture

Deputy Directors and Others Attendees (providing advice and support to the Board)

Name	Position	Declaration Details
Dr Dave Earl	Deputy Medical Director	1. Director of Earlmed Ltd, provider of private anaesthetic services 2. Treasurer of Harrogate Anaesthesia Services, administration and co-ordination of Anaesthetic Private Practice
Dr Clare 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
Jordan McKie	Deputy Director of Finance	No interests declared
Paul Nicholls	Deputy Director of Performance and Informatics	No interests declared
Shirley Silvester	Deputy Director of Workforce and Organisational Development	No interests declared
Dr Sylvia Wood	Deputy Director of Governance & Freedom to Speak Up Guardian	Familial relationship with Consultant Radiologist
Lynn Hughes	Interim Company Secretary	Familial relationship with KLS Martin Ltd, a company providing services to the NHS

Board of Directors Meeting (held in Public)

29 July 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 COVID19 pandemic, the meeting was held by video conference.

Present
Mrs Angela Schofield, Chairman
Dr Jacqueline Andrews, Executive Medical Director
Ms Sarah Armstrong, 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
Mr Steve Russell, Chief Executive
Mr Jonathan Coulter, Finance Director/Deputy Chief Executive
Mrs Jill Foster, Chief Nurse
Mr Robert Harrison, Chief Operating Officer
Ms Angela Wilkinson, Director of Workforce and Organisational Development

In attendance
Dr Clare Hall, Deputy Medical Director
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
Dr Jennifer Lockwood, Locum Consultant/Research Lead (Emergency Department)
Mrs Kath McClune, Elected Staff Governor (Nursing and Midwifery) (part of meeting)
Mr Steve Treece, Elected Public Governor (Wetherby and Harewood)

BoD/07/20/01 **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 COVID19 pandemic. The papers are shared with Governors and made available to members of the public via the Trust's website and Governors are able to observe the meeting by video conferencing or the teleconference facility.

1.2 Apologies for absence were received from Mr Jeremy Cross, Non-executive Director.

BoD/07/20/02 **Declarations of Interest and Register of Interests**

2.1 It was noted that Mr Coulter, Ms Armstrong and Mrs Foster 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/07/20/3 **Minutes of the Meeting held on 24 June 2020**

3.1 **Resolved:** the minutes of the last meeting held on 24 June 2020 were accepted as an accurate record.

BoD/07/20/4 **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**

The Action Log was discussed in turn.

148. Overview of Trust's Learning Disabilities policies and procedures are on track to take place at a future Board Workshop before November 2020.

12.2 Advanced Care Planning. Dr Hall and Dr Shepherd explained that there had been a recent discussion at the Quality Committee confirming that Dr Andrew's team are committed to take this forward. Learning from the COVID19 pandemic has identified some good examples of advanced care taking place in the hospital and future work is planned to build upon this going forward. It was agreed Dr Shepherd would provide an update in October on the lessons learned to date during the COVID19 pandemic regarding Advanced Care Planning. It was also agreed that the action would be reviewed and broadened to reflect the wider piece of work being taken forward by Dr Andrews. Dr Andrews agreed to reframe the action with Ms Hughes.

13.3 Learning from Deaths, Non-executive Director. Agreed this action would be closed and considered in the wider piece of work that is being taken forward by Dr Andrews (action 12.2 above).

13.2 NHS Resolution Report and 17.3 EDS2 Report. It was noted that these reports were planned to be presented to the September Board meeting. It was agreed to leave these actions open until the reports are received.

BoD/06/06/20/16 was agreed to be closed (*an update had been provided to the Board at its informal meeting held on 8 July 2020 on the Freedom to Speak Up Guardian future arrangements*). It was agreed to close this action.

BoD/07/20/5 **Overview by the Chairman**

5.1 The Chairman reported on the inaugural meeting of the People and Culture Committee held on 21 July 2020. Mr Cross had provided an update in advance of the Board meeting explaining that it was a successful meeting with consideration on the draft People Plan, the culture project process, and the Staff Survey results. Discussion took

place on the development of a one page of behaviours expected from all colleagues.

5.2 The Chairman was pleased to report that the Board Workshop held on 22 July 2020 had been productive. The Clinical Directors had shared their experiences of the last few months during the COVID19 pandemic and highlighted how the lessons learned can be used to develop the Trust's long-term strategy.

5.3 It has been agreed to revert to bi-monthly Board meetings (held in Public by videoconferencing) with Board Workshops held in the months in between. Arrangements will be put in place to revert to this arrangement. **ACTION (L Hughes)**

5.3.1 The next Board Workshop will be held on 26 August with a short Extra Ordinary Board meeting on the same day to consider the Business cases, which had been approved by WYAAT Committee in Common.

5.4 As part of the revised arrangements informal governor briefings would be held monthly and a newsletter for members would be circulated bi-monthly.

5.5 The Chairman explained that it was Mr Harrison's last Board meeting before he leaves the Trust to commence a new role. She thanked Mr Harrison for his dedication and professionalism during his time at the Trust, and was delighted that Mr Harrison will be taking on new responsibilities at South Tees Hospitals NHS Foundation Trust. Board members' echoed the Chairman's good wishes to Mr Harrison.

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

BoD/07/20/6 **Chief Executive's Report**

6.1 The Chief Executive's report was noted. He drew reference to leadership and culture section and confirmed that an Interim Chief Operating Officer had been appointed and would start on 1 September. A review of Executive Director portfolios is taking place for the longer term with interim arrangements put in place for digital and IT, estates, informatics, and performance. The process to appoint a substantive Chief Operating Officer would commence in September. The Chief Executive thanked Mr Harrison for the contribution he had made over the last 18 months, especially during the COVID19 pandemic. He welcomed in advance Mr Riley-Fuller who is due to take up the role of Deputy Chief Nurse in August, having previously been Head of Nursing for Critical Care at Leeds Teaching Hospitals NHS Trust.

6.1.1 The Trust continues to develop plans to take forward the findings of the Deloitte assessment. A Senior Management Team meeting and Board of Directors workshop were held on 15 July 2020 to update and involve colleagues on the planned areas of work. The model being used is based on the Trust's QI methodology, and seeks to ensure it is led by a wide range of colleagues with each project lead and executive support to be drawn from an 'away' team, which will be from outside of the function, or area that is being worked on. This part of work is expected to commence towards the end of August 2020.

6.1.2 The Chief Executive confirmed that the formal investigations into Radiology and Estates have now commenced and updates will continue to be reported to the Board going forward.

6.2 With regards to partnership working, the Chief Executive explained that the Humber, Coast and Vale (HCV) ICS continues to develop. The four acute Trust Chief Executives have agreed to develop an acute provider collaborative, which will be chaired by Chris Long, Chief Executive from Hull University Teaching Hospitals NHS Trust. The Trust's clinical flows were noted in the Carnell Farrar work to link into West Yorkshire, and there is no intention at this time for this to change. NHS England/Improvement (NHSE/I) have confirmed plans for capital to be allocated by each ICS. As part of this work a recent government announcement confirmed that additional funding is being made available to ICS's for Urgent and Emergency Care, backlog maintenance and mental health with ICS' responsible for the deployment of funding across providers.

6.2.1 It was noted that proposals for Local Government devolution in North Yorkshire and York are due to be submitted in September 2020.

6.3 The Chief Executive confirmed that coronavirus infections continues to remain at a low rate at the Trust with no new positive inpatient results between 3 - 17 July 2020. Work continues to protect patients and staff in relation to social distancing, PPE, and continued hand hygiene. Progress on the Risk Assessments carried for BAME colleagues, males over 55 years old, females over 65 years old, colleagues who are shielding, have underlying health conditions or pregnant was noted. Staff webinars were being offered to colleagues that fall within these categories as a means of support to cover the many changing environmental factors over the last few months.

6.3.1 The Chief Executive drew reference to the correspondence from NHSE/I, which has been issued to each ICS and to Trusts in relation to the recovery requirements.

6.3.2 Mr Papworth sought clarity around progress for the risk assessments for male colleagues of 55 years old and above and female colleagues of 65 years old and above. In response, the Chief Executive explained the process in place and confirmed that BAME staff and staff who were shielding had been the initial priority, and that there should now be greater progress with other groups at higher risk.

6.3.3 Ms Armstrong highlighted the huge amount of work that is being carried out by such a skilled workforce, which confirmed the commitment of colleagues at all levels to work tirelessly through such challenging times. She shared a recent experience at the Nightingale hospital when a member of staff went over and above their duties to make family welcome and supported. She also drew reference to a recent article in the Wetherby News, focussing on the incredible work of the Intensive Care team. Ms Armstrong explained that it is important for the Board to recognise the good things during such extreme times.

6.3.4 Mr Stiff confirmed that he was pleased to see the plans in place to assign a lead director to oversee actions from internal audit reports.

6.3.5 Mr Stiff complimented the Chief Executive on the scheme in place to support staff and their families with letters personally signed by the Chief Executive to say thank you on behalf of the Trust.

6.3.6 Ms Robson sought further assurance around the monitoring of the HIF contract and the potential conflict of interest with Estates reporting to Mr Coulter during the interim arrangements proposed to take place from August 2020. In response, the Chief Executive explained that he would take on the responsibility for contract monitoring during the interim arrangements. Ms Robson thanked the Chief Executive for confirming the arrangements to mitigate the conflict of interest.

6.3.7 Ms Robson requested that the limited assurance reports be provided to the relevant Board Committee meetings, in addition to Audit Committee, which the Chief Executive agreed would be arranged. **ACTION (L Hughes)**

6.4 The Chair's Summary Report from the Senior Leadership Team (SLT) meeting held on 17June 2020 was noted and the Chief Executive explained that in addition to the current scope, Internal Audit have been asked to review Learning from Deaths and implementation of CAS and Patient Safety Alerts, which will be sponsored by the Medical Director.

6.4.1 The Chief Executive invited each Executive Director to provide an update on the risks that they had oversight on including the controls and mitigations in place and explained that further work is planned to take place on risk registers.

6.4.1.1 Mr Coulter provided an update on CR14. He explained that the risk is fully mitigated until September 2020 and there are discussions taking place nationally on a revised allocation of funding, which will be allocated to the ICS. If the errors in the calculation of the current level of the block payment are not resolved, there is a risk that there would be a financial gap in the second half of the year. Mitigations for this include engagement with the ICS and regional NHS Improvement team and by the commissioning of work by an external organisation to gain a greater understanding on the Trust's underlying cost base and run-rate and potential productivity opportunities.

6.4.1.2 Mr Harrison provided an update on CR34 to CR53.

CR34 – *Risk to quality of care by not meeting NICE guidance in relation to the completion of autism assessment within 3 months of referral.* He explained waiting times have returned to marginally above one year, which had previously been below 52 weeks pre-pandemic. He highlighted that this is still an improvement on the two year waits at the end of 2018. Just under 50% of those waiting have had a partial assessment carried out where the elements were possible with non-face to face contact. The service is now in the process of recommencing face to face appointments.

CR41 - *Risk due to increasing waiting times across a number of specialties, including as a result of the impact of COVID19*. Assurance was provided on capacity for P1 patients. Controls were noted to

include: COVID19 recovery plans have been developed and continue to be reviewed; plans have been submitted to NHSE/I via HCV ICS for financial support; all waiting lists prioritised against the national guidelines; the Nightingale hospital CT is being used to clear the CT backlog; the green zone used to maximise Endoscopy and Theatre Capacity; and the increased use of online consultations, and consultant triage to improve the timeliness of pathways of care. Mitigating actions include participation in the national 'Adapt and Adopt' programme; planned waiting list validation; and plans for a second CT scanner. With regards to P2 patients, 160 were on the waiting list at that time which is above the 100 that the Trust normally has at any point in time. This has resulted in some patients waiting longer than normal with arrangements in place to prioritise them with the aim of returning to usual levels by the end of August/mid-September 2020.

CR45 - *Risk to MAU/CAT Clinic service provision due to current service being covered by single consultant.* Current controls include the use of a locum when needed. Mitigating actions in place include the approved business cases to increase the number of acute physicians; and a number of changes made to improve the number of Consultants working in Acute Medicine, which should address the risk. Plans are in place for the next Corporate Risk Review Group to downgrade this risk due to the controls and mitigations in place.

CR49 - *Risk associated with delayed imaging in ED department due to risk of x ray equipment failure.* Controls and mitigating actions in place include the scheme being categorised as urgent and a business case has been submitted to the ICS, with confirmation of funding awaited. There are also business continuity contingencies in place in the event of equipment failure.

CR52 - *Risk to patient safety, quality of care and the psychological impact of delays in cancer diagnostics, treatment plans and surveillance because of the COVID19 response to national guidance.* Controls and mitigating actions in place include the review of all patients on a two-week wait pathway to establish who is required to continue on the pathway or if alternative arrangements are required; Nightingale hospital in Harrogate used effectively to clear the CT backlog with the scanner available for use until the second CT scanner is in place.
CR53 – this risk has been consumed within CR55.

6.4.1.3 Ms Wilkinson provided an update on CR54. *Risk to staff well-being and morale (short term and longer term) in the context of the COVID19 pandemic.* Controls and mitigating actions in place include the risk assessment process and the leadership development offer to colleagues.

6.4.1.4 Mrs Foster provided an update on CR55 and CR57.
CR55 - *Risk to patient safety and experience if service provision is overwhelmed by demand during recovery phase of COVID19*. Current controls in place include: continuing to clinically prioritise patients with waiting lists reviewed by consultant teams; surge planning for critical care; and surge planning for the safeguarding team and designated nurses. Mitigating actions in place were noted to include participation

in the Adapt and Adopt Programme; and implementation of National Initiatives on Urgent and Emergency Care.

CR 57 - *Risk to patient safety, quality of care and staff welfare due to increased levels of domestic abuse and children's safeguarding associated with the response to COVID19*. Controls and mitigating actions are referenced in the Chief Nurse report provided to Board. A summary of the current controls and mitigating actions in place were noted: weekly meeting of Safeguarding Children CAG; domestic abuse review following two instead of four communications; staff training increased to support families; increased compliance of supervision and training; development of COVID19 related case studies for supervision and training; levels of safeguarding monitored; and demand and capacity managed through COVID19 recovery governance processes.

6.4.1.5 The Chief Executive explained that at the last Board meeting Dr Shepherd had provided an update on CR58. It was noted that there are plans in place to review the management of risk registers going forward.

6.4.1.6 The Chairman thanked the Chief Executive and Executive Directors for the detailed update, which enabled a valuable use of the Board's time. She welcomed the update on changes and progress made on the revised risk management process going forward.

6.5 **Resolved:** the Chief Executive report, including the detailed update on the corporate risks rated 12 and above were noted.

BoD/07/20/7 **Freedom to Speak Up Guardian Report**

7.1 The Chief Nurse spoke to the report, which was noted. She explained that the report follows previous reports, which were presented biannually to the Board and outlined barriers to speaking up, how they are identified and addressed. She drew reference to the work being taken forward nationally, data and themes relating to local Guardians and Fairness Champions, progress with local work and further work to be undertaken at the Trust. It was noted that the Guardians work alongside many other systems and processes that staff can use to raise concerns which include directly with managers, with HR and Risk Management, staff governors, Trade Union representatives, Executive and Non-executive Directors.

7.2 The Chief Nurse drew reference to the letter from the NHS National Guardian, Dr Henrietta Hughes to Trust Chairs and Chief Executive Officers dated 15 June 2020 stressed that: "*Freedom to Speak Up has never been more important and we must keep safe speaking up channels available and promoted to those whose voices are not so often heard*."

7.3 At the outset of the COVID19 pandemic, there were no speaking up cases reported. There was an increase noted from the end of April 2020 to date. The increasing number of contacts to the FTSUGs provides important information about concerns, which help improvements and learning to be achieved.

7.4 The Chief Nurse confirmed that one of the recommended actions in the Deloitte report is to improve the speaking up arrangements at the Trust. Following Board discussion and debate, revised arrangements are being taken forward. Interim arrangements are currently in place with the FTSUG role planned to be advertised in August 2020.

7.5 Following discussion, it was agreed that to ensure the Trust's speaking up arrangements are continually assessed and improved going forward a Freedom to Speak Up self-review will be carried out by the Board; triangulation of speaking up cases will be carried out with HR metrics; and FTSU Training will be arranged.

7.6 Mr Papworth thanked Mrs Foster for the comprehensive report and he looked forward to comparing the information within the report with the information received at the People and Culture Committee meetings going forward. Mrs Foster explained that she aimed to meet with the FTSUGs, Fairness Champions and the Chaplains prior to each People and Culture Committee meeting to ensure that the most up to date information can be provided. The Chairman requested that the Staff Governors are included in this work to support the People and Culture Committee's effectiveness, which Mrs Foster agreed to take forward.

ACTION (J Foster)

7.7 **Resolved:** the Freedom to Speak Up Guardian report was noted.

BoD/07/20/8 **Integrated Board Report**

8.1 The Integrated Board Report for the month ending 30 June 2020 was noted and the Chairman invited any questions in relation to the report.

8.2 Ms Robson queried if the bank and agency ceiling had been reduced. In response, Mr Coulter explained that the ceiling had been reduced and that it is a national requirement to reduce agency spend year on year. The Trust agency spend in June equated to £411,000, 2.5% of the pay expenditure. The year to date expenditure was below the ceiling level.

8.3 Mr Stiff drew reference to 1.4 and queried if there is infection control information available for hospital acquired COVID19 cases. In response, Mrs Foster explained that the Trust monitors this as part of the daily governance arrangements and that whilst this is not included in the performance report, the Quality Committee and the Board are informed separately on any hospital acquired COVID19 cases. Mr Stiff highlighted that if COVID19 is a long-term concern the inclusion of hospital acquired cases would be valuable but accepted that at the current time reporting out-breaks is an efficient method.

8.4 Mr Stiff drew attention to 4.18 'Children's Services and the Use of the Home Environment Assessment Tool' and queried if there is data available from February 2019 to February 2020. In response, Dr Lyth explained that there is currently an issue with the reporting of this data and she provided re-assurance that assessments incorporating the use of this tool had re-commenced.

8.5 Dr Shepherd drew reference to the Emergency Department four hour standard. He explained that he reported to the Board last month the achievement of the 95% standard. Due to the increase in activity in

June and the implications of the social distancing/PPE requirements, the 95% standard had not been achieved in month.

8.6 The Chairman sought an update on safer staffing. In response, Mrs Foster explained that reporting on safe staffing is planned to re-commence and an update will be provided to the Board at its September 2020 meeting.

8.7 Mr Sampson queried if staff appraisals had been paused during COVID19. In response, Ms Wilkinson explained that reporting on staff appraisals had been excluded from reports during COVID19 but were still being carried out across the Trust. Work is taking place to capture this information for inclusion in future reports.

8.8 **Resolved:** the Integrated Board Report was noted.

BoD/07/20/9 **Resources Committee Chair's Report**

9.1 The Resources Committee Chair's report from the meeting held on 27 June 2020 was discussed. Ms Taylor, Committee Chair reported that COVID19 costs and planning issues are not reflected in the NHSE/I plan, and the Trust reported a small surplus of £17,000. COVID19 costs were reported as £3m to date with a total cumulative top up of £6.6m. The discrepancies in the NHSE/I planning assumptions are under discussion with NHSE/I with no decision made to date.

9.2 The Committee had reviewed and discussed the recovery plan, which has commenced and the Trust is working with West Yorkshire and Harrogate ICS on Elective work and Theatre Capacity as part of the national Adapt and Adopt programme. There had been good progress reported on recruitment during June 2020. An update on planning was received with the current interim arrangements expected to continue to September 2020 before revised arrangements are put in place.

9.3 The consolidated cash position (Trust and HIF) as at 31 May 2020 is as a balance of £18.8m with a break-down presented to the Committee to identify the underlying cash position (excluding top-ups and payments in advance) and this is estimated to stand at £4.64m. She was pleased to report that the Committee noted that 80% of invoices due to be paid in the quarter had been paid within 30 days; and the Committee noted and supported the extension of the Trust's membership in the North East Partnerships consortium arrangement for provision of the financial ledger.

9.4 **Resolved:** the Resources Committee Chair's report was noted.

BoD/07/20/10 **Finance Report**

10.1 The Finance Report for the month ending 30 June 2020 was noted. Mr Coulter explained that it is expected that COVID19 expenditure will increase in July 2020 as a result in the treatment of some Nightingale hospital costs, and an anticipated increase in testing costs for the Trust. Close monitoring on the cash position will continue despite it being in a good position at £18m, due to the current regime where payments are made to the Trust in advance.

10.2 He drew reference to his update on the financial risk reported at 6.4.1.1. above with discussions taking place nationally on a revised allocation of funding which will be allocated to the ICS. If sufficient funding to address the planning issues is not received from the ICS there would be a financial gap in the second half of the year. He advised the Board that a piece of work had been commissioned from an external supplier to gain a greater understanding on the Trust's underlying cost base and run-rate as part of mitigating this risk.

10.3 The Trust Use of Resources rating was noted as 1 against the plan of 1.

10.4 The Chairman queried when the Trust would be notified by the ICS on its capital submission. In response, Mr Coulter explained that the Trust has received an indication that payment for the majority of phase 1 capital will be approved shortly. He explained that it was not known when phase 2 and 3 capital allocations would be confirmed, although it has been indicated that it should be at some point during August 2020.

10.5 **Resolved:** the Finance position as at 30 June 2020 was noted.

BoD/07/20/11 **COVID19 Recovery Plan Update**

11.1 Mr Harrison confirmed that the Trust has submitted its acute recovery plan, step up activity profiles and the associated capital requirement to NHSE/I.

11.2 Recovery continues to prioritise the protection of cancer services. Some diagnostics including endoscopy services were unable to function during the pandemic, which poses the most risk at present to the cancer pathway. Endoscopy recommenced in June 2020, with an increase in capacity week on week, and the confidence of patients to access services has been evident in the increasing number of referrals being received. He drew reference to the continued challenges within ENT and community dental due to aerosol-generated procedures.

11.3 Ms Armstrong queried the arrangements in place for visitors. In response, Mr Harrison explained that the Trust's Chief Nurse was encouraging visitors to adhere to infection control standards by wearing PPE when visiting relatives.

11.4 Mr Papworth commended the report, which he found most informative. He sought clarity around the long waiters and outcome of the review. In response, Mr Harrision explained that patients waiting more than 52 weeks for treatment increased due to routine care being stood down during March to June 2020. It is anticipated that without remedial action there could be 315 patients waiting over 52 weeks by the end of July 2020. The Trust has commenced planning and mobilisation of lists to support long wait patients and where possible this will recommence from July 2020. All referrals are triaged by a speciality consultant, resulting in them being prioritised and all patients on the waiting list for surgery have a prioritisation category, based on the Royal College of Surgeons clinical prioritisation framework.

11.5 Mr Stiff queried if plans are in place for future reports to include the 0-19 service. In response, Mr Harrison explained that all community services have restarted.

11.6 Mr Stiff sought clarity around the arrangements in place at the Selby MIU. In response, Mr Harrison explained that Selby now functioned as an Urgent Treatment Centre (UTC) with a very high level of performance provided. All patients are seen within the four hour standard and most have been seen within two hours.

11.7 **Resolved:** the COVID19 Recovery Plan Update was noted.

BoD/07/20/12 **Quality Committee Chair's Report**

12.1 The Quality Committee Chair's report from the meeting held on 1 July 2020 was discussed. Ms Robson, Quality Committee Chair reported that the meeting opened with a presentation from the Clinical Lead for Audiology who had been invited to provide an update on service changes and what affect that had on patient care during the pandemic. It was noted that remote working had reduced non-attendances and a wide range of services could be provided this way. The Committee found the presentation represented innovative patient centred thinking. The Chairman was pleased to note that the meeting had commenced with an experienced shared on the COVID19 pandemic.

12.2 It was noted that the sepsis screening results had improved and that an electronic solution had enabled better recording of data. Planning has commenced for the 2020/21 Influenza Campaign. The Chief Nurse had reported on the Woodlands Ward move, which had taken place due to a risk of legionella that had been identified. The risk was reported as low, which had been identified through routine testing.

12.3 **Resolved:** the Quality Committee Chair's report was noted.

BoD/07/20/13 **Chief Nurse Report**

13.1 The Chief Nurse Report was noted. This report, in conjunction with the Medical Director's report aimed to provide assurance for the quality of care (safety, effectiveness and experience) and professional standards at the Trust. The Chief Nurse report included a summary of key issues in relation to the Annual Patient Experience and Complaints Report, the Safeguarding Children Resilience Assurance Report and the Learning Disabilities Annual Report, which were included on the agenda as separate items.

13.2 She drew reference to Revalidation and noted that in response to the COVID19 pandemic nurses, midwives and health visitors due to revalidate in March to June 2020 have had their revalidation dates automatically extended for 12 weeks; and those due to revalidate in July or August 2020 could request a 12 week extension. The Chief Nurse reassured the Board that the Trust has a robust process in place to ensure all nurses, midwives and health visitors have a valid registration.

13.3 The Chief Nurse reported that a second outbreak of hospital acquired COVID19 infection had resulted in 50 staff members being tested and all ad confirmed negative results. Two patients were involved who have

been subsequently discharged and the outbreak on the Byland ward was declared closed on 10 July 2020.

13.4 She explained that routine testing carried out identified a very low risk of legionella, which resulted in a move of Woodlands Ward as a precautionary measure. The Chief Nurse thanked Lauren Heath, Infection Control Consultant for her supportive approach throughout the pandemic period to date.

13.5 The Chief Nurse drew reference to the Annual Patient Experience Report, which provided assurance around the work taking place, which is supported by the Patient Advice and Liaison Service who had received 953 contacts in 2019/20. The Board noted that there were 325 compliments and 236 complaints received in 2019/20. It was noted that work continues to drive forward improvements on the timeliness of responses to complaints.

13.6 It was noted that Children's Safeguarding 0-19 service during COVID19 has seen an increase in the numbers of incidents requiring a response. The services have developed and implemented a number of methods and processes to ensure children are continuously safeguarded and staff are supported.

13.7 The Chief Nurse provided a further update to support the discussion at the last meeting on the impact of the pandemic on people with a Learning Disability. The number of deaths of patients with a Learning Disability increased in North Yorkshire during the COVID19 period of March to May 2020. There had been 25 deaths during this period against an average of 11 in comparison to the same period last year. It was noted that each death is subject to a Learning Disability Mortality Review (LeDeR).

13.8 Mr Papworth commended the new format of reports. Mrs Taylor queried if arrangements were planned to re-instate Patient Stories at Board meetings in the future. In response Mrs Foster explained that the Patient Experience Team are working on this with the aim of patient stories being presented to future meetings by members of staff instead of patients during the pandemic period.

13.9 Ms Armstrong drew reference to the high targets to increase expectations with the management of complaints. In response, the Chief Nurse explained that this remained an important priority for the Trust to ensure it is respectful to patients and families who may have concerns.

13.10 Mr Sampson drew reference to the safeguarding arrangements in place and the assurance provided by the Chief Nurse. He queried if there are any areas of concern. In response, the Chief Nurse explained that the inpatient service is seeing an increasing number of serious cases and confirmed that there is a process in place to capture all risks. Dr Lyth explained that the increase in numbers and severity is a challenge for staff and managers and work continues to support colleagues through this.

13.11 The Chairman queried when the outcome of the LD investigation would be reported. In response, the Chief Nurse explained that there was a York and North Yorkshire panel taking place that day and she would update the Board at a future meeting.

13.12 **Resolved:** the Chief Nurse report was noted.

BoD/07/20/14 Annual Patient Experience and Complaints Report

14.1 **Resolved:** the Annual Patient Experience and Complaints Report was received and noted.

BoD/07/20/15 Safeguarding Children Resilience Assurance Report

15.1 **Resolved:** the Safeguarding Children Resilience Assurance Report was received and noted.

BoD/07/20/16 Learning Disabilities Annual Report

16.1 **Resolved:** the Learning Disabilities Annual Report was received and noted.

BoD/07/20/17 Medical Director Report

17.1 Dr Andrews presented her first report since taking up the position of Executive Medical Director at the Trust. She provided background to the work she would be taking forward to create a Medical Directorate and a senior medical leadership team. The Medical Directorate portfolio was noted would include: professional standards and workforce developments, with clinical governance and risk management (shared portfolio with the Chief Nurse), research and development, quality improvement and transformation and professional leadership aspects of the medical education portfolio (shared with the Director of HR).

17.2 She confirmed that an excellent appointment was made to the Community Paediatric Dentistry position on 15 July with the successful candidate due to commence in Spring 2021.

17.3 Dr Andrews explained that in response to observations made in the Third Report of the Shipman Inquiry, the Department of Health and Social Care (DHSC) created the Medical Examiner (ME) role. MEs provide independent and transparent scrutiny of the death certification process whilst supporting clinicians, administration staff and bereaved relatives. The role of Lead ME at the Trust is currently out to advertisement. Once an appointment has been made the ME will lead a new team of MEs in the Trust, with arrangements in place for additional positions will be advertised to support the Lead ME. It was noted that the Lead ME would work with the Medical Director to refresh and oversee the Trust's Learning from Deaths framework.

17.4 The Trust is an active member of the COVID19 research community with 451 patients recruited into COVID19 studies to date. It was noted that the Trust is a site for the National Institute of Research funded RECOVERY study, which demonstrated the positive effects of dexamethasone in the treatment of COVID19, with rapid national adoption which is currently part of the routine management of ITU patients with the virus at the Trust. She explained that research focus is moving to public health surveillance studies such as the SIREN study in the next stage of the pandemic; with an objective of determining if,

prior SARS-CoV2 infection in health care workers confers future immunity to re-infection. It will also allow organisations to estimate the prevalence of SARS-CoV-2 infection in healthcare workers and utilise this information to determine wider staff testing.

17.5 Dr Andrews drew attention to the very active and visible Improvement and Transformation Team at the Trust. The team have interviewed over 250 colleagues at the Trust to gain an understanding of their experience of working during the pandemic. Work is underway to deliver a comprehensive 'COVID19 lessons learned' internal and external communication plan with the outcome aimed to assist the Trust in its preparations for the event of a second wave of the virus. The Team are now focussing on creating and managing the delivery of the Trust's major Culture Change Programme.

17.6 The Chairman thanked Dr Andrews for her comprehensive report. Ms Armstrong queried the progress made with PESH to date. In response Dr Andrews explained that PESH had met on three occasions and was progressing well with colleagues meeting via one hour huddles as well as monthly workshops to discuss themes. It was noted that anyone in the Trust is welcome to attend PESH meetings.

17.7 The Chairman suggested that the QI methodology is covered at a future workshop. It was agreed this would be arranged and added to the workshop workplan. **ACTION (J Andrews/L Hughes)**

17.8 **Resolved:** the Medical Director report was noted.

BoD/07/20/18 **Guardian of Safe Working Q4 Report**

18.1 **Resolved:** the Guardian of Safe Working Q4 report was noted.

BoD/07/20/19 **Director of Workforce and Organisational Development Report**

19.1 The Director of Workforce and Organisational Development report was noted. Ms Wilkinson explained that the report aimed to provide assurance around individual Risk Assessments; the BAME Network and associated activities; and workforce and organisational development reset of mandatory and Essential Skills Training and leadership development.

19.2 The Board noted the Trust had made good progress with staff risk assessments for the at risk categories. This has been achieved through a number of supportive programmes of work including occupational health support, COVID19 HR dedicated email facility; and with most recently weekly line manager webinars to provide support and advice for colleagues who are due to return to work from previous shielding.

19.3 Discussion took place around the BME Staff Network, which was launched in March 2020, which has 30 members with an advertisement made for a Chair of the Network. The LGBT+ Network inaugural meeting is scheduled for 31 July 2020, which has 13 initial members at present; with the Disability and Long Term Illness Network scheduled to meet at the end of July 2020. Chairs for these network groups will also be advertised in the near future.

19.4 The Board noted the plans in place to re-start mandatory training and leadership development, which had been paused during COVID19.

19.5 Ms Robson queried the governance process in place for Networks and if there are plans in place for them to report to a Board Committee. In response, the Chief Executive and Ms Wilkinson confirmed that plans are in place for the Networks to operationally report into SMT with assurance provided to the People and Culture Committee through its programme of work.

19.6 **Resolved:** the Workforce and Organisational Development report was noted.

BoD/07/20/20 **Any Other Business**

20.1 There was no other business.

BoD/07/20/21 **Board Evaluation**

21.1 The Chairman thanked Executive Directors for the standard of reports provided in the revised format. Dr Shepherd drew reference to the valuable discussions and debates that had taken place, which enabled a balance of constructive challenge.

21.2 The Chairman sought views on rotation of reports going forward which was agreed to be taken forward from September. **ACTION (L Hughes)**

21.3 Mr Treece, Governor thanked the Board for the opportunity of overserving the meeting and explained that he particularly found the update on risk most informative and effective.

BoD/07/20/22 **Date and Time of Next Meeting**

22.1 The next meeting is scheduled to take place on Wednesday, 30 September 2020 at 9am via virtual arrangement.

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.

Board of Directors (held in Public) Action Log							
Minute Number	**Date of Meeting**	**Subject**	**Action Description**	**Responsible Officer**	**Due Date**	**Comments**	**Status -** completed is defined as confirmation received from ED responsible lead that the proposed action is completed as described in the comments column. Completed actions will not be closed until the Board has confirmed that action taken is satisfactory.
148	25 September 2019	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.	Chief Nurse	01 December 2020	Included on workplan for December 2020 Board Workshop	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.	Chief Nurse	30 September 2020 and 31 March 2021	Completed. Included in Chief Nurse Report for 30 September meeting.	Open
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.	Chief Nurse	30 September 2020	Completed. Included in Chief Nurse Report for 30 September meeting.	Completed
BoD/07/20/4 and Bc	29 July 2020	Advanced Care Planning	Two actions agreed to be reviewed by new Medical Director and reframed.	Medical Director/ Medical Examiner	01 December 2020	Plans for this action to be taken forward by the Medical Director with the support of the Medical Examiners Office to incorporate Learning from Deaths/mortality a the December Board Workshop	Open
BoD/07/20/5	29 July 2020	Overview by the Chairman	Agreed to revert to bimonthly Board meetings (held in Public) with Board Workshops held in the month's in between Board meetings. Arrangements will be put in place to revert back to this arrangement	Interim Company Secretary	07 August 2020	Website updated and venues booked for Board workshops in August, October and December at the Pavilions	Completed
BoD/07/20/5	29 July 2020	Overview by the Chairman	Remuneration Committee to be held in September.	Interim Company Secretary	17 August 2020	Arranged to take place following the Board and Trustee meetings on 30 September	Completed
BoD/07/20/5	29 July 2020	Overview by the Chairman	Trustee meeting to be held in September following the Board meeting	Interim Company Secretary	07 August 2020	Arranged to take place following the Board meeting on 30 September	Completed
BoD/07/20/6	29 July 2020	Chief Executive's Report	Ms Robson requested that the limited assurance reports that fall under the responsibilities of the Board Committees are provided to future Committee meetings, which the Chief Executive agreed, would be arranged	Interim Company Secretary	02 September 2020	Tom Watson, Internal Audit has been requested to provide limited assurance audit reports to Board Committees and SMT. This work has commenced.	Open

BoD/07/20/7	29 July 2020	FTSUG Report	Agreed Staff Governors would be invited to participate in the work streams that support the People and Culture Committee along with the FTSUGs and Fairness Champions	Chief Nurse	30 November 2020	People and Culture Committee Terms of Reference updated to reflect regular attendance required by the Lead FTSUG. Discussion took place and People and Culture Committee on 23 September and agreed the Chief Nurse would invite the interim FTSUG to meetings until the formal arrangements are completed.	Open
BoD/07/20/17.7	29 July 2020	Medical Director Report	Agreed QI methodology would be covered at a future workshop. It was agreed this would be arranged and added to the workshop workplan	Medical Director/Interim Company Secretary	Date to be determined	Discussion taken place as possible option for December 2020 or 2021 workshop	Open
BoD/07/20/21.2	29 July 2020	Board Evaluation	In response to the Chairman's request it was agreed Director reports would be rotated on the agenda from September onwards	Interim Company Secretary	30 September 2020	Order of reports have been changed on the agenda and will be rotated going forward.	Completed

Harrogate and District NHS Foundation Trust

Board meeting held in Public
30 September 2020
Report of the Chief Executive

Agenda Item Number:	**6.0**
Presented for:	Information and Discussion
Report of:	Chief Executive
Author (s):	Chief Executive
Report History:	None
Publication Under Freedom of Information Act:	This paper has been made available under the Freedom of Information Act 2000

Links to Trust's Objectives	
To deliver high quality care	X
To work with partners to deliver integrated care	X
To ensure clinical and financial sustainability	X

Recommendation:
The Board is asked to note this report.

6

Board of Directors

30 September 2020

Report of the Chief Executive

1.0 Executive Summary

1.1 In the period since the last Board meeting there has been significant focus on resuming routine services which were paused during the first wave of the COVID19 pandemic, and this remains a priority for further focused work to ensure we are able to offer planned care to as many of our residents who are waiting for assessment and treatment as possible. This was initially in the context of doing so whilst COVID19 still was present, but when rates of infection were relatively low and this has presented significant challenges that we continue to work on.

1.2 Unfortunately that context has changed with a much more significant rise in infection rates nationally in the recent days. At this stage, admissions to hospital have remained relatively low, but it is clearly likely that this will change.

1.3 Reflecting on the response to the first wave, the whole system prepared rapidly for a sharp rise in the demand for critical care, which thankfully did not materialise, supported many people at home, and the pausing of all but urgent treatment created capacity for the anticipated critical care demand.

1.4 As we stress test our plans for responding to the second wave the NHS as a whole is mindful of the risks to and impact upon patients that arose from pausing services, and from patients being discouraged to access all but the most urgent care.

1.5 As such, this next phase will be framed with an equally high order principle of protecting 'routine' treatment as far as possible, working with partners to ensure the NHS remains available for urgent and critical care, but also to those waiting for diagnostics and elective treatment. The challenges of providing services 'living with COVID19' will be accentuated by the potential additional pressure on the demand for hospital beds for patients with COVID19 as we head into a traditionally more challenging period.

1.6 At the same time, our system (North Yorkshire and York) has now received confirmation of the block funding we will receive for the second half of the year, setting the financial frame for the activity.

1.7 As we seek to meet these demands within that financial enveloped, we must continue to focus on, and support on our 0-19 and community services, who have the same scale of challenge of recovery and 'catch up' even if the national focus is more weighted towards acute care.

1.8 The Chairman and I have sent a personal thank you to each and every one of our colleagues to recognise the commitment and resilience that they have shown. We had all hoped that we might be returning to a more stable environment, but clearly our colleagues and our partners are again going to be asked to draw on their reserves to again to protect, support and care for the populations we serve across North Yorkshire and the North East.

1.9 The initial response has had quite a significant impact on colleagues and we are considering how we can best provide proactive support to colleagues at a time when

pressures and anxieties are both high, and when there is 'business as usual' work that needs to continue across our services.

2.0 Leadership and culture

2.1 I, and other colleagues, are delighted to welcome Tim Gold as Chief Operating Officer. Tim has commenced his 6 month secondment from Bradford Teaching Hospitals NHS Foundation Trust and has made a very significant and positive impact in his first three weeks. Much of his focus has been on the recovery of services, which as is set out in later papers is a key issue and a significant risk for us and he has already helped address some of the gaps, and identified root causes.

2.2 Following an internal advert which was ring-fenced to Directorate Triumvirates and direct reports to the COO, Matt Shepherd has been appointed as Deputy Chief Operating Officer for an initial period of 12 months. This is not a full time role, and is an additional responsibility in addition to his role as Clinical Director for the Long Term Condition and Urgent Care Directorate (LTUC). Turning to leadership in Planned and Surgical Care (PSC), following an internal advert, Beth Barron has been appointed as Interim Operational Director for and is already providing significant leadership to the recovery plan.

2.3 We have now agreed the model for improvement for our work to address the findings of the Deloitte review and have just launched this under the banner of 'teamHDFT – at our best'. The first stage sees very widespread engagement through virtual workshops to define what behaviours we want to see at HDFT, and how we want it to feel working as part of the team. These workshops start in November, and are preceeded by a short focused cultural survey which is live until early October. The national NHS staff survey will follow this.

2.4 Our other initial priority areas of work are recruitment, creating a vision, and taking action to become an anti-racist organisation, considering the issue of terms and conditions of service in Harrogate Integrated Facilities and improving the physical working environment whilst the formal investigations into Radiology and bullying and harassment in Estates continue. The capacity and capability assessment of HIF has been completed.

3.0 Partnerships

3.1 We continue to develop relationships within Humber, Coast and Vale, and in the North Yorkshire and York system.

3.2 NHS England and NHS Improvement have issued financial envelopes to systems for the second half of the year and systems are required to work together to deliver within this overall envelope. The Director of Finance will provide more detail on this in his report later in the meeting.

3.3 Phase 3 capital has still not been confirmed and this remains a key risk. In addition to this, the Board will be aware that the Trust previously took out planned loans for a Carbon Efficiency Scheme and for Endoscopy which were repayable, and have been repaid in line with plan since then. This has been funded through the generation of surpluses. The new financial framework sets a break-even position for the Trust and although emergency loans (which the Trust had not taken out) were written off, planned loans were not. This means that the source of funds to repay the loans are not available without reducing the capital programme below retained depreciation. This risk has been raised with NHS England's regional team before, but now the regime, and the implications are known will require further discussion and support.

3.4 The Trust has been fortunate to receive support for capital investment for A&E (ED) resilience, critical care and diagnostics.

4.0 COVID-19

4.1 On 20th September we commenced a 'reboot' week focused on PPE, social distancing and hand hygiene as some of the key measures to minimise the risks of transmission of COVID19. This is being led by Rebecca Leigh and Simon Riley-Fuller.

4.2 The Flu campaign for 2020 has commenced, and the report of the Chief Nurse provides further detail.

5.0 Use of resources

5.1 At month 5, the Trust has continued to break even, in line with the financial regime. Our spending on COVID19 and our total top up has remained broadly static showing that that there are appropriate controls in place. The detailed position is covered by the Director of Finance/Deputy Chief Executive.

5.2 The new financial regime will require us to recommence our efficiency programme. This will be informed by the external review that the Trust commissioned to consider our run-rate and required funding envelope for the second half of the year.

6.0 Use of Trust Seal

6.1 The Board are asked to note that the following documents have been signed and engrossed under the Trust's seal:

- Deed of Variation (2) to the Contact for the Provision of Public Health Services, 0-19 Health Child Service between the Trust and Stockton Borough Council
- TR1, Transfer of Land adjoining 8 Rydal Road Harrogate from the Trust to A Twiss and K Sugden
- TR1, Transfer of Land adjoining 10 Rydal Road, Harrogate from the Trust to B Keating
- Contract for the Sale of Freehold Land with Vacant Possession for land adjoining 8 and 10 Rydal Road, Harrogate between the Trust and A Twiss and K Sugden
- Contract for the Sale of Freehold Land with Vacant Possession for land adjoining 8 and 10 Rydal Road, Harrogate between the Trust and B Keating
- Lease relating to Room 11, Tyne View Children's Centre, Rose Street, Gateshead, Tyne and Wear

7.0 Development of Board Assurance Framework and Risk Register

The Trust has developed a revised Board Assurance Framework BAF), which it plans to maintain and report regularly to the Board. The BAF records risks that threatens the achievement of the Trust's long term (strategic objectives) together with the controls and actions in place to mitigate these risks. A Corporate Risk Register is also in place, which records the most serious operational risks, these risks are scored by consequence x likelihood of 12 to 25.

7.1 Board Assurance Framework

7.1.1 Proposed risks were presented to the Board at its Workshop in July 2020 which were agreed would be added to a revised BAF. Following the Workshop the BAF has been developed by Lead Executive Directors.

7.1.2 The Board is asked to consider and approve the BAF (Appendix B), which is aimed to be developed by regularly reviews by Executive Director Leads, reported and overseen by relevant Board Committees at each of their meetings, and by the Board on a quarterly basis. Any changes to the BAF are planned to be highlighted and brought to the attention of Board Committees/Board meetings going forward.

7.2 Corporate Risk Register

7.2.1 The full Corporate Risk Register (CRR) is reviewed by the Corporate Risk Review Group and Senior Management Team on a monthly basis. At the last Board meeting held in July the corporate risks were discussed in detail and Lead Executive Directors provided updates on the controls and assurances in place to manage these risks. The Corporate Risk Register is attached as Appendix B.

8.0 Recommendation

8.1 It is recommended that the Board note this report, and identify any areas in which further assurance is required which is not covered in the Board papers.

9.0 Supporting Information

9.1 The following papers make up this report:
Appendix A – Board Assurance Framework
Appendix B - Corporate Risk Register.

Board Assurance Framework

1. STRATEGIC OBJECTIVE: PEOPLE (description to be determined)																
Risk ID	**Principle Objective**	**Principle Risk to the Delivery of Objective**	**Residual (Current) Risk Rating**			**Target Risk Score**	**Target Date Risk Score will be met/closed**	**Change since last Report**	**Existing Key Controls**	**Assurances in Controls**		**Gaps in Assurances/Controls**	**Latest Update**	**Responsible Committee**	**Lead Executive Director**	**Date Reviewed**	**Associated Corporate Risk Number**
			Likelihood	**Conseq**	**Rating**					**Internal**	**External**						
BAF#1	To be an outstanding place to work	There is a risk that individual staff engagement and high performing team cultures are compromised **because** there is an insufficient focus on the culture of the Trust and the health and wellbeing of staff which will **impact** on the Trust's ambition to be an outstanding place to work and in turn will impact on the quality of patient experience.	3	4	12	2x2=4	Apr-22		Your Voice Vision and Values Programme which incorporates multiple improvement projects/programmes of work First Line Leaders Programme and other development programmes Shadow SMT Reverse mentoring programme EDI work programme	Board of Directors SMT People and Culture Committee	ICS metrics (TBC) Staff Survey	Currently no oversight arrangements in place by regulators	risk, controls, assurances and gaps in controls added following Board discussion and approval at Board Workshop	People and Culture Committee	A Wilkinson, Director of Workforce and OD	22.09.20	to be populated once risk is accepted

Board Assurance Framework

2. STRATEGIC OBJECTIVE: WORKING WITH PARTNERS TO DELIVER INTEGRATED CARE

Risk ID	Principle Objective	Principle Risk to the Delivery of Objective	Residual (Current) Risk Rating			Target Risk Score	Target Date Risk Score will be met/closed	Change since last Report	Existing Key Controls	Assurances in Controls		Gaps in Assurances/Controls	Latest Update	Responsible Committee	Lead Executive Director	Date Reviewed	Associated Corporate Risk Number
			Likelihood	Conseq	Rating					Internal	External						
BAF#2.1	To improve population health and wellbeing, provide integrated care and to support primary care	There is a risk that the Trust does not maximise its contribution to improving population health and reducing health inequalities **because** of a lack of strategic relationships with primary care and local authorities and an internal focus which will **impact** on our strategic ambition to improve population health and wellbeing, provide integrated care and to support primary care.	3	3	9	2x2=4	Apr-23		Medical Director attendance at LMC and HARA	MD Board Report SMT Medical Directorate Team meeting	HARA Yorkshire Health Network LMC	Distributed portfolio across Executive Directors for partnerships	risk, controls, assurances and gaps in controls added following Board discussion and approval at Board Workshop	SMT	J Andrews, Executive Medical Director	22.09.20	None included
BAF#2.2	To be an active partner in population health and the transformation of health inequalities	There is a risk that the Trust's population is not able to fully benefit from being part of an integrated care system **because** our secondary care patient flows are to West Yorkshire and our place based population health activities sit within North Yorkshire which are in two different ICSs and there is insufficient management bandwith to participate in both. This will **impact** on our ambition to be an active partner in population health and the transformation of health inequalities.	3	3	9	2x2=4	Apr-23		West Yorkshire ICS and Humber Coast and Vale ICS meetings by Executive Team members			Duplication of effort and lack of leadership capacity	risk, controls, assurances and gaps in controls added following Board discussion and approval at Board Workshop	SMT	J Andrews, Executive Medical Director	22.09.20	None included

Board Assurance Framework

3. STRATEGIC OBJECTIVE: DELIVER HIGH QUALITY CARE

Risk ID	Principle Objective	Principle Risk to the Delivery of Objective	Residual (Current) Risk Rating			Target Risk Score	Target Date Risk Score will be met/closed	Change since last Report	Existing Key Controls	Assurances in Controls		Gaps in Assurances/ Controls	Latest Update	Responsible Committee	Lead Executive Director	Date Reviewed	Associated Corporate Risk Number
			Likelihood	Conseq	Rating					Internal	External						
BAF#3.1	To provide outstanding care and outstanding patient experience	There is a risk to achieving outstanding service quality and patient experience **because** there is insufficient focus on an systematic organisation-wide approach to and culture of quality improvement which will **impact** on the Trust's ambition to continuously address the underlying barriers to excellence every time and to provide outstanding care.	3	4	12	3x3=9	Apr-22		Quality Assurance reports Quality Committee Workplan	CQC Action Plan Quality Account	CQC Inspections Bi-monthly Assurance meetings with CCG	Do not have consistent quality control in place	risk, controls, assurances and gaps in controls added following Board discussion and approval at Board Workshop	Quality Committee	J Foster, Chief Nurse	22.09.20	to be populated once risk accepted
BAF#3.2	To provide a high quality service	There is a risk that some of our secondary care based services are not clinically and financially sustainable **because** of the size of population we serve and our ability to respond to sub-specialisation and to recruit and retain staff which will **impact** on our ambition to provide high quality services.	4	4	16	3x3=9	Apr-23		**External:** Carnell Farrer report Ongoing Clinical Services review to develop Clinical Strategy Ongoing conversations with WYATT	SMT Directorate Oversight on Annual Clinical Plans Quality Committee Board of Directors	WYATT Committee in Common	No Project Management Support for clinical review and support to draft strategy	risk, controls, assurances and gaps in controls added following Board discussion and approval at Board Workshop	Quality Committee	J Andrews, Executive Medical Director	22.09.20	to be populated once risk accepted

Board Assurance Framework

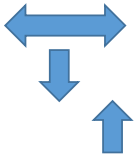
4. STRATEGIC OBJECTIVE: ENSURE CLINICAL AND FINANCIAL SUSTAINABILITY

Risk ID	Principle Objective	Principle Risk to the Delivery of Objective	Residual (Current) Risk Rating			Target Risk Score	Target Date Risk Score will be met/closed	Change since last Report	Existing Key Controls	Assurances in Controls		Gaps in Assurances/ Controls	Latest Update	Responsible Committee	Lead Executive Director	Date Reviewed	Associated Corporate Risk Number
			Likelihood	Conseq	Rating					Internal	External						
BAF#4.1	To continually improve services we provide to our population in a way that are more efficient	There is a risk that the focus on the Trust's strategic ambitions are compromised **because** of a prolonged recovery from COVID-19 which will **impact** on service transformation and underlying financial improvement.	4	3	12	2x3=6	Mar-22		Current financial regime; national framework, ICS discussions; engagement in regional and local service transforation programmes; internal transformation programme; alliances with Leeds; membership and engagement with WYAAT	SMT reports and oversight Resource Committee reports and oversight Board of Directors reports and oversight	WYAAT reports and Committee in Common engagement and oversight NHSE/I regulatory oversight	**Internal:** capacity to deliver internal service transformation **External:** no governance structure or programme of work with Leeds regarding transformation	risk, controls, assurances and gaps in controls added following Board discussion and approval at Board Workshop	Resource Committee	J Coulter, Deputy Chief Executive/ Finance Director	22.09.20	to be populated once risk accepted
BAF#4.2	To provide high quality care and to be a financially sustainable organisation	There is a risk to the Trust's ability to meet its long term financial sustainability obligations, and generate sufficient resources to invest in capital **because** of an inability to generate sufficient cash through inward investment or cash releasing efficiency savings over and above the national efficiency requirement. This will **impact** on the Trust's ability to provide high quality care and to be a financially sustainable organisation.	4	4	16	4x2=12	Mar-23		Captial asset register and planning process; financial plan; currrent financial regimeto			**Internal:** No Capital Programme group in place No efficiency programme for 2020/21 **External:** Currently no ICS Strategy or process in place Currently no commitment by the ICS/NHSI to address the gap	risk, controls, assurances and gaps in controls added following Board discussion and approval at Board Workshop	Resource Committee	J Coulter, Deputy Chief Executive/ Finance Director	22.09.20	to be populated once risk accepted

Risk Matrix

	Likelihood				
	1	2	3	4	5
Consequence	Rare	Unlikely	Possible	Likely	Almost Certain
5. Extreme	5	10	15	20	25
4. Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2. Minor	2	4	6	8	10
1. Negligible	1	2	3	4	5

Changes in Ratings



No change in risk rating since from previous Assurance Framework

Risk rating has been downgraded from previous version

Risk rating has increased from previous version

Progress on Actons

1 Fully on plan across all actions
2 Actions defined - most progressing, where delays are occurring interventions are being taken
3 Actions defined - work started but behind plan
4 Actions defined - but largely behind plan
5 Actions not yet fully defined

Appendix B

Summary of Corporate Risk Register (Risks Rated 12-25 as at September 2020)

Ref	Description	Current Risk Score	Target Risk Score (date aimed to be achieved)	Risk Movement	Current status	Gaps in Controls	Lead Executive Director
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	9 (March 2021)	↔	• Face to face services have restarted, and the service has returned to near pre-Covid capacity in the baseline service. Additional capacity of c10 per month has been created. • The patients who required a face to face assessment are expected to be seen by January and from this point capacity and demand will be in balance, and the waiting list should reduce by 10 per month.	• Lack of commissioned capacity and resources to deliver additional capacity	Chief Operating Officer
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	12	6 (March 2021)	↓ (previously 15)	• The Trust continues to treat P1 and P2 patients within the required timescales. • The implementation of the recovery actions will reduce the gap between capacity and demand. • The routine waiting list has only risen by 34 from August to mid-September. • Significant additional focus on effective use of capacity has been introduced through new governance arrangements.	• Requirement for social distancing in recovery and ward areas may impede capacity. • Lower risk appetite for	Chief Operating Officer
CR49	ED Imaging Risk of delayed imaging causing potential extended waiting in ED department due to risk of x ray equipment failure (1998).	9	4 (April 2021)	↔	• There has been no increase in this risk and the equipment has continued to operate. • A contingency plan remains in place • A scheme is in place to replace the equipment by early January 2020.		Chief Operating Officer
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	8 (April 2021)	↔	• CT activity is at appropriate levels. MRI capacity will improve in October. • The number of cases waiting over 62 days for treatment is stable having previously been increasing. • Additional endoscopy capacity is being introduced in October with the 5th room. • All patients have been clinically triaged.	• Streamlined monitoring / tracking requirements • Psychological support • Limited diagnostic testing • Limited theatre capacity • Limited capacity in Breast one-stop service	Chief Operating Officer
CR54	Staff: Staff well-being and morale Risk to staff wellbeing and morale in the context of the Covid pandemic.	12	9 (April 2021)	↔	• Staff absence remains stable, and the Employee Assistance Programme remains available. • However, there is informal evidence of anxiety rising. Scoping work to provide additional psychological support is being undertaken to provide additional support to address the gap in control that is outlined.	• Uncertainty associated with the potential impact of a second peak. • National guidance on isolation may result in an increase in the number of staff isolating. • More intensive mental health support (i.e. management time to support colleagues and ways of working and financial support for external psychologists)	Director of Workforce & OD
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	9	8 (January 2021)	↔	• There has been no change to this risk. The additional safeguarding support remains in place.	• Availability of specialist expertise	Chief Nurse

Ref	Description	Current Risk Score	Target Risk Score (date aimed to be achieved)	Risk Movement	Current status	Gaps in Controls	Lead Executive Director
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	8 (April 2021)	↔	• A locum appointment remains in place. Substantive recruitment was not successful. • Support to enable a colleague to return to work is being explored and further options to recruit substantively are being explored	• Availability of a sufficient pool of candidates.	Chief Operating Officer

Two Risks Removed from Corporate Risk Register since last reported to Board:

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

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.

Harrogate and District NHS Foundation Trust

Board of Directors Meeting (held in Public)
30 September 2020

Committee Name:	Senior Managers Team Chair's Log
Committee Chair:	Chief Executive
Date of meeting:	23 September 2020
Date of Board meeting this report is to be presented	30 September 2020

Summary of key issues

The Shadow SMT met on 22 September 2020 and provided comments, advice and their own recommended decisions in respect of the items SMT considered at the meeting on 23 September. Their feedback continues to be welcomed and provides an important different and broader voice into our decision making.

The key issues discussed by SMT were as follows:

- Actions required to address the gaps in the recovery plan and its implementation.
- Revisions to the operational governance arrangements were agreed.
- The People Strategy was approved, with some feedback for minor modifications.
- The progress with appointing the new Freedom to Speak Up Guardian(s) was noted.
- The action plan for the WRES and WDES were agreed, and the proposal to develop a vision and actions to become an anti-racist organisation were endorsed.
- The flu plan was endorsed, with feedback about areas for further focus.
- The new financial framework was noted, and it was agreed that the reintroduction of the efficiency programme in M7-12 was required and that the findings of the external review should inform this.
- The principles of moving to a fairer more equitable approach for additional activity were endorsed, but there were concerns about the potential impact on activity.
- The launch of teamHDFT - at our best was endorsed.
- The key principles of the Conflicts of Interest policy were discussed.

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

The key risks identified related to the recovery plan (which is discussed in more detail in a later item) and the potential impact of implementing changes to the additional payments.

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

None.

Harrogate and District NHS Foundation Trust

Board of Directors (held in Public)
30 September 2020
Conflict of Interest / Managing Relationships at Work Policy

Agenda Item Number:	**7.1**
Presented for:	Information/Note
Report of:	Director of Workforce and Organisational Development
Author (s):	Director of Workforce and Organisational Development Interim Company Secretary
Report History:	Senior Management Team People and Culture Committee
Publication Under Freedom of Information Act:	This paper is made available under the Freedom of Information Act 2000 if requested.

Links to Trust's Objectives

To deliver high quality care	√
To work with partners to deliver integrated care	√
To ensure clinical and financial sustainability	√

Recommendation:

The Board is asked to note that:

1. the policy includes additional requirements for the management of relationships at work / loyalty interest for all staff, processes will be developed and taken forward to implement this overseen by the HR;
2. recommendations made by Internal Audit following their 2019 audit of gifts and hospitality have been taken into account when updating this policy and supporting procedures. All gifts / hospitality offered are required to be declared and discussed and approved by line managers or Executive Directors before acceptance. Returns are required as and when interests change and at least annually including nil returns;
3. one standard form will be available electronically to complete;
4. mandatory training requirements will be arranged to support the implementation of the policy including incorporating into the induction programme for new starters; and
5. a register will be maintained and displayed on the Trust's website.

Board of Directors

30 September 2020

Conflict of Interest / Managing Relationships at Work Policy

1.0 Background

1.1 In response to pressure for greater transparency on declaration of interests with the NHS, in October 2016, NHS England released a consultation document for Managing Conflicts of Interest.

1.2 In February 2017, NHS England published 'Managing Conflicts of Interest in the NHS, Guidance for Staff and Organisations', which sets out guidance for all NHS organisations which they were required to follow from 1 June 2017. Organisations were required to have a Register of Interest in place which is published for all 'decision making staff' on their website.

1.3 In response to these requirements, HDFT drafted a policy, which was approved in January 2018 for the management of Conflicts of Interest.

1.4 In 2019, Internal Audit carried out an audit against the policy and recommended some changes to strengthen the management of conflict of interests specifically around gifts and hospitality. Changes have been made to the policy and to supporting processes in response to the audit including the requirement for gift and hospitality offered being reported and any acceptance of gifts and hospitality require approval by a line manager or and Executive Director. Arrangements are planned to raise awareness of individual requirements throughout the Trust's Induction programme and mandatory training.

1.5 In addition to the Internal Audit, the independent Cultural Review highlighted a number of concerns and recommendations in relation to relationships at work / loyalty interests and how they were being managed across the Trust. In response to those concerns / recommendations this policy has been updated (***at 9.7 of the Policy***) to strengthen the reporting and management of such interests. As part of the pre-employment checks arrangements will put in place requiring all staff to declare any interests, and staff involved in recruitment campaigns will be required to declare interests at: 1) Shortlisting stage: Recruiting Manager to complete declaration; and 2) Interview Stage: All panel members to complete declaration.

1.5.1 Risk Assessments will be required to be completed by line managers with any mitigating actions discussed and agreed with staff. This information will be required to be documented and reported to Human Resources which will be audited on a regular basis.

2.0 Equality Analysis

2.1 The Equality Impact Analysis carried out on this policy resulted in level 1. This policy is applicable to all staff groups.

3.0 Monitoring Performance

3.1 Monitoring of compliance against the policy will be carried out by the Director of Workforce and Organisational Development for relationships at work / loyalty

interests and all other interests and processes by the Company Secretary. Reports will be provided to the Audit Committee on compliance against the policy on an annual basis and any breaches will be discussed with the Chief Executive and / or Local Counter Fraud as appropriate.

4.0 Recommendation

The Board is asked to:

1. note that the policy includes additional requirements for the management of relationships at work/loyalty interest for all staff, processes will be developed and taken forward to implement this overseen by the HR;
2. note that recommendations made by internal audit following their 2019 audit of gifts and hospitality have been taken into account when updating this policy and supporting procedures. All gifts/hospitality offered are required to be declared, discussed, and approved by line managers or Executive Directors before acceptance. Returns are required as and when interests change and at least annually including nil returns;
3. note that one standard form will be available electronically to complete;
4. note that mandatory training requirements will be arranged to support the implementation of the policy including incorporating into the induction programme for new starters; and
5. note that a register will be maintained and displayed on the Trust's website.

5.0 Supporting Information

5.1 The following papers make up this report and are provided in the supplementary information pack:

- Conflict of Interest/Managing Relationships at Work Policy
- Appendix 1. Monitoring, Audit and Feedback Summary & Consultation Summary
- Appendix 2. Risk Assessment for Relationship at Work/Loyalty Interests
- Appendix 3. Example of Declaration of Interest Form

Board of Directors (held in Public)
30 September 2020
HDFT People Plan

Agenda Item Number:	**7.2**
Presented for:	Approval
Report of:	Director of Workforce and Organisational Development
Author (s):	Director of Workforce and Organisational Development & Deputy Director of Workforce and Organisational Development
Report History:	SMT (23 September 2020) People and Culture Committee (23 September 2020)
Publication Under Freedom of Information Act:	This paper has been made available under the Freedom of Information Act 2000

Links to Trust's Objectives

To deliver high quality care	√
To work with partners to deliver integrated care	√
To ensure clinical and financial sustainability	√

Recommendation:
The Board are asked to approve the HDFT People Plan.

Board of Directors (held in Public)
30 September 2020

People Plan

Director of Workforce and Organisational Development

1.0 Executive Summary

1.1 Our People Plan, sets out our approach to developing, strengthening and retaining colleagues over the coming years, through the enactment and bringing to life of this strategy, making The Best Place to Work in the NHS being @teamHDFT

1.2 Creating this strategy has involved listening to our colleagues, and exploring best practice both within the NHS and other organisations. We will continue to listen and explore as we implement the strategy in practice.

2.0 Background

2.1. @teamHDFT we are known for outstanding patient and service user care. This is only made possible by our outstanding and dedicated people.

2.2 To enable them to be their best and to help us to develop a diverse and inclusive workforce, where everyone feels valued and supported we need to also be known as the Best Place to Work.

2.3 Our People Plan describes how we aim to achieve this.

3.0 Recommendation

3.1 The Board is asked to approve the HDFT People Plan

4.0 Supporting Information

4.1 The following papers make up this report:

2020-2023 People Plan

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7.2

The Best Place to Work

@teamHDFT

You matter most

2020 - 2023 People Plan

The Best Place to Work

@teamHDFT

@teamHDFT we are known for outstanding patient and service user care. This is only made possible by our outstanding and dedicated people.

To enable them to be their best and to help us to develop a diverse and inclusive workforce, where everyone feels valued and supported we need to also be known as the Best Place to Work.

Our People Plan describes how we aim to achieve this.

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Our Vision

EXCELLENCE EVERY TIME

Our Values

RESPECTFUL PASSIONATE RESPONSIBLE

Welcome

Welcome to our People Plan, which sets out our approach to developing, strengthening and retaining colleagues over the coming years. Through the enactment and bringing to life of this strategy, making The Best Place to Work in the NHS being **@teamHDFT**.

Now more than ever we need our people to feel valued, safe, equipped and empowered to provide the best possible experience and outcomes for their patients and service users. To enable them to do this consistently, on every single day of the 365 days a year, we need to provide our colleagues with the best possible daily lived experience of working **@teamHDFT**.

The challenges brought by a global pandemic, together with an ageing and growing population, a greater prevalence of chronic diseases and innovations in technology, mean we need to think differently about how we work together and how we provide care.

Every colleague has a key role to play in helping us to deal with these challenges. We know that those who are involved in the daily delivery of care and support to our patients and the very people who have the knowledge and expertise to help us to continually improve and strengthen our services. We also know that equality, diversity and inclusion must be a consistent thread that runs through everything that we do, for ourselves, our colleagues, our patients/service users and our wider communities.

Creating this strategy has involved listening to our colleagues, and exploring best practice both within the NHS and other organisations. We will continue to listen and explore as we implement the strategy in practice. We have also focused on the priorities in the 'We are the NHS – People Plan 2020/21' and those of our partners in the Harrogate Place and within our Integrated Care System (ICS).

Angela Wilkinson
Director of Workforce & Organisational Development

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…feel valued, safe, equipped and empowered
to provide the best possible experience and outcomes
for their patients and service users.

Meeting the National People Plan

In 2020 the NHS launched the National People Plan 2020-21 which acknowledges the scale of the workforce challenges the NHS is facing. The People Plan sets out the two year strategy to recruit, retain and develop more staff to meet the growing demand for 21st century care

teamHDFT's People Plan translates the national vision into System and Local ambitions, which are supported by detailed delivery plans.

We will continue to listen and evolve the teamHDFT Plan in response to our changing environment both locally and at system as we implement our plans.

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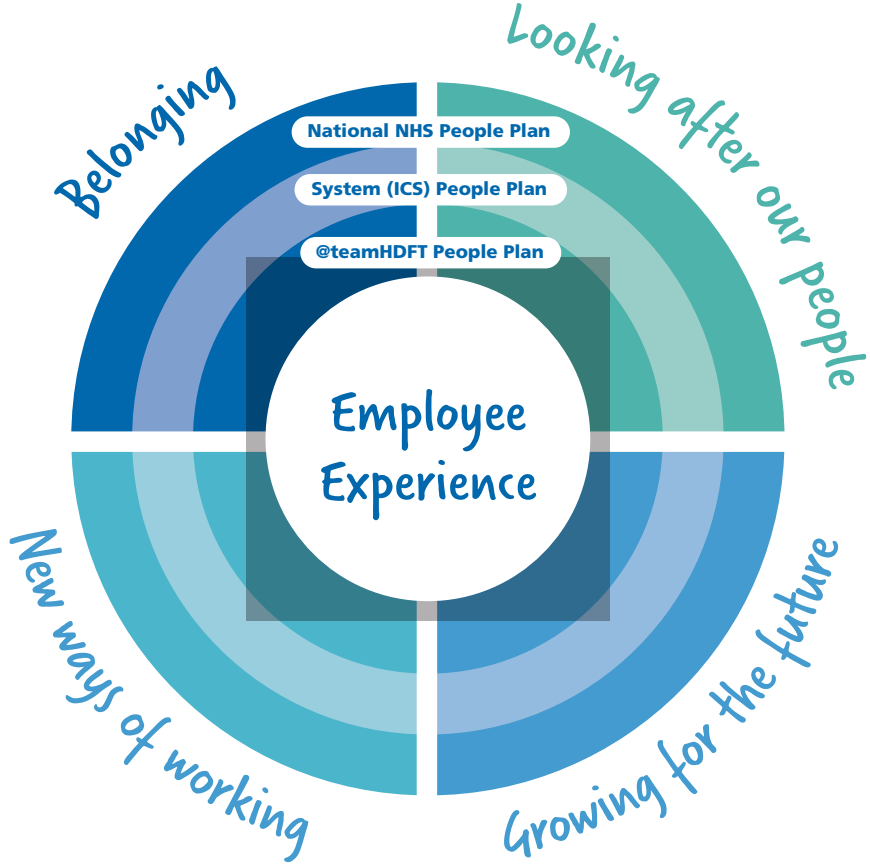
The Best Place to Work in the NHS
@teamHDFT



Looking after our people

Our Ambition

We have work environments where our colleagues are physically and emotionally sustained to enable them to be and to give their best and to be able to be at work more of the time in order to better serve our patients and service users. Leaders are highly visible, capable, positive, confident and enthusiastic. They inspire and motivate others by behaving consistently in line with our values.

This includes:

- Recognising the importance of skilled and visible first line leadership at all levels that is kind, compassionate and inclusive
- Consistent access to physical safety and comfort needs
- Human connection and team/peer support
- Formal psychological care in stepped ways dependant on level of need, utilising our range of Health & Wellbeing services
- Develop retention plans focused on areas of @teamHDFT with the highest rates of turnover and vacancy

Years 1-2

- Develop a graduated range of emotional and psychological wellbeing interventions to support colleagues, e.g Restorative Supervision across services . Continue to embed and improve the range of Health & Wellbeing Services
- Develop/roll-out specific interventions to equip leaders with the skills to support their direct reports, e.g. Leadership Circles, First Line Leader Programme and Licence to Lead@teamHDFT.
- Train leaders and managers in coaching-based approaches to enable them to hold great welfare and career conversations as part of our ambition to develop, deploy and retain talent more effectively.
- Offer a range of interventions that facilitate a supportive team environment
- Ensure that our offer meets the needs of our diverse workforce with equity and equality of access
- Review the appraisal process to incorporate a behaviours based appraisal, include a welfare discussion for all colleagues and improve the rate and quality of appraisals across all staff groups.
- Develop improving working environment and facilities
- Strengthen employee communications and mechanisms for two-way feedback and engagement, maximising the use of social media
- Understand better why people leave and how we can address the causes

Years 3+

- Close the gender pay gap and improve on all aspects of diversity
- Deliver improved parking and transport solutions
- Introduce mentoring programme
- Restorative Supervision fully rolled-out across all areas @teamHDFT
- Provide joint leadership programmes with partners organisations across the Harrogate Place and our ICS footprint

Measures

- Reduction in sickness absence levels – with a focus on mental health related
- Increase in number of staff receiving appraisals and feedback on quality of experience
- Increase in retention
- Referrals for specialist psychological help
- Self reported engagement and wellbeing measures (via surveys)
- Feedback on welcome interviews and exit interviews
- Number of participants in leadership programmes and other key programmes
- Measurable outcomes from leadership development
- Leadership questions in the NHS staff survey

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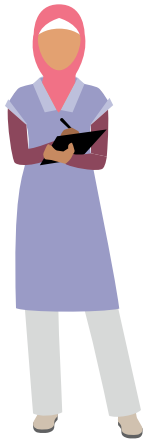
Belonging



Our Ambition

Through an open-minded culture and practical policy of inclusiveness, we understand and support all colleagues' beliefs and will support them to have a great daily lived experience and to fulfil their career aspirations. @teamHDFT is a place where people are proud to work, and where they feel valued, recognised and supported to develop their true potential. People feel free to speak up, enjoy coming to work, and have a sustainable work/life balance.

This includes:

- A working environment which is inclusive and values equality and diversity at all levels and across all our services
- Ensuring we give thanks and recognition to our hardworking colleagues
- Having vibrant colleague networks that have an active voice in decision making @ teamHDFT
- Creating multiple channels for all colleagues to have a voice, be heard and feel safe and empowered to speak up
- Identifying ways to ensure we have diverse and representative pool of leaders
- An open minded leadership culture, free from conscious or unconscious bias

Years 1-2

- BME Reciprocal mentoring in place for all members of SMT to enable sharing of experiences, ideas and challenges and a broadening of access to diverse views and perspectives to aid decision making.
- BME First Line Leader programme co-designed with BME network members and programme implemented.
- Fully established colleague networks
- BME/LGBT+/Disability – where colleagues participate and have a voice in leadership groups, decision making and recruitment process – flexible approach to enable employees from all backgrounds/faiths and beliefs to share ideas and enable change through positive networks.
- Department/ward specific trans-gender training to support open, fair, just and safe culture for colleagues and patients, and service users through a culture of inclusivity at all levels.
- BME Freedom to Speak Up Guardian (FTSU) appointed to encourage and enable a culture of fairness, openness and learning.
- Aspirational diversity targets in place for all appointments.
- Programme of Patient/Service User education around equality, diversity and inclusion plus expected behaviours towards colleagues launched
- Review all key Human Resources policies and processes to ensure that they meet the fair, safe and just criteria

Years 3+

- Develop an accredited BME leadership programme (with academic partners)
- Work across wider communities and linked with other public/emergency services, e.g. police, fire, ambulance, launched around, diversity and inclusion plus expected behaviours towards colleagues
- Widen access to Reciprocal mentoring to system level

Measures

- Improvement across all aspects of WRES/DWES data
- Diversity Target - Number of BME/LGBT+/ Disabled colleagues in leadership roles
- Diversity Target – Number of BME/LGBT+/ Disabled colleagues short-listed and recruited
- Colleague network activity
- Reduction in grievance and disciplinary cases and employment tribunals
- Stonewall positive status
- Two tick disability standard met
- Improvement in employee relations processes

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New ways of working and delivering care

Our Ambition
We enable all colleagues to reach their full potential through the provision of education, learning and development opportunities. @teamHDFT we have the skills, competencies and leadership qualities to deliver outstanding patient and service user care. We ensure our colleagues are well equipped to meet the service delivery demands of both now and of the future. We understand our workforce diversity and maximise opportunities for al individuals regardless of background and belief. We develop innovative workforce solutions which allow us to make the best use of the talent and skills available to us.

This includes:
- Developing a richer skills mix and new ways of working with colleagues empowered to work to top of scope rather than capacity
- The introduction of new roles, scaled up with multi-professional and hybrid roles that provide sustainable solutions to current workforce supply challenges
- Creating opportunities for diverse thinking to influence decision making
- Developing opportunities for innovation and ideas to be championed
- Taking an active part in the Integrated Care System (ICS) delivering the benefits of system led initiatives at a local level.
- Maximising the use of both Continuing Professional Development funding and the Apprenticeship Levy.

Years 1-2
- Develop and embed Trust learning and development offer, ensuring colleagues have opportunities for secondments, project work, shadowing, stretch assignments and self directed learning
- Implement a new technology enhanced learning environment and develop interactive e-learning modules that are accessible to all colleagues.
- Match best practice in statutory, mandatory and essential skills training
- Investment Plan for CPD funding developed through consultation across the Trust and the development of a learning needs analysis. Robust governance and recording of activity established.
- Develop and widen Apprenticeship Programme with greater outreach into local communications and secondary education providers.
- Develop Career Progression framework from apprenticeship through to professional registration and beyond.
- Utilise workforce transformation methodology such as the Calderdale Framework to enable skills mix review, clinical transformation and improvement
- Introduce and develop new roles to tackle long-term staff shortages

Years 3+
- Provide training as part of the wider system approach to learning and development
- Transform the way we deliver care by closer collaboration between primary care, community and secondary care services
- Develop opportunities for income generation for specialist training interventions to other private and public sector organisations
- Scale up new roles to tackle key staff shortages
- Develop a range of further new and innovative roles to better meet patient and service user needs.

Measures
- Implementation of new roles and ways of working that alleviate capacity demand, whilst delivering quality care through reduced vacancies and improved staff satisfaction
- Training and development questions in the NHS staff survey
- Increased retention
- Rates of statutory, mandatory and essential skills training
- Number of apprenticeships/levy spend

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Growing for the future

Our Ambition
We plan ahead to anticipate and meet changes in patient and service user needs and demand for our services within the constraints that we face. We have confidence in our data, enabling us to be forward-thinking, evidence based and collaborative. Our workforce is ever more diverse and our talent management processes support the development of emerging and growing talent.

This includes:
- Having a succession planning in place for key roles across teamHDFT
- Developing our approach to talent management to ensure all colleagues have the opportunity to maximise their potential.
- Better co-ordination of recruitment
- Developing effective systems to deal with the end-to-end recruitment process, streamlining our recruitment to ensure time to hire efficiency and supporting line managers to make effective, fair and safe recruitment decisions
- Reviewing our approach to welcoming new starters to ensure that they have an excellent experience in joining team HDFT.
- Increasing focus on developing the NHS workforce of the future by increasing our placement capacity and ensuring that our students have an excellent educational experience.

Years 1-2
- Develop a comprehensive strategic workforce plan
- Recruitment Review including implementation of TRAC recruitment software, to ensure process meets the need of candidates and recruiting managers
- Review of our approach to welcoming new starters, including Corporate and Local Induction and utilising technology to improve the new starter experience
- Introduce electronic job planning and e-rostering for all medical staff and implement new system of e-rostering for non-medical staff
- Review our recruitment process to ensure we attract and recruit a diverse range of colleagues through a fair and responsive process
- Review flexible working opportunities and implement the Working Carers passport to support retention of colleagues and enable work-life balance
- Develop our approach to talent management and succession planning
- Shadow SMT fully established as part of the formal governance structure to enable sharing of experiences, ideas and challenges and a broadening of access to diverse views and perspectives to aid decision making. Succession planning for future SMT membership.
- Provide an excellent learning environment for the NHS workforce of future by providing a wide range of placements for both medical and non-medical students and maintain and develop strong partnerships with higher education providers and Health Education England (HEE)

Years 3+
- Introduce an in-house Careers Advisory Service, potentially with local partner organisations across the Harrogate Place
- Embed an inclusive and positive employer brand that works in partnership with our local communities to encourage diverse recruitment and represents @teamHDFT, its people and its values
- Collaborative and integrated recruitment with system partners

Measures
- Tracking of headcount/Whole Time Equivalent pay bill against trajectory
- Mix of substantive staff versus bank, agency and overtime – reduction of reliance on agency and temporary staff
- Short and medium term recruitment targets and success against trajectory
- Time to recruit and all KPIs associated with each step of the process
- Percentage of workforce with flexible working patterns
- Feedback and evaluation from students on placement/HEE Placement Quality Assurance Reviews


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Harrogate and District NHS Foundation Trust

Board of Directors (held in Public)
30 September 2020
Director of Workforce and Organisational Development Report

Agenda Item Number:	**7.3**
Presented for:	Discuss/Note
Report of:	Director of Workforce and Organisational Development
Author (s):	Deputy Director of Workforce and Organisational Development Lead for Equality, Diversity and Inclusion Lead for Workforce Information Medical Staffing Lead
Report History:	None
Publication Under Freedom of Information Act:	This paper has been made available under the Freedom of Information Act 2000

Links to Trust's Objectives	
To deliver high quality care	√
To work with partners to deliver integrated care	√
To ensure clinical and financial sustainability	√

Recommendation:
The Board is asked to discuss and note this report.

7.3

Board of Directors

30 September 2020

Director of Workforce and Organisational Development

1.0 Executive Summary

1.1 The Workforce & Organisational Development Public Board paper for September contains up-dates on some key priority areas as follows;

- Improvement to Recruitment system
- Facility Time Publication Requirements
- Health & Wellbeing – Risk Assessment and Shielding colleagues up-date
- WRES/WDES Action Plans
- Up-date on Chief Operating Officer recruitment campaign

2.0 New Recruitment system

2.1 As part of the Workforce Directorate Improvement plan, we are launching a new recruitment system called 'TRAC' Recruitment, with a 'go live' date of week commencing 21st September 2020. Currently, HDFT has been operating a predominantly manual process across 3 different IT systems – which whilst operated efficiently, gave rise to many clear opportunities for improvement and streamlining for HR staff, Candidates and recruiting managers alike. This more streamlined recruitment process will allow recruiting managers to have more access to their candidates' progress information.

2.2. The main changes TRAC will bring are as follows;

2.2.1 **Vacancy control** (VC) – The process will no longer be paper-based VC. Requests will be submitted via the TRAC system and approval will be electronically authorised by the panel via the system. This is historically a long process at HDFT however we will now receive management information on this stage of the process to enable us to motor and improve it.

2.2.2 **Advert requests** – Much like the VC process, we are going as paperless as we can go! Adverts are requested via the system by inputting all of the data currently put onto the existing advert request form and attaching a job description and setting the criteria for prospective candidates.

2.2.3 **Shortlisting** – Shortlisting will no longer take place on NHS Jobs. Applicants will be moved from NHS jobs in to TRAC and can be easily shortlisted against the set criteria with the scoring of applications based on how much they meet the criteria. The scoring will then enable the system to order the candidates which will make it easier to shortlist.

2.2.4 **Interviews** – Interview schedules are set up on TRAC and the Recruitment Team will invite candidates to interview with the details provided.

2.2.5 **Successful candidates** – When preferred candidate(s) have been identified from interview, the paperwork is submitted via TRAC and will be processed within 48 hours.

2.2.6 **Updates** – Automatic weekly update reports on all candidates a recruiting manager has going through the system will be provided, as will access to the system to establish the status of a recruitment and vacancies.

A copy of the communications produced to support the implementation of TRAC are shown in Appendix A.

3. Facility Time Publication Requirements

The Trade Union (Facility Time Publication Requirements) Regulations 2017, enacted in April 2017, requires specified public-sector employers, including NHS Trusts, to report annually a range of data in relation to their usage and spend on trade union facility time within the organisation.

The cost of facility time in the public sector is paid for out of public funds. The objective of the legislation is to ensure that taxpayers' money is spent on trade union facility time in the public sector is properly monitored and reported. It is felt that this transparency will enable Government employers and taxpayers to verify whether taxpayer's money is only spent on appropriate and accountable trade union work that represents value for money.

The reporting Period is 1st April 2019 to 31st March 2020 and the detail can be seen at Appendix B. The percentage of the total pay bill spend on facility time, is 0.02%.

3 Health & Wellbeing – Risk Assessments and Shielding Colleagues Up-date

3.1 The latest data on Risk Assessments is shown in the tables below.

TOTAL RISK ASSESSMENTS (OF THOSE REQUIRED)

	# RA completed	# RA required	RA % Done
Childrens and County Wide Community Care	111	117	94.9%
Corporate Services	65	68	95.6%
Long Term and Unscheduled Care	272	291	93.5%
Planned and Surgical Care	238	249	95.6%
Harrogate Healthcare Facilities Management	107	111	96.4%
TOTAL (including HIF)	793	836	94.9%

TOTAL RISK ASSESSMENTS (OF ALL STAFF)

	# RA completed	Headcount 1st Staff	RA % Done
Childrens and County Wide Community Care	159	1,326	12.0%
Corporate Services	73	334	21.9%
Long Term and Unscheduled Care	305	1,095	27.9%
Planned and Surgical Care	268	847	31.6%
Harrogate Healthcare Facilities Management	111	231	48.1%
TOTAL (including HIF)	916	3,833	23.9%

BAME Risk Assessments

	# RA completed	# RA required	RA % Done
Childrens and County Wide Community Care	35	40	87.5%
Corporate Services	27	30	90.0%
Long Term and Unscheduled Care	183	200	91.5%
Planned and Surgical Care	158	165	95.8%
Harrogate Healthcare Facilities Management	20	21	95.2%
TOTAL (including HIF)	423	456	92.8%

[redacted] Risk Assessments

	# RA completed	# RA required	RA % Done
Childrens and County Wide Community Care	10	10	100%
Corporate Services	2	2	100%
Long Term and Unscheduled Care	4	4	100%
Planned and Surgical Care	3	3	100%
Harrogate Healthcare Facilities Management	2	2	100%
TOTAL (including HIF)	21	21	100%

AGE Risk Assessments (Male 55 and over, Female 65 and over)

	# RA completed	# RA required	RA % Done
Childrens and County Wide Community Care	18	19	94.7%
Corporate Services	30	30	100%
Long Term and Unscheduled Care	67	69	97.1%
Planned and Surgical Care	58	62	93.5%
Harrogate Healthcare Facilities Management	83	86	96.5%
TOTAL (including HIF)	256	266	96.2%

PREGNANCY Risk Assessments

	# RA completed	# RA required	RA % Done
Childrens and County Wide Community Care	10	10	100%
Corporate Services	0	0	#DIV/0!
Long Term and Unscheduled Care	7	7	100%
Planned and Surgical Care	10	10	100%
Harrogate Healthcare Facilities Management	1	1	100%
TOTAL (including HIF)	28	28	100%

[redacted] Risk Assessments (e.g. Diabetic, other conditions)

	# RA completed	# RA required	RA % Done
Childrens and County Wide Community Care	45	45	100%
Corporate Services	8	8	100%
Long Term and Unscheduled Care	22	22	100%
Planned and Surgical Care	21	21	100%
Harrogate Healthcare Facilities Management	4	4	100%
TOTAL (including HIF)	100	100	100%

7.3

3.2 As of 11 September, 21 colleagues were shielding, and each Directorate has been asked to engage with their shielding colleagues to identify potential ways forward with support from the respective Human Resources Business Partner.

4. #teamHDFT People Plan – The Best Place to Work

4.1 The draft team HDFT People Plan covering the period 2020 to 2023 is included as a separate item on the agenda for review. Creating this plan has involved listening to our colleagues and exploring best practice both within the NHS and within other organisations. We have also focused on the priorities in the NHS People Plan 2020-2021, and taken into consideration system collaboration with our ICS partners over workforce matters.

5. WRES / WDES Action Plan

5.1 Following collection and analysis of our WRES and WDES data, action plans have been developed to support team HDFT in addressing the issues that the data has identified. We have set ambitious targets for ourselves in terms of improving our performance as a Trust on this data, and in doing so, have set our intent to improve the daily-lived experience of our BME and disabled colleagues to ensure that they are coming to work to an inclusive and diverse organisation that values and respects all colleagues equally.

5.2 The detailed action plans are shown in Appendix C and D.

6. Up-date on Chief Operating Officer recruitment campaign

6.1 Following Rob Harrison's departure in August, Tim Gold commenced on an interim post as Chief Operating Officer for a fixed term period to ensure there was no subsequent gap and to ensure continuity. We have now commenced our substantive Chief Operating Officer recruitment campaign which went live as of 18 September 2020. Odgers Sanderson are assisting us with an executive search; however the job will also go live on NHS Jobs as well as social media as of 23 September. The closing date is 18 October 2020 and we are hoping to appoint by the beginning of December. Further updates will be circulated in the next report.

7 Supporting Information

7.1 The following papers make up this report:

Appendix A – TRAC Recruitment (included in supplementary information pack)
Appendix B – Facility Time Publication Requirements Report (included in supplementary information pack)
Appendix C – WRES Annual Report 2020 WITH Action Plan (included in supplementary information pack)
Appendix D – WDES Annual Report 2020 with Action Plan (included in supplementary information pack)

NHS
Harrogate and District
NHS Foundation Trust

Board Committee Report to the Board of Directors

Committee Name:	Audit Committee
Committee Chair:	Richard Stiff
Date of meeting:	1 September 2020
Date of Board meeting this report is to be presented	30 September 2020

Summary of key issues

The Committee met via Microsoft Teams and was well attended. The matters considered included –

- Minutes of the Corporate Risk Review Group and the latest version of the Corporate Risk Register – the appropriate inclusion of Covid related risk factors was noted;
- The 2020 Quality Report – the Committee commended Dr Wood and others involved in completing the substantial amount of work required to prepare the draft report and agreed that the draft should be considered by the Board with no alterations being required by the Audit Committee;
- An update on the redevelopment of the BAF - report noted;
- The Treasury Management policy and report – policy approved, and the annual report recommended to the Board;
- The quarterly procurement report noting savings achieved from national, regional and local procurements – the underperformance of national schemes was noted;
- HHFM Accounts 2019-20 – noted with no significant comments;
- Approval of a capital procurement proposal in relation to two urgent projects – agreed to facilitate prompt delivery of Covid response related projects;
- Approval of the Internal Audit Charter – an annual review, no changes in the Charter this year;
- The Internal Audit progress report – continuing concerns in relation to a small number of limited assurance reports and delays in the implementation of some Internal Audit report recommendations;
- Two Single Tender Actions – noted with no issues; and
- The appointment of external auditors – the Committee agreed to recommend reappointment subject to clarification of some details with KPMG, a significant fee increase was noted.

The Committee will meet next on 2nd December 2020.

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

None.
Any matters of escalation to Board for decision or noting (list if appropriate)
Recommendation of the reappointment of KPMG as the Trust's external auditors for a further year within the current 4+2 contracted arrangement, noting that re-tendering of the external audit contract will be required in 2021. Commending of reviewed Treasury Management policy and associated annual report to the Board.

Harrogate and District NHS Foundation Trust

Board of Directors (held in Public)
30 September 2020
Recovery Plan Update Report

Agenda Item Number:	**8.2**
Presented for:	Information/Discussion
Report of:	Chief Operating Officer
Author (s):	Chief Operating Officer
Report History:	None
Publication Under Freedom of Information Act:	This paper has been made available under the Freedom of Information Act 2000.

Links to Trust's Objectives	
To deliver high quality care	
To work with partners to deliver integrated care	
To ensure clinical and financial sustainability	√

Recommendation:
The Board of Directors is asked to receive and note the content of the report.

8.2

NHS
Harrogate and District
NHS Foundation Trust

Board of Directors Meeting 30th September

Recovery Plan Update

Highlight Report Definitions:
Overall – Overall Programme/workstream delivery status
Phase 3 Recovery Trajectory – performance against the activity required to deliver our Phase 3 NHSE & I Plan
Actions/Milestones – Programme/workstream delivery trajectory against a clearly defined implementation plan
Issues – Programme/workstream issues that are impacting delivery of the implementation plan and/or Phase 3 Recovery Trajectory
Risks – Programme/workstream risks that if not mitigated, could become an issue that could impact the delivery of the implementation plan and/or Phase 3 Recovery Trajectory

8.2

Contents

1 Planned Care Recovery Programme Highlight Report: September 2020

Senior Responsible Owner (SRO): Tim Gold **Programme Manager (PM):** Beth Barron **Clinical Lead (CL):** Kat Johnson

Overall Programme Summary

Overall Planned Care Recovery Programme status reported as amber. This is to reflect that there is not currently a clearly defined implementation plan and implementation governance and reporting need to be strengthened. Activity is behind required run rate for Day Case procedures, with endoscopy capacity being the biggest cause of deficit. The two issues that require urgent resolution are 1) Improving booking effectiveness across all Points of Delivery (PODs); and 2) Sourcing staff to open the 5th Endoscopy Room. Key risks to manage in October: 1) Ensuring Day Surgery Units 1 and 2 open at the start of month; and 2) Maintaining planned care capacity alongside the likely increased winter and Covid pressures.

Key activities this highlight period

1. Submitted NHS E/I Phase 3 Plan submission
2. Defined and launched a weekly Trust Performance and Access Meeting (TPAM)
3. Agreed 10 sessions p/week to be delivered at The Duchy for HDFT patients and agreed provision of overnight medical cover
4. Introduced twice daily Booking Remediation meetings to increase the number of patients booked into theatres, outpatients and diagnostics in Sep and Oct.

Planned next highlight period

1. Produce detailed implementation plan for Planned Care Recovery Programme
2. Continue to track and improve bookings against all PODs
3. Conclude 1m+ social distancing risk assessment for endoscopy recovery area, DSUs and outpatient waiting areas
4. Confirm endoscopy 5th room staffing model and take-up of extra sessions
5. Define plan for improving endoscopy productivity e.g. reduce cleaning downtime and increase number of trolleys in recovery areas.

Programme/Workstream	Overall		P3 Recovery Trajectory		Actions/ Milestones		Issues		Risks	
Planned Care Recovery Programme	●	↗	●	↗	●	→	●	→	●	→
W1: Outpatients Recovery	●	↗	●	↗	●	→	●	→	●	→
W2: Inpatients Recovery	●	↗	●	↗	●	→	●	→	●	→
W3: Daycase Recovery	●	↗	●	↗	●	→	●	→	●	→
W4: Diagnostics Recovery	●	↗	●	↗	●	↗	●	→	●	→

Key Programme Actions for Next Period

#	Milestone	Due by	Status	
1	Planned Care Recovery Implementation Plan Produced	02/10/20	●	→
2	Improve Sep/Oct booking run-rate	25/09/20	●	↗
3	Confirm Duchy overnight cover in place for Oct lists	23/09/20	●	↗
4	Open 5th Endoscopy Room	31/10/20	●	→
5	Open DSU 1 and 2	30/09/20	●	→
6	Conclude 1m+ risk assessment and agree recommendations with CAG & DT	31/10/20	●	→

Key Programme Issues

#	Issue	Own.	Rating	Action	Due by
1	Staff unable to be recruited to open up 5th room in October	JH	High	Confirm nursing agency and recruitment. Confirm take up of WLIs.	30/09/20
2	Booking rate below 6 weeks for most specialties	BB	High	Run bi-daily Booking Remediation meetings to recover performance	23/09/20

Key Programme Risks

#	Risk Description	Own.	Score
1	Risk that DSU 1&2 opening delayed leading to reduced capacity	JH	8
2	Planned care capacity is reduced and recovery trajectory missed as a result of responding to Covid/Winter pressures.	BB	15

2 Planned Care Recovery – Performance

Harrogate and District NHS Foundation Trust

Summary

- Outpatient clinics delivered are slightly down on Phase 3 target, however new clinic templates now agreed and October run rate will improve
- Elective day case gap driven by endoscopy being down on plan – gap will continue in October, however Waiting List Initiative payments and agency staff to be used to mitigate where possible
- Inpatient and day case Patient Tracking List (PTL) is marginally increased for all patient priorities (Soon, Urgent, Routine), however the day surgery unit will open from October and capacity has been increased at The Duchy which will reduce backlog in future months
- Primary care referrals are tracking c. 20% behind 19/20 levels and however it is expected that referrals will return to close to pre-Covid levels in the forthcoming months
- There were 421 patients waiting over 52 weeks at the end of the month and 1,436 waiting over 40 weeks. Extra capacity at The Duchy will support the reduction of long-waiting orthopaedic patients who make up c. 40% of the 52W total
- Only 6 patients on the waiting list have been waiting 75+ weeks
- Work ongoing in Community Dental to better manage waiting lists and improve data quality and recording across the community sites. Waiting times are starting to reduce and treatments starting for patients in clinical priority and waiting time order.

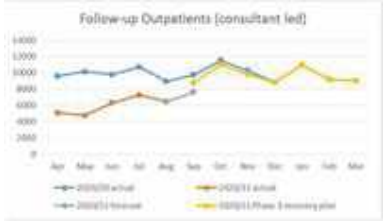
Performance Against September Phase 3 Trajectory

72% of Sep Phase 3 run-rate

82% of Sep Phase 3 run-rate

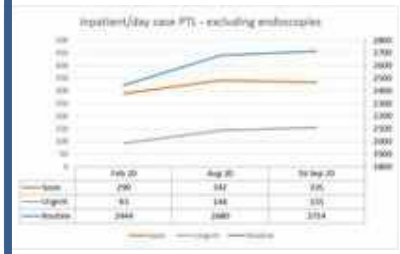
110% of Sep Phase 3 run-rate

91% of Sep Phase 3 run-rate



Referrals

Inpatient/Day Case PTL



Incomplete RTT Waiting List

	Weeks Wait						Grand Total
	0-17	18-31	32-40	41-51	52-75	75-100	
Number of Patients Waiting	11,586	1,561	1,600	1,150	511	6	16,414

3 Urgent Care & Cancer

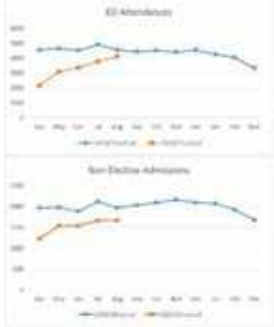
NHS Harrogate and District NHS Foundation Trust

Summary

- Performance against the A&E 4-hour standard was below 95% in August (87.2%), a decrease on last month.
- Significant variance in Emergency Care Standard (ECS) performance pre and post Covid. Emergency Care Intensive Care Support Team (ECIST) have been commissioned to allow us to diagnose the causality of the variance and develop our recovery plan (see opposite).
- Demand: ED attendances tracking at c. 90% of 19/20 and expected to return to pre Covid levels; Non-elective admissions running at c. 80% of 19/20 levels allowing us to currentl operate within reduced bed levels.
- Urgent Care governance needs to be strengthened (see opposite) – an Urgent Care Improvement Board will be established to drive the ECIST Recovery Plan and a weekly ECS Breach Review Huddle will be held to put in place tactical fixes where required.
- The Winter Plan is being developed to confirm surge capacity required for Winter pressures and how ward cohorting will change in the event of a Covid Second surge. A Bed and Ward cohorting workshop is being held w/c 28th September to support this.
- Whilst 62 day and 14 Day cancer standards have been met in August, there needs to be an increasesd performance focus on clearing our Cancer 62 Day and 104 Day backlogs – these will be tracked in the weekly Trust Performance & Access Meeting.
- Performance for 2WW non-cancer related breast referrals was above the operational standard of 93% for the first time since April.

Cancer Backlog

Urgent Care Demand

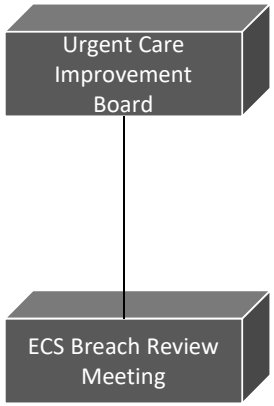


ECIST ECS Causality Review

Emergency Care Improvement Support Team
Safer, faster, better care for patients

- The ECIST team will work alongside our clinicians to help us better understand the causes of ECS variation and how we can drive our recovery across 3 levels: ED department, wider Trust, wider system
- The work will include a data review and three focussed days with the team. Each day has a verbal debrief with the team and a report will be produced with key recommendations presented back to COO, Director Team.
- **Day1 :** Acute front door + SDEC walkthrough & workshop with ED/AM & Acute Surgical Teams
- **Day 2:** Ward processes – visiting 3 wards – site management review, discharge teams workshop
- **Day 3:** System wide conversation/ workshop – escalation/ discharge/ system working
- ECIST Recovery Plan to be in delivery phase in November 20

Future Urgent Care Governance



- Provides assurance that the ECIST Recovery Plan is being delivered to time, cost and quality principles and risks and issues are managed by exception
- Provides assurance that trends/actions from ECS Breach Review are being actioned

- Weekly ED team huddle (ops, nursing and medical) to review AED performance
- Monitoring of potential new measures for AED i.e. time to initial clinical assessment, time to emergency treatment for critically ill and injured patients, mean time in AED and Utilisation of Same Day Emergency Care.

4 Key September Messages

- Further work is required in October to strengthen the implementation plan and governance for the Planned Care Recovery Programme;
- Activity is behind Phase 3 trajectories for Day Case and Endoscopy – the priority improvement area for October and November is to open up a fifth endoscopy room and improve productivity on Upper GI endoscopy lists;
- ECIST are currently supporting us to review performance against the ECS standard and an Urgent Care Improvement Board and Recovery Plan will be launched in November;
- Current ward and cohorting arrangements are being reviewed to support production of the Winter Plan in October; and
- Increased performance focus will be brought to the Cancer 62D and 104D backlogs to ensure these are reducing on a weekly basis.

Harrogate and District NHS Foundation Trust

Board of Directors (held in Public)
30 September 2020
Finance Report

Agenda Item Number:	**8.3**
Presented for:	Information / Discussion
Report of:	Deputy Chief Executive/Finance Director
Author (s):	Deputy Director of Finance
Report History:	None
Publication Under Freedom of Information Act:	This paper has been made available under the Freedom of Information Act 2000.

Links to Trust's Objectives

To deliver high quality care	
To work with partners to deliver integrated care	
To ensure clinical and financial sustainability	√

Recommendation:
The Board of Directors is asked to receive and note the content of the report.

8.3

Harrogate and District
NHS Foundation Trust

Finance Report

Board of Directors – 30th September 2020

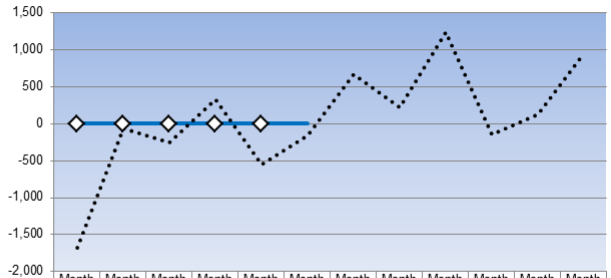
8.3

Financial Position

NHS Harrogate and District NHS Foundation Trust

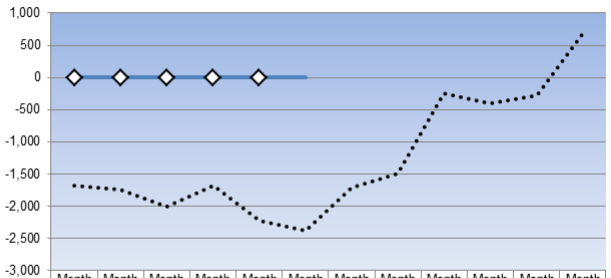
The Trust reported a balanced position in month 5, as anticipated through the current planning arrangements. The process of retrospective top up will continue until month 6. From month 7 onwards this will be replaced by system agreed prospective top up funding, and organisations will be allowed to deviate from a breakeven position as long as there is a breakeven system position.

HDFT Monthly Financial Performance (£'000s)



	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12
NHSEI Plan	0	0	0	0	0	0						
Actual	0	0	0	0	0							
Prior Year	-1,677	-67	-256	326	-554	-158	674	217	1,241	-150	126	960

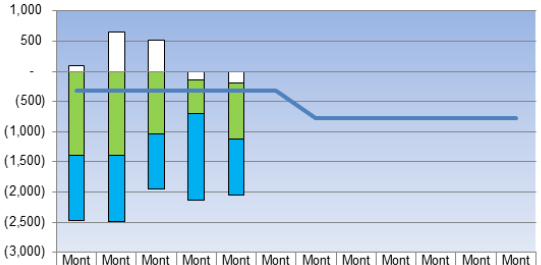
HDFT Cumulative Financial Performance (£'000s)



	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12
Prior Year	-1,677	-1,744	-2,000	-1,674	-2,229	-2,387	-1,713	-1,496	-254	-404	-278	682
NHSEI Plan	0	0	0	0	0	0						
Actual	0	0	0	0	0							

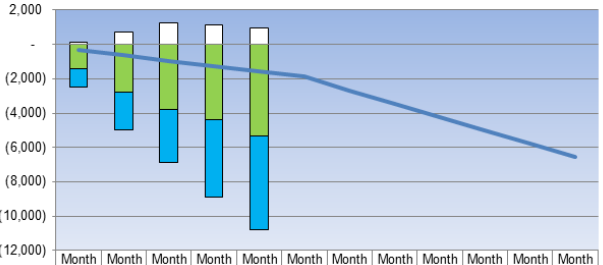
The following information outlines the pre top up/true up position of the Trust. Without any top up or true up funding the Trust would have reported a deficit to month 5 of £11.4m. The position pre top up/true up is consistent with last month.

HDFT Monthly Pre Top Up/True Up Performance (£'000s)



	Mont h 1	Mont h 2	Mont h 3	Mont h 4	Mont h 5	Mont h 6	Mont h 7	Mont h 8	Mont h 9	Mont h 10	Mont h 11	Mont h 12
Covid19 Costs	(1,070)	(1,099)	(912)	(1,448)	(930)							
Plan Issues	(1,395)	(1,389)	(1,035)	(560)	(925)							
Other	98	649	516	(134)	(196)							
Plan (excl top up/true up)	(314)	(314)	(314)	(314)	(314)	(314)	(781)	(781)	(781)	(781)	(781)	(781)

HDFT Cumulative Pre Top Up/True Up Performance (£'000s)



	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12
Covid19 Costs	(1,070)	(2,169)	(3,081)	(4,529)	(5,459							
Plan Issues	(1,395)	(2,784)	(3,819)	(4,379)	(5,304							
Other	98	747	1,263	1,129	933							
Plan (excl top up)	(314)	(628)	(942)	(1,256	(1,570	(1,884	(2,665	(3,445	(4,226	(5,006	(5,787	(6,567

Discussions continue about deployment of system funds to support the top up position, however, NHSEI recently shared their view of plans without this for the second half of the year, resulting in a £4.7m deficit for this period. This has been profiled in the graph above, reflecting a number of the issues previously discussed more accurately.

Financial Position – Covid 19 Expenditure

Harrogate and District NHS Foundation Trust

The table to the right outlines the position described in previous slide.

The variances related to income and expenditure are outlined in more detail on slide 5.

Revenue costs for Covid 19 are significant, representing 4.8% of Pay and Non Pay expenditure, reducing to 4.1% when removing Nightingale costs.

The information from other WYAAT providers is currently not available for the most recent month. Verbal feedback is that positions are broadly similar as previously reported in relation to Covid 19 expenditure, however, some levels of spend have increased as Trusts re-establish and recover activity levels. Similar trends are experienced in providers across Humber, Coast and Vale ICS.

	NHSI Plan £m	Trust Actual £m	Covid Costs £m	Top-Up £m	Var to Plan £m
Income (Exc Top-Up)	107.75	103.55			4.20
Cost	-108.16	-107.05	-5.46		4.34
EBITDA	**-0.41**	**-3.49**	**-5.46**	**0.00**	**8.54**
Dep/Int	-1.18	-2.45			1.28
Net I & E (Exc Top-Up)	**-1.59**	**-5.94**	**-5.46**	**0.00**	**9.82**
Pre-Notified Top-Up	1.59			1.58	0.00
Retrospective Top-Up				9.82	-9.82
Bottom Line	**0.00**	**-5.94**	**-5.46**	**11.40**	**0.00**

The Recovery Plan has been agreed and activity is restarting. This plan and its impact – on activity, money and people – continues to be monitored weekly through our Operational Delivery Group and reported separately to Resources Committee for assurance and oversight.

In Summary, Month 5 has been a continuation of the trend to date, with costs pre covid and planning issues below that anticipated in the NHSEI plan. The underlying position needs to be monitored carefully and we need to ensure costs are managed in line with recover plans.

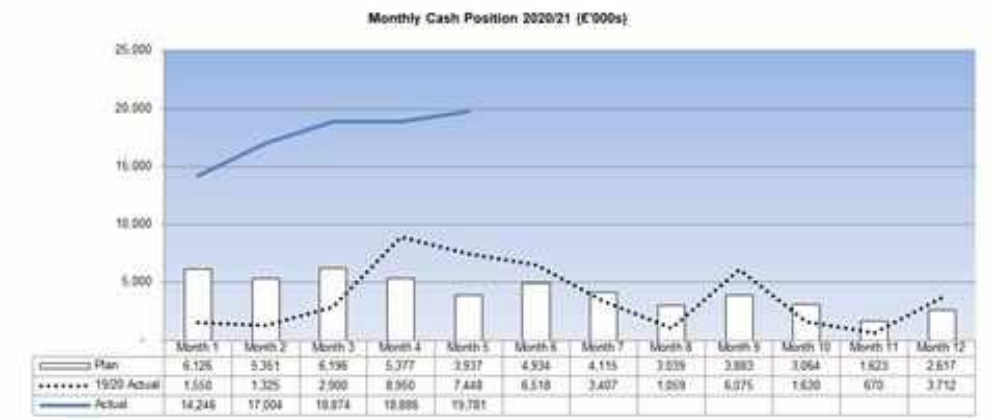
Cashflow, Debtors and Creditors

Harrogate and District NHS Foundation Trust

The Trust cash position is outlined in the graph to the right. This positive position is the result of the prepayment of commissioner income as a result of the current finance regime. At some point the Trust is likely to not receive this prepayment and therefore we need to continue to carefully manage this position.

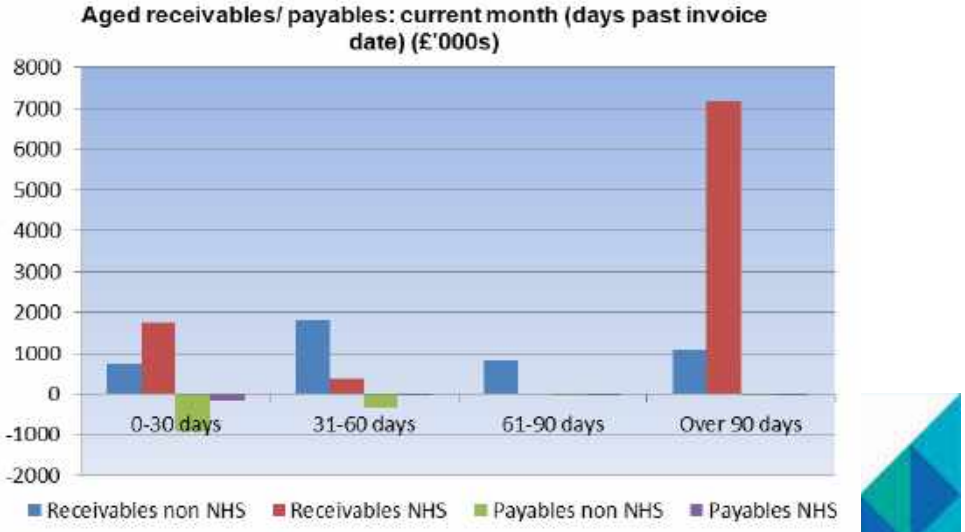
Although the prepayment is positive, no funding has been received in relation to capital linked to the Covid 19 response this financial year. The Trust has already spent £4.2m, £1m greater than our internally generated funding less loan repayments.

As demonstrated below the payment of invoices has improved, however, there is still some work to do to reach the target value of 95% of invoices paid within 30 days. Budget holders are asked to ensure approvals are done in a timely fashion to assist with this.



Other indicators	Year to date			
	Current month %	Previous month %	Movement %	Trend
BPPC % of bills paid in target				
- By number	66.3%	64.2%	2.2%	
- By value	56.7%	54.4%	2.3%	

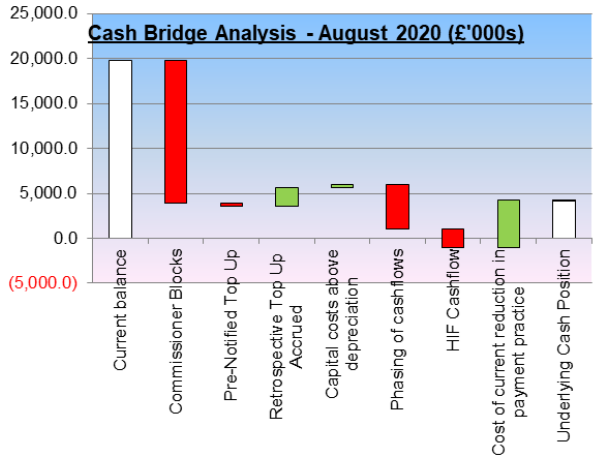
	Year to date		
	Current month	Previous month	Movement
BPPC % of bills paid in target			
Non NHS			
- By number	67.1%	64.7%	2.4%
- By value	54.4%	51.5%	2.8%
NHS			
- By number	56.2%	56.4%	(0.3%)
- By value	63.1%	63.0%	0.1%



Cashflow, Debtors and Creditors

The cash position of the Trust is influenced significantly by current policy. Stripping out these impacts gives the underlying cash position as described below -

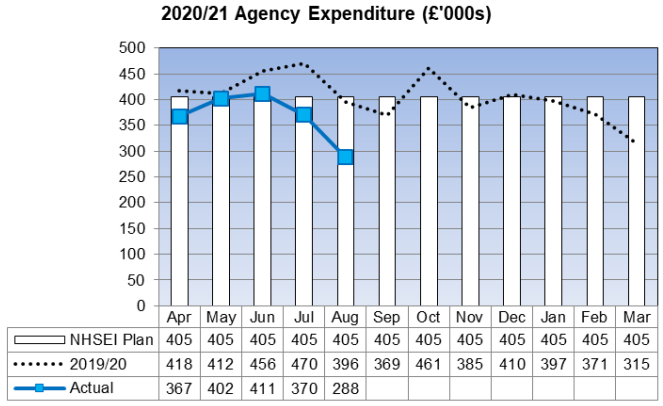
	£'000s	£'000s
Current balance		**19,781.000**
Commissioner Blocks	(15,863.000)	
Pre-Notified Top Up	(317.000)	
Retrospective Top Up Accrued	2,050.000	
Capital costs above depreciation	350.000	
Phasing of cashflows	(5,000.000)	
HIF Cashflow	(2,000.000)	
Cost of current reduction in payment practice	5,285.000	
Underlying Cash Position		**4,286.000**



Regulatory Indicators

The Trust Use of Resource Rating and performance against agency ceiling are outlined below.

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



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
NHSEI Plan	405	405	405	405	405	405	405	405	405	405	405	405
2019/20	418	412	456	470	396	369	461	385	410	397	371	315
Actual	367	402	411	370	288							

Harrogate and District NHS Foundation Trust

Board of Directors (held in Public)
30 September 2020
Integrated Board Report – August 2020 data

Agenda Item Number:	**9.0**
Presented for:	Information
Report of:	Executive Directors
Author (s):	Head of Performance & Analysis
Report History:	None
Publication Under Freedom of Information Act:	This paper has been made available under the Freedom of Information Act 2000

Links to Trust's Objectives	
To deliver high quality care	✓
To work with partners to deliver integrated care	✓
To ensure clinical and financial sustainability	✓

Recommendation:
It is recommended that the Board note the items contained within this report.

9

Harrogate and District NHS Foundation Trust

Integrated board report - August 2020

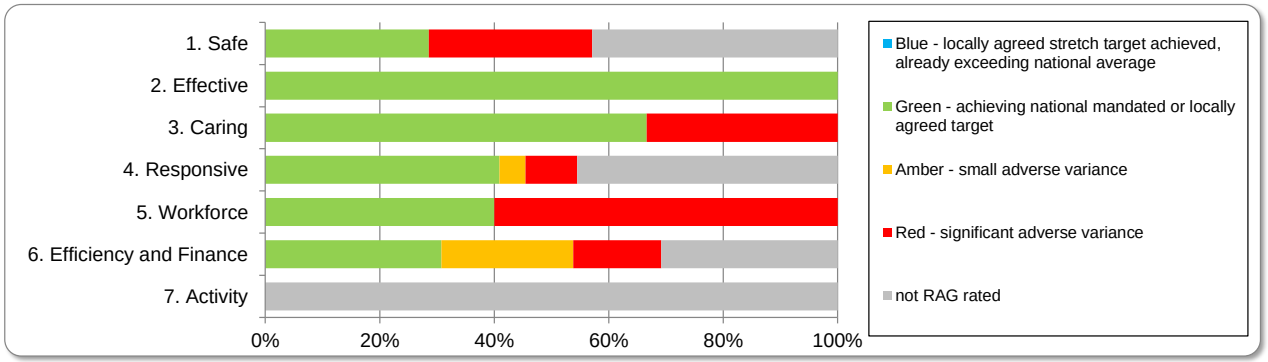
Key points this month

1. The Trust reported a balanced position in month 5, in line with the national expectation for providers. This position is supported by a £11.1m top up payment, supporting the costs of Covid19 and some underlying variances as a result of the plan.

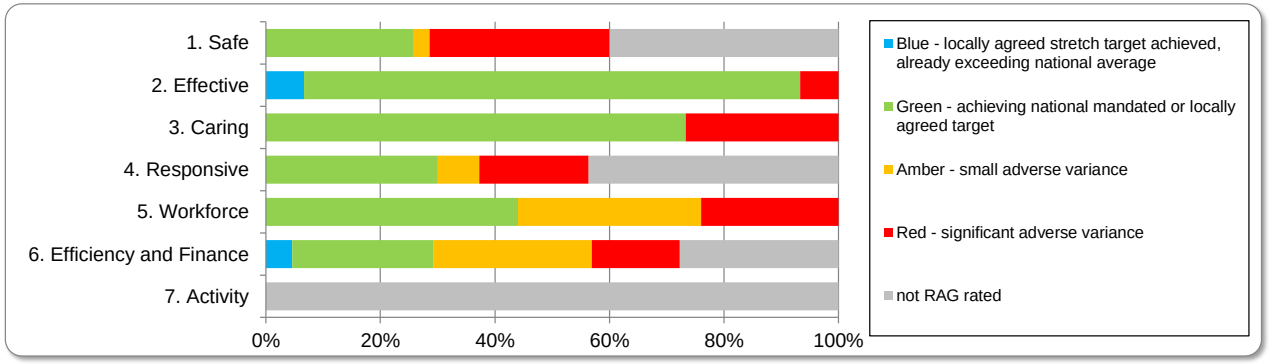
2. HDFT's performance against the A&E 4-hour standard was below 95% in August (87.2%). This is a decrease on last month. The year to date position for 2020/21 now stands at 91.6%.

3. Provisional data shows that performance against the 62 day cancer standard in August was at 90%, a decrease on the July figure of 92.3% but remaining above the 85% standard.

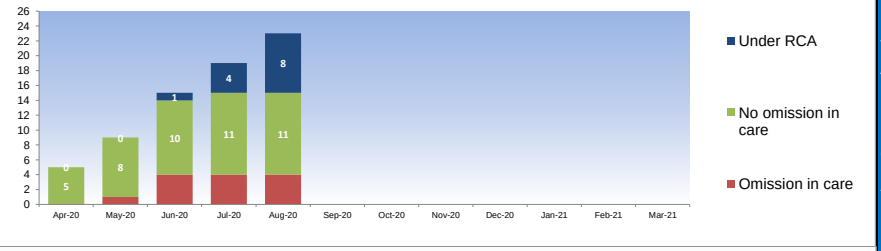
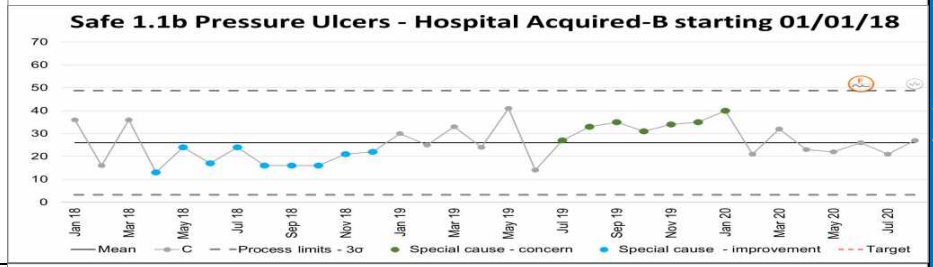
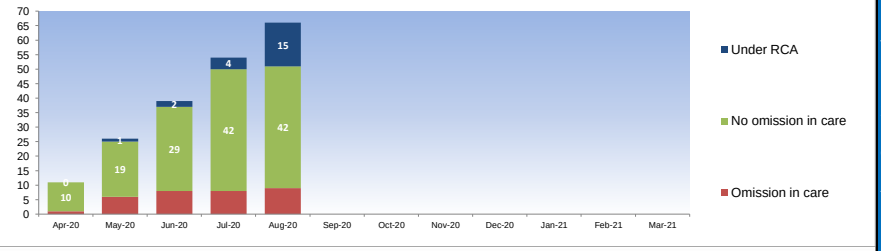
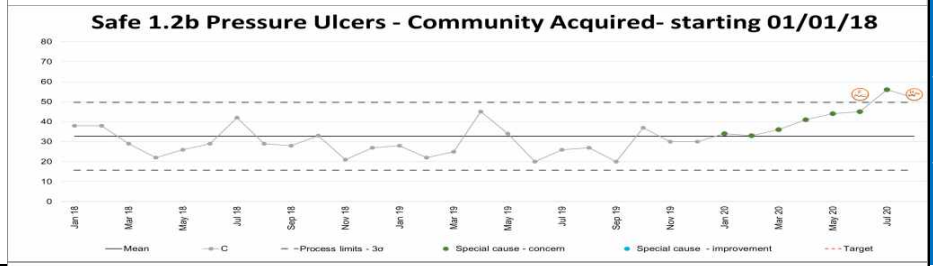
Summary of indicators - current month



Summary of indicators - year to date

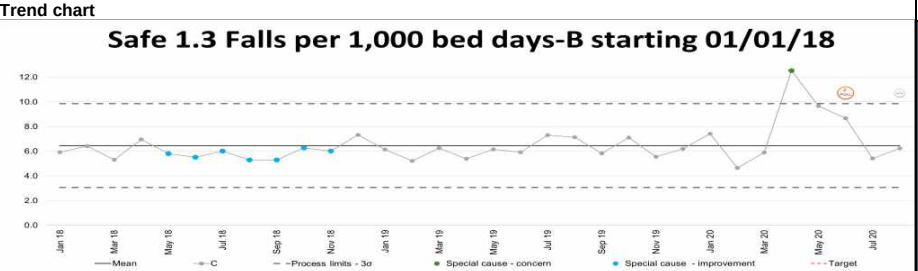
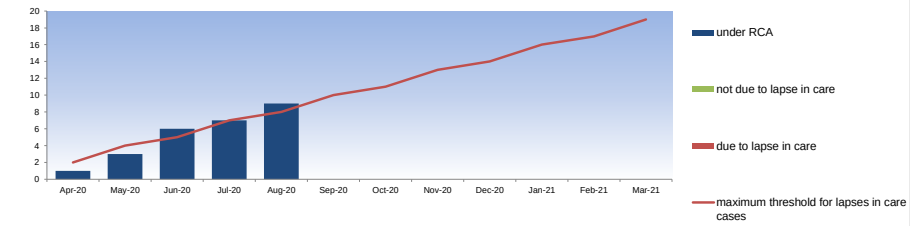
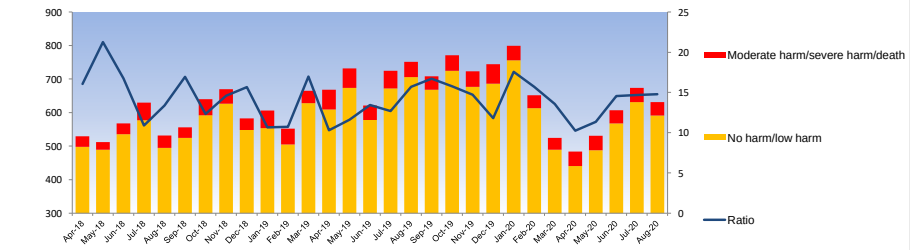
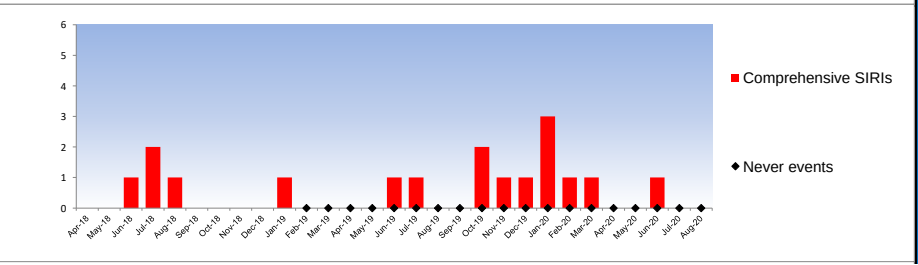


Section 1 - Safe - August 2020

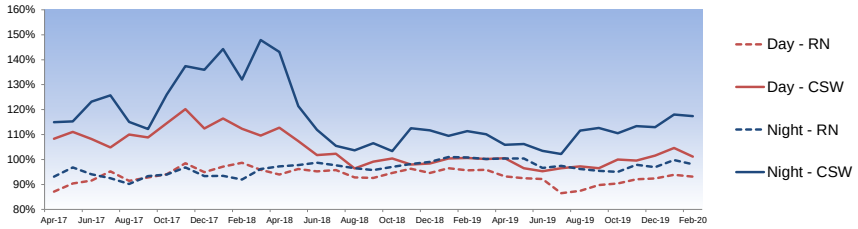
Indicator number	Indicator name / data quality assessment	Trend chart	Interpretation
1.1a	Pressure ulcers - hospital acquired		There were 7 hospital acquired category 3 and above pressure ulcers reported in August (including device related and device related mucosal). This is lower than last year with an average of 8 per month reported in 2019/20. 4 of these require RCA, taking the total requiring RCA YTD to 23. Of the 7* reported, there were 4 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 August was 27. The reported number is inclusive of device related and device related mucosal pressure ulcers.
1.2a	Pressure ulcers - community acquired		There were 27 community acquired category 3 and above pressure ulcers reported in August (including device related and device related mucosal). 12 of these require RCA, taking the total requiring RCA YTD to 66. The average per month reported in 2019/20 was 14. Of the 27* reported, there was 1 omission in care and 11 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 August was 52. The number reported is inclusive of device related and device related mucolsal pressure ulcers. The Pressure Ulcer Steering Group will review this data in depth and look to understand any specific reasons for the reported increase.

Harrogate and District NHS Foundation Trust

Section 1 - Safe - August 2020

Indicator number	Indicator name / data quality assessment	Trend chart	Interpretation
1.3	Falls		The rate of inpatient falls was 6.2 per 1,000 bed days in August. This is a slight increase on recent months and equal to the average HDFT rate for 2019/20 (6.2).
1.4	Infection control		There were 2 cases of hospital apportioned C. difficile reported in August. No MRSA cases have been reported in 2019/20 or 2020/21 to date. The annual maximum threshold for lapses in care cases for 2020/21 is 19. This data is yet to be finalised by Infection Control. This graph shows cumulative data YTD.
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 13.1, a reduction on the last publication and remaining in the bottom 25% of Trusts nationally. HDFT's latest local data for July gives a ratio of 13.
1.6	Incidents - SIRIs and never events		No SIRIs were reported in August, with the YTD position remaining at 1 reported case. No Never Events have been reported YTD. No Never Events were reported in 2017/18, 2018/19 or 2019/20.

Section 1 - Safe - August 2020

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

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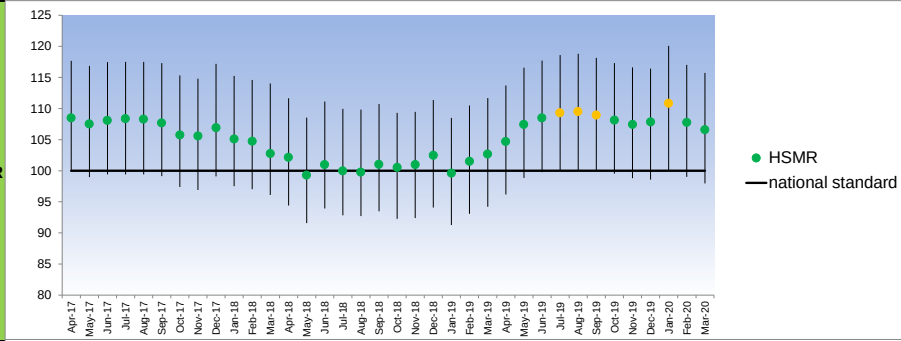
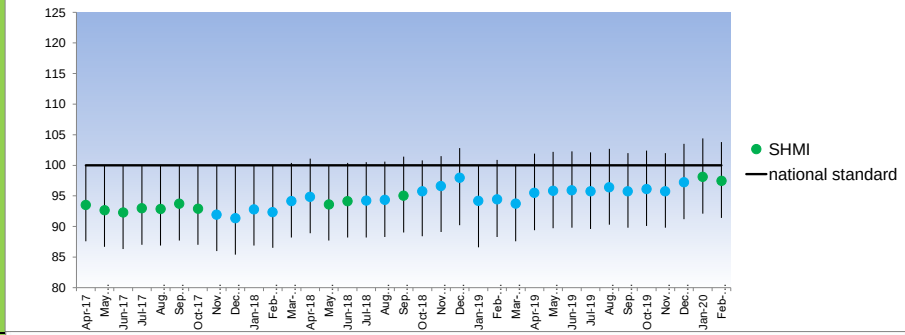
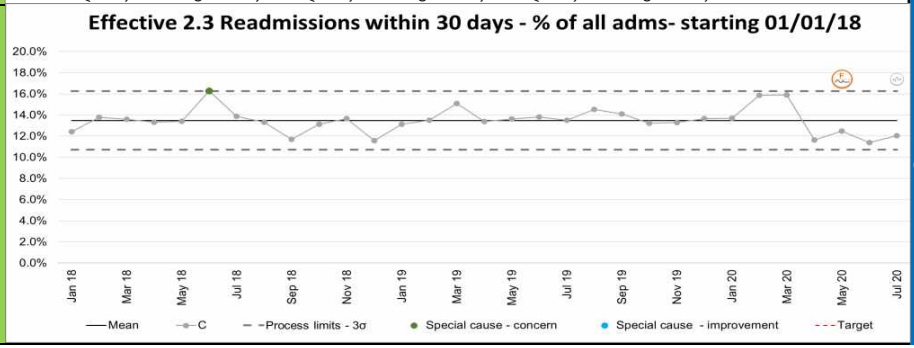
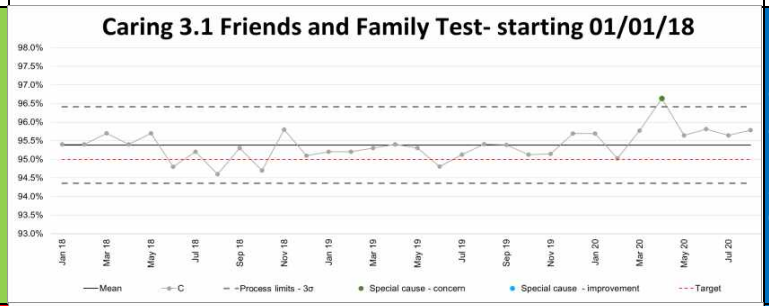
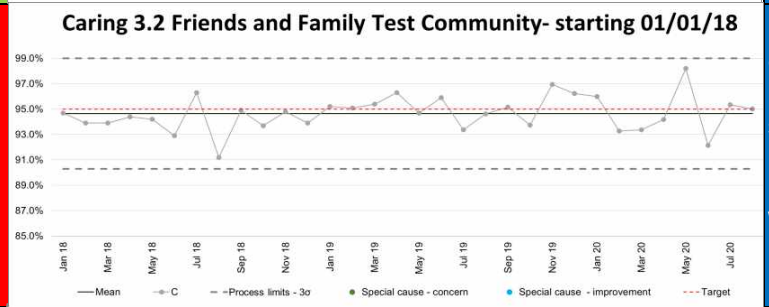
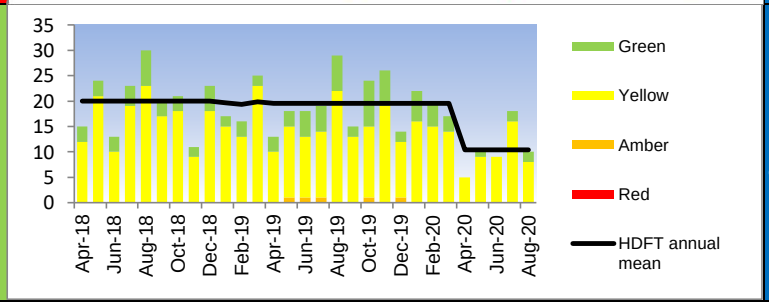
Section 2 - Effective - August 2020

Indicator number	Indicator name / data quality assessment	Trend chart	Interpretation
2.1	Mortality - HSMR		HDFT's HSMR has decreased to 106.58 for the rolling 12 months ending March 2020, 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. *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 Februrary 2020 is 97.45, remaining within 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 slightly increased to 12.1% in July. This is below the 2019/20 average of 14.0%.

Section 3 - Caring - August 2020

Indicator number	Indicator name / data quality assessment	Trend chart	Interpretation
3.1	Friends & Family Test (FFT) - Patients		95.8% of patients surveyed in August would recommend our services remaining above the latest published national average (93.3%). 2,347 patients responded to the survey this month, of which 2,248 would recommend our services.
3.2	Friends & Family Test (FFT) - Adult community services		95% of patients surveyed in August would recommend our services, a decrease on last month (95.3%). Current national data (February 2020) shows 95.6% of patients surveyed would recommend the services. 141 patients from our community services responded to the survey this month, of which 134 would recommend our services.
3.3	Complaints		10 complaints were received in August (8 yellow, 2 green) which is 8 less than July and lower than the average for 2019/20 of 20 per month.

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Section 4 - Responsive - August 2020

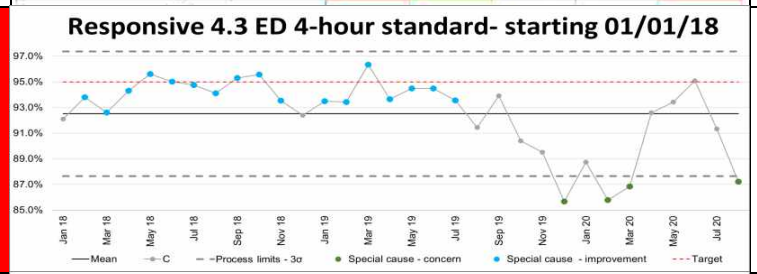
NHS Improvement Single Oversight Framework

4.1 NHS Improvement Single Oversight Framework

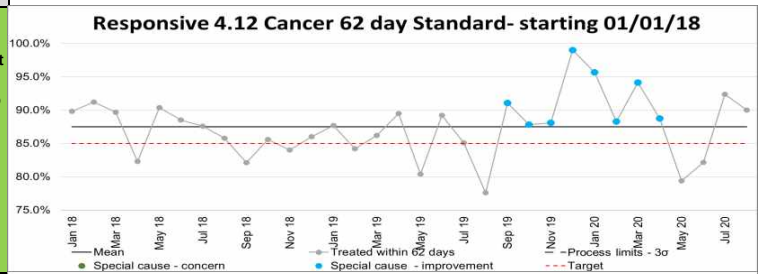
Standard	Q1	Q2 to date	Q3	Q4	YTD
RTT incomplete pathways					
A&E 4-hour standard	93.9%	89.2%			91.6%
Cancer - 62 days	83.7%	91.0%			87.0%
Diagnostic waits	55.5%	76.46%			68.0%
Dementia screening - Step 1	92.2%	95.1%			93.5%
Dementia screening - Step 2	80.0%	90.9%			84.6%
Dementia screening - Step 3	87.0%	100.0%			91.4%

4.2 RTT Incomplete pathways performance

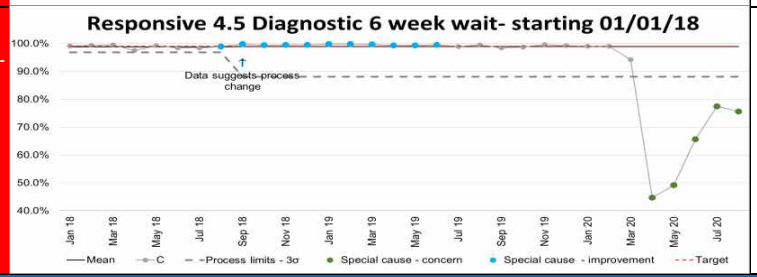
4.3 A&E 4 hour standard



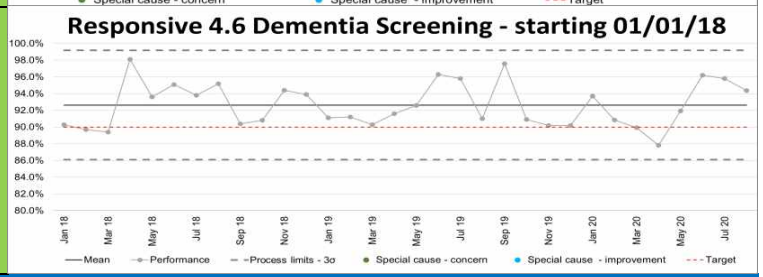
4.4 Cancer - 62 day wait for first treatment from urgent GP referral to treatment



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 August (87.2%), a decrease on last month. The number of ED attendances continues to increase with attendances now at 90% of the attendances in the corresponding month last year.

Provisional data shows that performance against the 62 day cancer standard in August was at 90.0%, a slight decrease on the previous month (92.4%) but above the 85% operational standard for the second consecutive month. Performance for 2WW non-cancer related breast referrals was above the operational standard of 93% for the first time since April (see a more detailed summary below).

Data shows the performance on diagnostic waiting times decreased slightly with 75.6% waiting less than 6 weeks at the end of August, and remains below the performance standard of 99%. 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 indicates that steps 2 and 3 will not be delivered for August.

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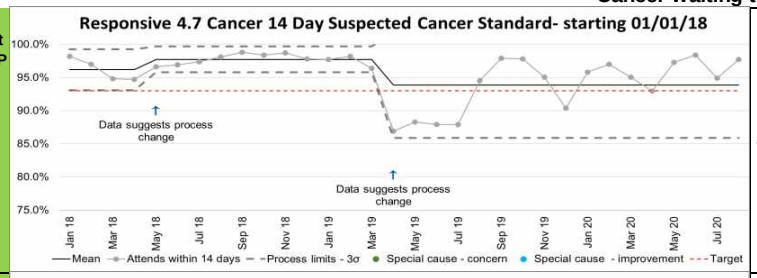
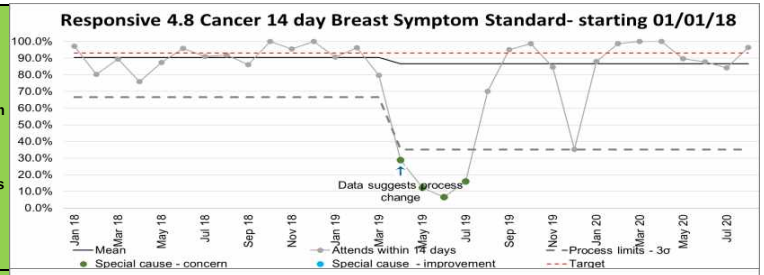
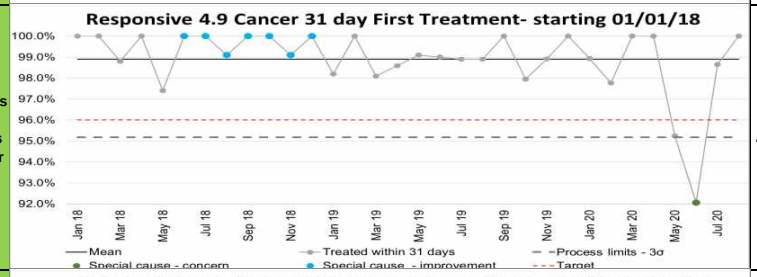
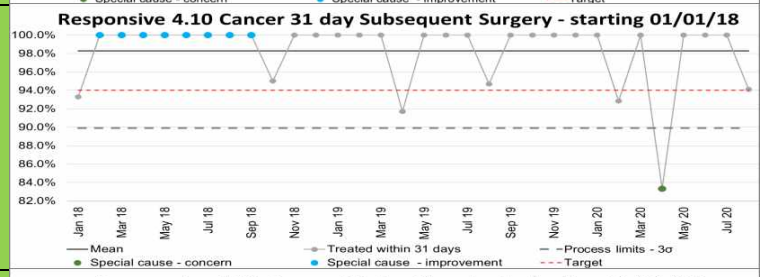
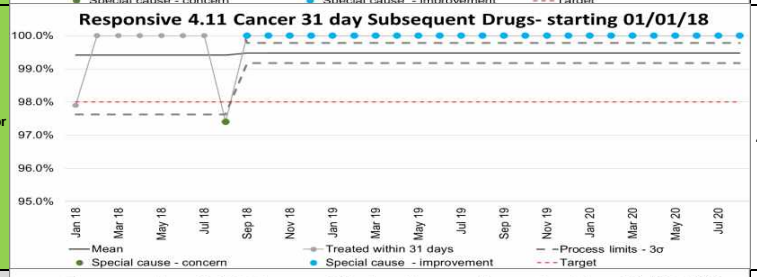
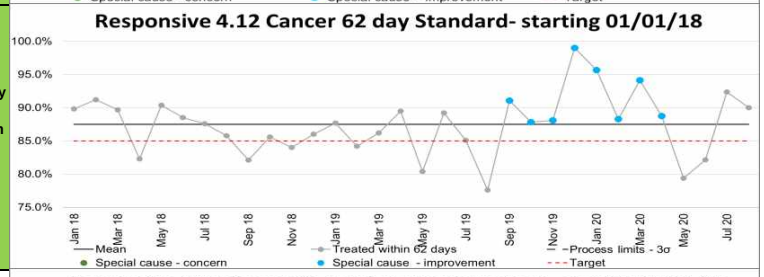
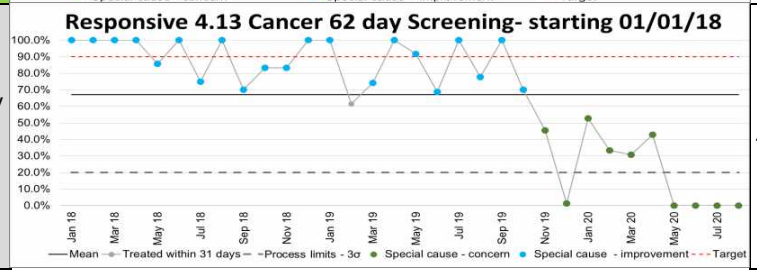
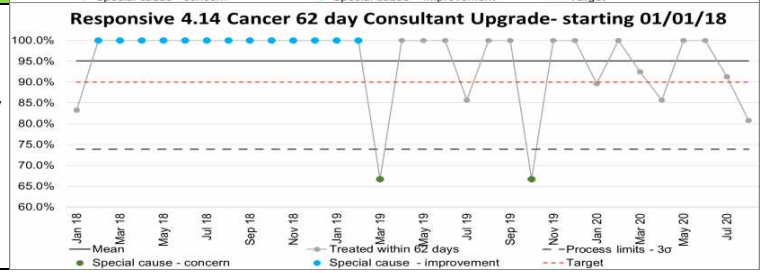
Section 4 - Responsive - August 2020

Cancer waiting times standards

4.70	Cancer - 14 days max wait from urgent GP referral for suspected cancer		4.80	Cancer - 14 days maximum wait from GP referral for symptomatic breast patients	
4.9	Cancer - 31 days maximum wait from diagnosis to treatment for all cancers		4.10	Cancer - 31 day wait for second or subsequent treatment: Surgery	
4.11	Cancer - 31 day wait for second or subsequent treatment: Anti-Cancer drug		4.12	Cancer - 62 day wait for first treatment from urgent GP referral to treatment	
4.13	Cancer - 62 day wait for first treatment from screening service		4.14	Cancer - 62 day wait for first treatment from consultant upgrade	

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Section 4 - Responsive - August 2020

Narrative

Provisional data indicates that 6 of the 7 applicable cancer waiting times standards were achieved in August. 62 day Screening performance was below the standard of 90% with all patients treated after 62 days - due to the suspension of the Bowel Screening service in recent months activity levles were below the de minimus for the month with only 3 patients treated and attributable to HDFT (equivalent to 2.5 accountable treatments).

2WW referrals (including breast symptomatic) fell slightly in August with an average of 185 per week compared to 195 per week in July - in terms of activity, this translates to a 5.5% reduction in suspected cancer first attendances and a 1.8% reduction in breast symptomatic attendances. Referrals and attendances are still below pre-Covid levels with an average of 685 suspected cancer attendances per month from June 2020 to August 2020 compared to 806 attendances per month from April 2019 to February 2020.

Following the resumption of Endoscopy services work continues to reduce the diagnostic backlog for patients on a GI cancer pathway, whilst also ensuring all patients awaiting endoscopic procedures are appropriately prioritised.

62 day standard performance is expected to be above 85% in August at 90.0%. Provisionally there were 60.0 accountable treatments in August (an increase of 14.0 on July) with 6.0 over 62 days. Of the 10 tumour sites treated in August, performance was above 85% for all but one (Colorectal). Colorectal pathways have been significantly affected by Covid-19 with 6.0 accountable treatments delivered in August (7 patients) and 5.0 over 62 days (16.5% within 62 days) - throughout the pandemic all of these pathways have been reviewed and prioritised at MDT in order to ensure that any delays to pathways impacted by Covid-19 do not adversely affect patient outcomes. All breaches will be reviewed by the breach panel at the end of September. No patients waited over 104 days for treatment in August.

Provisional data indicates that 62.5% (5/8) of patients treated at tertiary centres in August were transferred by day 38.

Of 17 patients receiving surgery as a subsequent treatment in August, 1 colorectal patients was treated on day 42, meaning performance was just above the 94% standard (94.1%) - this delay was due to the necessary Covid-related precautions (post-op planning and 2 week period of isolation pre-op).

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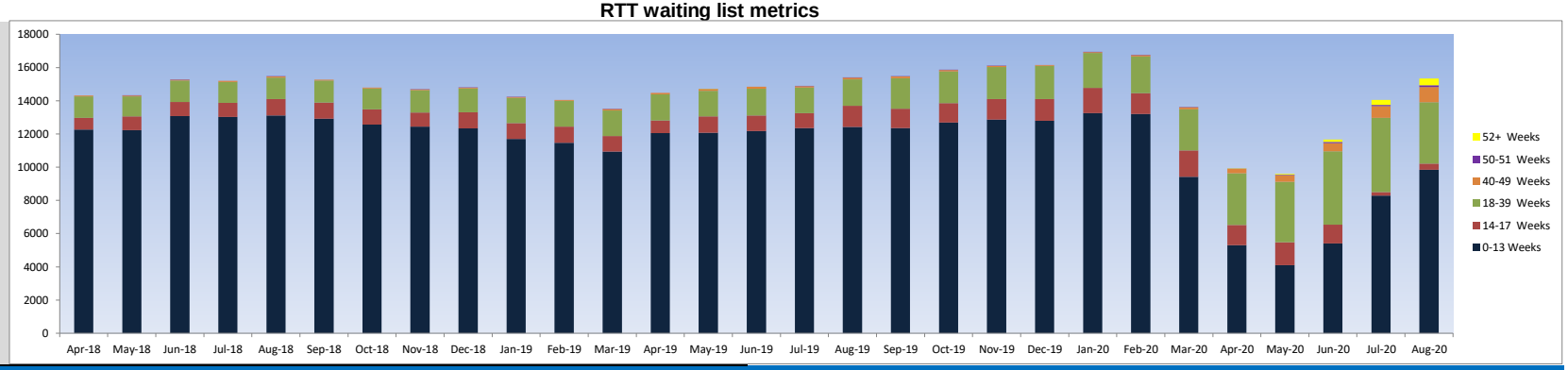
Section 4 - Responsive - August 2020

RTT waiting list metrics

4.15	RTT waiting list split by weeks



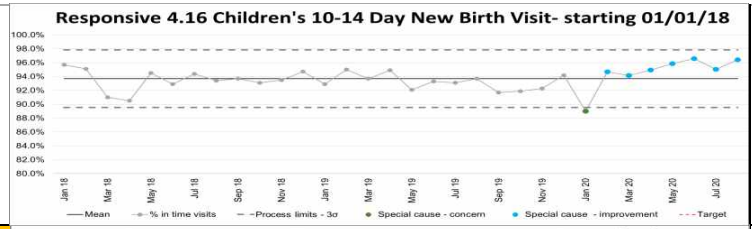
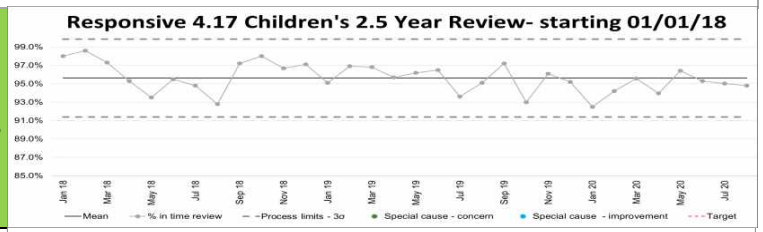
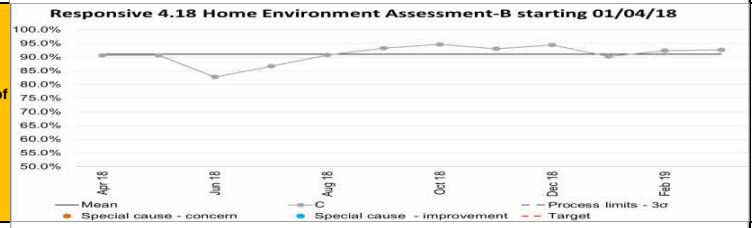
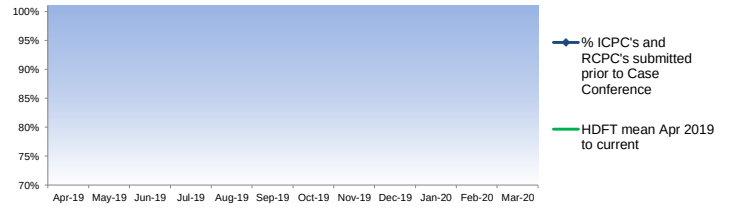
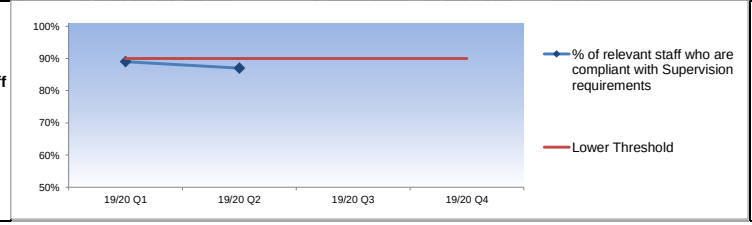
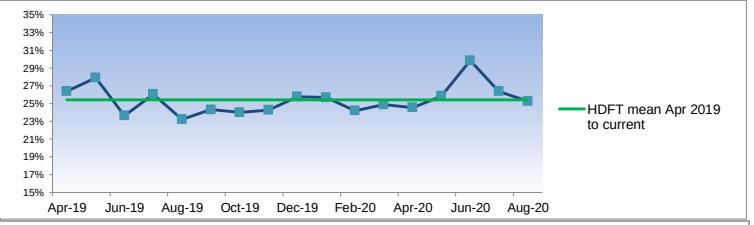
Narrative

Provisional data shows that there were a total of 15,345 patients on the RTT waiting list at the end of August. There were 421 patients waiting over 52 weeks at the end of the month. The large reduction in the total number of patients waiting in 2020/21 to date is linked to the reduction in elective referrals received following the stepping down of elective services in response to Covid-19. It is anticipated that the number of pathways will now start to increase back to historic levels as elective referrals continue to increase in the coming months.

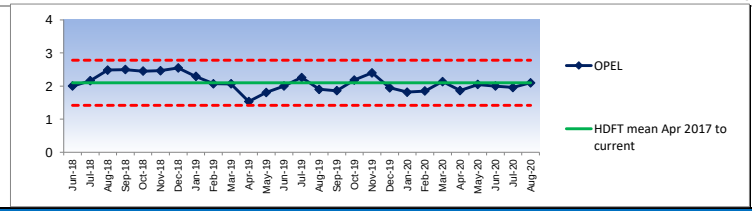
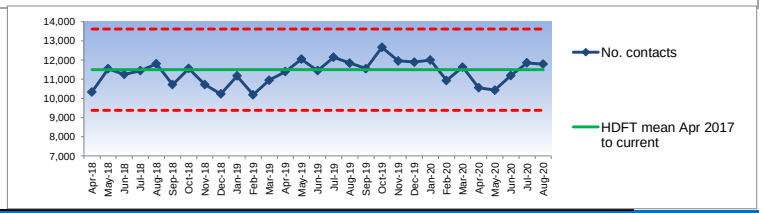
NHS Harrogate and District NHS Foundation Trust

Section 4 - Responsive - August 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

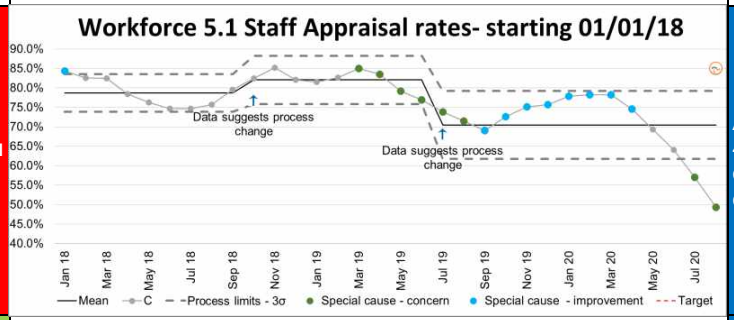
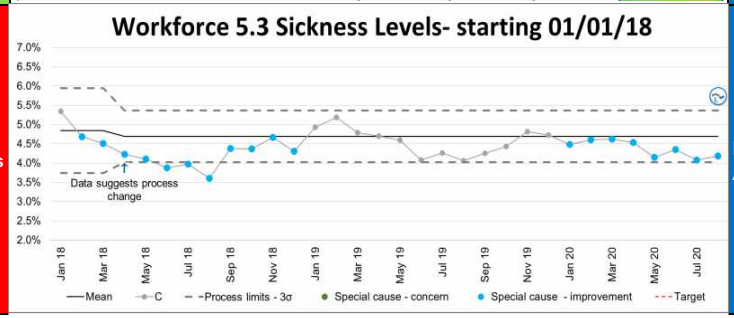
4.22	OPEL level - Community Care Teams		4.23	Community Care Teams - patient contacts	

Narrative

The Children's Services and Adult Community Services metrics are currently showing no adverse variance. Following discussions at the Quality Committee, the Trust has increased the standard for the Safeguarding Supervision indicator to 90%, previously 75%.

Harrogate and District NHS Foundation Trust

Section 5 - Workforce - August 2020

Indicator number	Indicator name / data quality assessment	Trend chart	Interpretation
5.1	Staff appraisal rates		Although appraisals were put on hold during the peak of Covid-19, our current completion rate stands at 49.3%. We have over the past few years operated an appraisal window, where all appraisals with the exception of CCCW should be completed between April and September. In comparison to last year, the completion rate is 24.5% lower in August.
5.2	Mandatory training rates		The data shown is for the end of August 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 91% which is higher than the last reporting cycle (89%). At present, 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		Non-Covid-19 related sickness has increased in August 2020 by 0.1% since July 2020 and is higher than August 2019.

Competence Name	Renewal Period	Required	Achieved	Compliance %
Information Governance & Data Security	Annual	4168	3620	87%
Equality, Diversity and Human Rights	3 Yearly	4168	3903	94%
Fire Safety	Annual	4168	3701	89%
Infection Control	Once Only	4168	4036	97%
Safeguarding Children	3 Yearly	4168	3853	92%
Risk Awareness eLearning	Once Only	4168	4008	96%
Fire Safety Facilitator Led Training	2 yeary	4168	3300	79%
Health, Safety and Welfare	5 Yearly	4168	3990	96%

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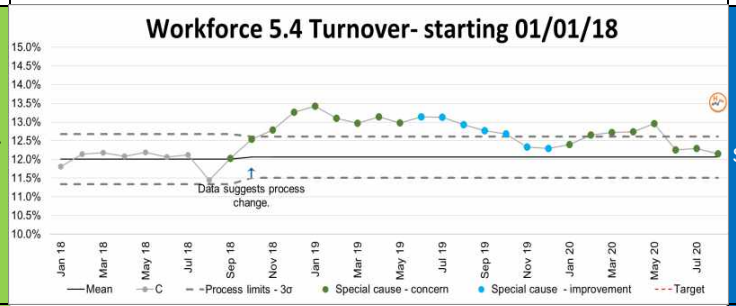
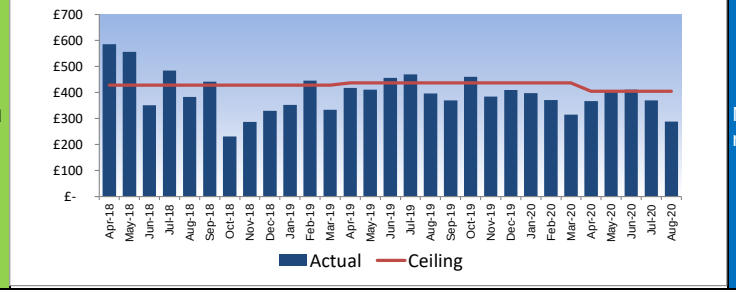
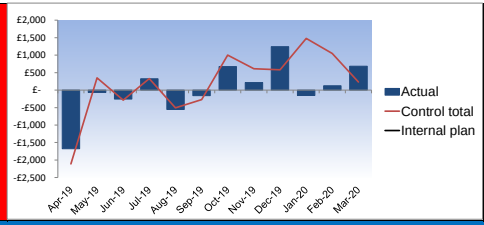
Section 5 - Workforce - August 2020

Indicator number	Indicator name / data quality assessment	Trend chart	Interpretation
5.4	Staff turnover rate		Staff turnover, both voluntary and involuntary, remains stable.
5.5	Agency spend in relation to pay spend		Month 5 agency spend reduced to £288k. This is a consolidated position and specifically reflects a reduced requirement and improved controls within HIF.

Section 6 - Efficiency and Finance - August 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

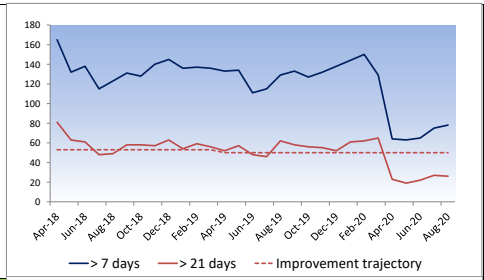
The Trust reported a balanced position in month 5, in line with the national expectation for providers. This position is supported by a £11.1m top up payment, supporting the costs of Covid-19 and some underlying variances as a result of the plan.

Currently reported as a 1, however, the Trust awaits further guidance on this monitoring during the response to Covid 19. It should be noted that this rating is currently not being formally reported to NHSE/I.

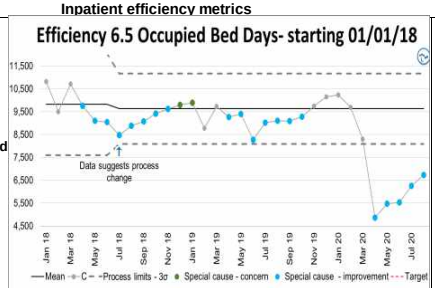
The Trust continues to be in discussion with NHSEI regarding the capital plan for 2020/21. Trust spend is outlined in the graph, with a forecast position of approx. £14m dependant on approvals.

Inpatient efficiency metrics

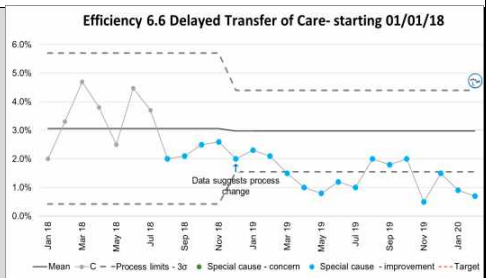
6.4 Long stay patients



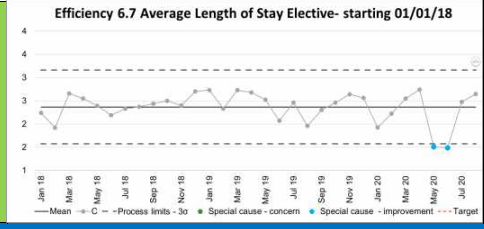
6.5 Occupied bed days



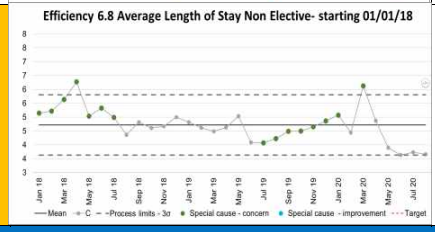
6.6 Delayed transfers of care



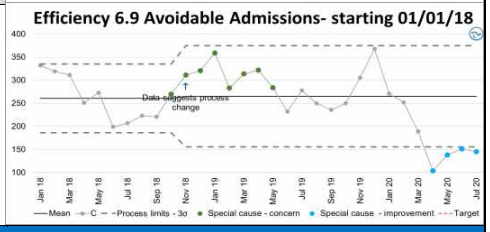
6.7 Length of stay - elective



6.8 Length of stay - non-elective



6.9 Avoidable admissions



Narrative

In August, long stay patient numbers and occupied bed days increased slightly. Elective length of stay increased this month, whilst non-elective length of stay decreased slightly, with non-elective remaining below the Trust mean, but elective increasing to just above. Avoidable admissions remain stable and below the Trust mean.

Section 6 - Efficiency and Finance - August 2020

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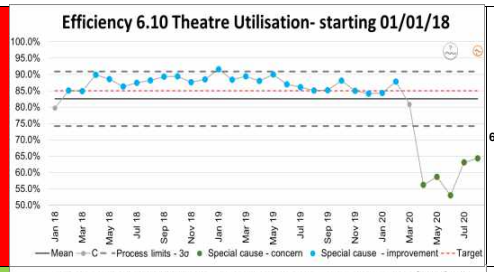
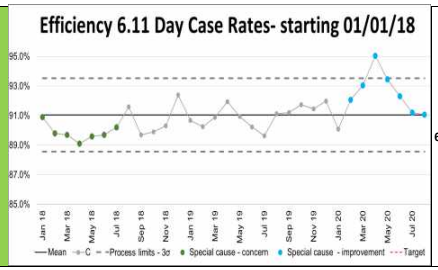
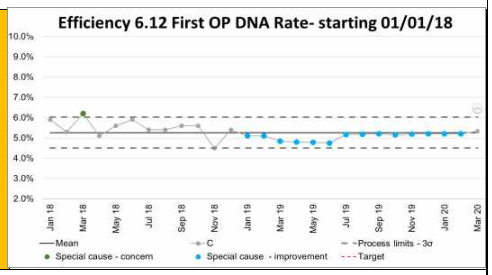
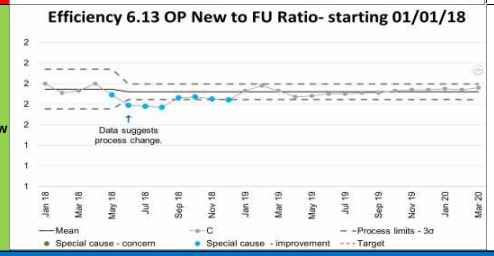
6.10	Theatre utilisation		6.11	Day case rate		6.12	Outpatient DNA rate	
6.13	Outpatient new to follow up ratio							

Narrative

Theatre utilisation increased slighty in August but 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 Covid-19. It is anticipated that theatre utilisation will start to rise from July 2020 as the Trust's recovery plan comes into effect.

Outpatient DNA rates and new to follow up ratios have both increased very slightly but remain mostly consistent.

Harrogate and District NHS Foundation Trust

Section 7 - Activity - August 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 has now submitted the acute recovery plan base case and step up activity profiles to NHSE/I as detailed in this month's Operational Performance Report to board.

North Yorkshire CCG AIC

GROUP	2019/20 AUG	2020/21 AUG	2019/20 YTD	2020/21 YTD	2020/21 vs 2019/20	2020/21 vs 2019/20 %
REFERRALS	3,057	2,599	16,278	10,662	**-5,616**	**-34.5%**
NEW OP	5,302	3,800	28,142	14,978	**-13,164**	**-46.8%**
FU OP	10,483	7,509	56,171	34,437	**-21,734**	**-38.7%**
ELECT IP	189	104	937	332	**-605**	**-64.6%**
ELECT DC	1,805	1,050	9,252	4,124	**-5,128**	**-55.4%**
NON ELECT	1,508	1,267	7,643	5,911	**-1,732**	**-22.7%**
A&E ATTENDS	3,203	2,958	16,692	12,338	**-4,354**	**-26.1%**

Non-North Yorkshire CCG - PbR*

GROUP	2019/20 AUG	2020/21 AUG	2019/20 YTD	2020/21 YTD	2020/21 vs 2019/20	2020/21 vs 2019/20 %
REFERRALS	1,429	824	8,039	2,888	**-5,151**	**-64.1%**
NEW OP	2,256	1,151	11,325	4,597	**-6,728**	**-59.4%**
FU OP	3,715	2,324	20,120	10,799	**-9,321**	**-46.3%**
ELECT IP	101	31	558	104	**-454**	**-81.4%**
ELECT DC	836	320	3,714	1,094	**-2,620**	**-70.5%**
NON ELECT	476	400	2,344	1,721	**-623**	**-26.6%**
A&E ATTENDS	1,275	1,128	6,131	4,049	**-2,082**	**-34.0%**

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

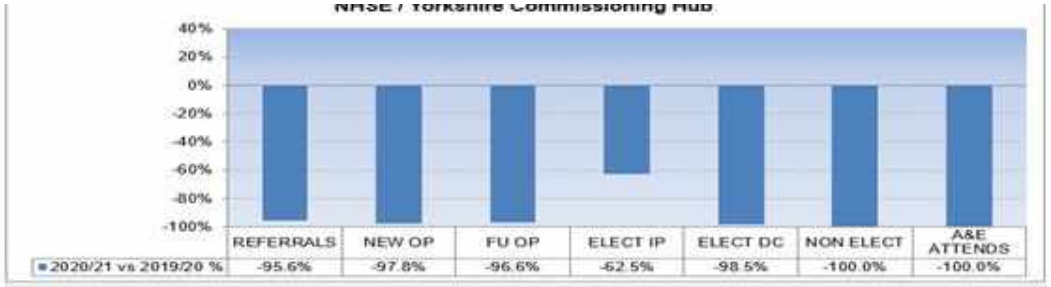
Activity Summary

NHSE / Yorkshire Commissioning Hub

Harrogate and District NHS Foundation Trust

NHSE / Yorkshire Commissioning Hub

GROUP	2019/20 AUG	2020/21 AUG	2019/20 YTD	2020/21 YTD	2020/21 vs 2019/20	2020/21 vs 2019/20 %
REFERRALS	199	14	996	44	**-952**	**-95.6%**
NEW OP	193	2	1,040	23	**-1,017**	**-97.8%**
FU OP	453	11	2,293	77	**-2,216**	**-96.6%**
ELECT IP	2	0	8	3	**-5**	**-62.5%**
ELECT DC	400	8	1,824	27	**-1,797**	**-98.5%**
NON ELECT	5	0	23	0	**-23**	**-100.0%**
A&E ATTENDS	22	0	93	0	**-93**	**-100.0%**



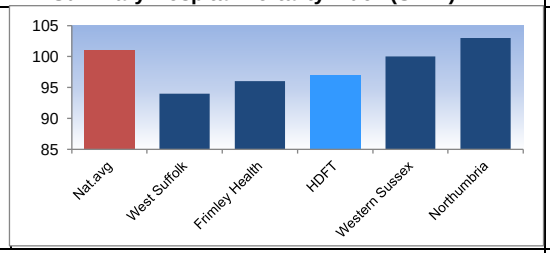
Trust Total

GROUP	2019/20 AUG	2020/21 AUG	2019/20 YTD	2020/21 YTD	2020/21 vs 2019/20	2020/21 vs 2019/20 %
REFERRALS	4,685	3,437	25,313	13,594	**-11,719**	**-46.3%**
NEW OP	7,751	4,953	40,507	19,598	**-20,909**	**-51.6%**
FU OP	14,651	9,844	78,584	45,313	**-33,271**	**-42.3%**
ELECT IP	292	135	1,503	439	**-1,064**	**-70.8%**
ELECT DC	3,041	1,378	14,790	5,245	**-9,545**	**-64.5%**
NON ELECT	1,989	1,667	10,010	7,632	**-2,378**	**-23.8%**
A&E ATTENDS	4,500	4,086	22,916	16,387	**-6,529**	**-28.5%**

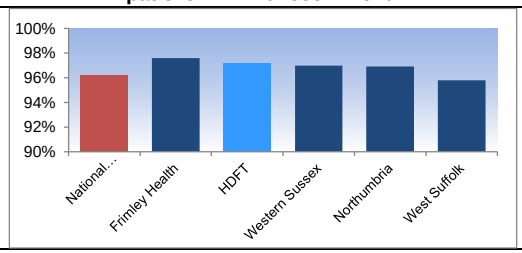
Harrogate and District NHS Foundation Trust

Section 8 - Benchmarking - August 2020

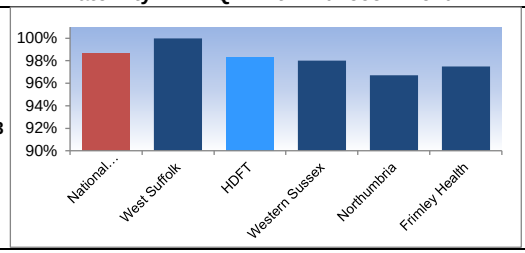
Summary Hospital Mortality Index (SHMI) — 8.1



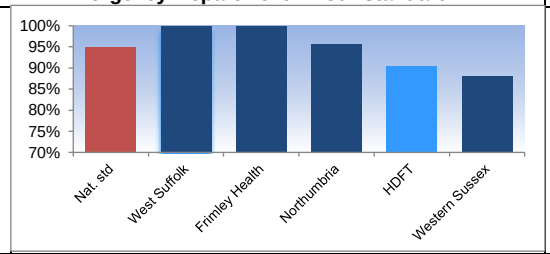
Inpatient FFT - % recommend — 8.2



Maternity FFT - Q2 Birth - % recommend — 8.3

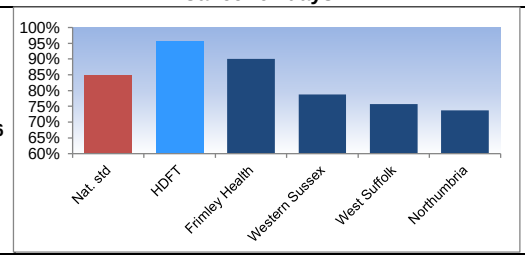


Emergency Department 4 hour standard — 8.4

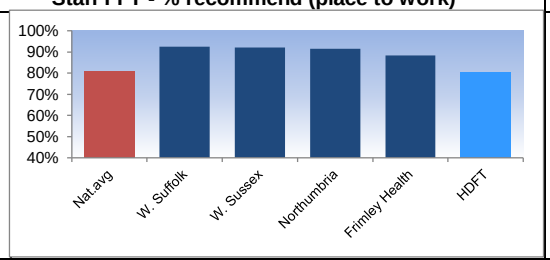


RTT incomplete pathways — 8.5

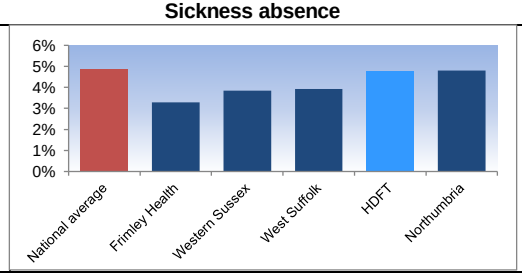
Cancer 62 days — 8.6



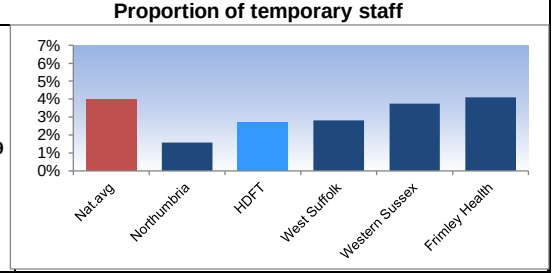
Staff FFT - % recommend (place to work) — 8.7



Sickness absence — 8.8



Proportion of temporary staff — 8.9



Narrative

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

Harrogate and District NHS Foundation Trust

Integrated board report - August 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

Data Quality - Exception Report

Harrogate and District NHS Foundation Trust

Domain	Indicator	Data quality rating	Further information
Safe	Pressure ulcers - community acquired - grades 2, 3 or 4	**Amber**	The observed increase in reported cases over the last two years may be partly due to improvements in incident reporting during the period.
Caring	Friends & Family Test (FFT) - Adult Community Services	**Amber**	The number of patients surveyed represents a small proportion of the community based contacts that we deliver in a year.
Efficiency and Finance	Theatre utilisation	**Amber**	This metric has been aligned with the new theatre utilisation dashboard from December 2017. Further metrics from the new dashboard are being considered for inclusion in this report from April 2018. The utilisation calculation excludes cancelled sessions - operating lists that are planned not to go ahead due to annual leave, study leave or maintenance etc. There are some known data quality issues with the utilisation data but it is anticipated that increased visibility of the data via the new dashboard will help to resolve these in the coming months.
Responsive	OPEL level - Community Care Teams	**Amber**	This indicator is in development.
Activity	Community Care Teams - patient contacts	**Amber**	During 2017/18, there were a number of restructures of the teams within these services and a reduction to baseline contracted establishment as the Vanguard work came to an end. This will have impacted upon the activity levels recorded over this period. Therefore caution should be exercised when reviewing the trend over time.

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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	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 2019/20, Green if YTD position is a reduction of between 20% and 50% of HDFT average for 2019/20, Amber if YTD position is a reduction of up to 20% of HDFT average for 2019/20, Red if YTD position is on or above HDFT average for 2019/20.	Locally agreed improvement trajectory based on comparison with HDFT performance last year.
1.4	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
1.5	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.
1.6	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.	
1.7	Safe	Safer staffing levels	Trusts are required to publish information about staffing levels for registered nurses/midwives (RN) and care support workers (CSW) for each inpatient ward. The chart shows the overall fill rate at HDFT for RN and CSW for day and night shifts. The fill rate is calculated by comparing planned staffing with actual levels achieved. A ward level breakdown of this data is provided in the narrative section and published on the Trust website.	Green if latest month overall staffing >=100%, amber if between 95% and 100%, red if below 95%.	The Trusts aims for 100% staffing overall.
2.1	Effective	Mortality - HSMR	The Hospital Standardised Mortality Ratio (HSMR) looks at the mortality rates for 56 common diagnosis groups that account for around 80% of in-hospital deaths and standardises against various criteria including age, sex and comorbidities. The measure also makes an adjustment for palliative care. A low figure is good.	Blue = better than expected (95% confidence interval), Green = as expected, Amber = worse than expected (95% confidence interval), Red = worse than expected (99% confidence interval).	Comparison with national average performance.
2.2	Effective	Mortality - SHMI	The Summary Hospital Mortality Index (SHMI) looks at the mortality rates for all diagnoses and standardises against various criteria including age, sex and comorbidities. The measure does not make an adjustment for palliative care. A low figure is good.		
2.3	Effective	Readmissions	% of patients readmitted to hospital as an emergency within 30 days of discharge (PbR exclusions applied). To ensure that we are not discharging patients inappropriately early and to assess our overall surgical success rates, we monitor the numbers of patients readmitted. A low number is good performance. This data is reported a month behind so that any recent readmissions are captured in the data.	Blue if latest month rate < LCL, Green if latest month rate < HDFT average for 2019/20, Amber if latest month rate > HDFT average for 2019/20 but below UCL, red if latest month rate > UCL.	Locally agreed improvement trajectory based on comparison with HDFT performance last year.
3.1	Caring	Friends & Family Test (FFT) - Patients	The Patient Friends and Family Test (FFT) gives patients and service users the opportunity to give feedback. They are asked whether they would recommend the service to friends and family if they required similar care or treatment. This indicator covers a number of hospital and community services including inpatients, day cases, outpatients, maternity services, the emergency department, some therapy services, district nursing, community podiatry and GP OOH. A high percentage is good.	Green if latest month >= latest published national average, Red if < latest published national average.	Comparison with national average performance.
3.2	Caring	Friends & Family Test (FFT) - Adult Community Services	The Patient Friends and Family Test (FFT) gives patients and service users the opportunity to give feedback. They are asked whether they would recommend the service to friends and family if they required similar care or treatment. This indicator covers a number of adult community services including specialist nursing teams, community care teams, community podiatry and GP OOH. A high percentage is good.		
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 2019/20, Amber if on or above HDFT average for 2019/20, 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	

Indicator number	Domain	Indicator	Description	Traffic light criteria	Rationale/source of traffic light criteria
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 >=99%, Red if latest month <99%.	NHS England, NHS Improvement and contractual requirement
4.6	Responsive	Dementia screening	The proportion of emergency admissions aged 75 or over who are screened for dementia within 72 hours of admission (Step 1). Of those screened positive, the proportion who went on to have an assessment and onward referral as required (Step 2 and 3). The operational standard is 90% for all 3 steps. A high percentage is good.	Green if latest month >=90% for Step 1, Step 2 and Step 3, Red if latest month <90% for any of Step 1, Step 2 or Step 3.	NHS England, NHS Improvement and contractual requirement
4.7	Responsive	Cancer - 14 days maximum wait from urgent GP referral for all urgent suspect cancer referrals	Percentage of urgent GP referrals for suspected cancer seen within 14 days. The operational standard is 93%. A high percentage is good.	Green if latest month >=93%, Red if latest month <93%.	NHS England, NHS Improvement and contractual requirement
4.8	Responsive	Cancer - 14 days maximum wait from GP referral for symptomatic breast patients	Percentage of GP referrals for breast symptomatic patients seen within 14 days. The operational standard is 93%. A high percentage is good.	Green if latest month >=93%, Red if latest month <93%.	NHS England, NHS Improvement and contractual requirement
4.9	Responsive	Cancer - 31 days maximum wait from diagnosis to treatment for all cancers	Percentage of cancer patients starting first treatment within 31 days of diagnosis. The operational standard is 96%. A high percentage is good.	Green if latest month >=96%, Red if latest month <96%.	NHS England, NHS Improvement and contractual requirement
4.10	Responsive	Cancer - 31 day wait for second or subsequent treatment: Surgery	Percentage of cancer patients starting subsequent surgical treatment within 31 days. The operational standard is 94%. A high percentage is good.	Green if latest month >=94%, Red if latest month <94%.	NHS England, NHS Improvement and contractual requirement
4.11	Responsive	Cancer - 31 day wait for second or subsequent treatment: Anti-Cancer drug	Percentage of cancer patients starting subsequent drug treatment within 31 days. The operational standard is 98%. A high percentage is good.	Green if latest month >=96%, Red if latest month <96%.	NHS England, NHS Improvement and contractual requirement
4.12	Responsive	Cancer - 62 day wait for first treatment from urgent GP referral to treatment	Percentage of cancer patients starting first treatment within 62 days of urgent GP referral. The operational standard is 85%. A high percentage is good.	Green if latest month >=85%, Red if latest month <85%.	NHS England, NHS Improvement and contractual requirement
4.13	Responsive	Cancer - 62 day wait for first treatment from consultant screening service referral	Percentage of cancer patients starting first treatment within 62 days of referral from a consultant screening service. The operational standard is 90%. A high percentage is good.	Green if latest month >=90%, Red if latest month <90%.	NHS England, NHS Improvement and contractual requirement
4.14	Responsive	Cancer - 62 day wait for first treatment from consultant upgrade	Percentage of cancer patients starting first treatment within 62 days of consultant upgrade. The operational standard is 85%. A high percentage is good.	Green if latest month >=85%, Red if latest month <85%.	NHS England, NHS Improvement and contractual requirement
4.15	Responsive	RTT waiting list split by weeks	Number of referred patients waiting for treatment broken down into weeks.	tbc	tbc
4.16	Responsive	Children's Services - 10-14 day new birth visit	The percentage of babies who had a new birth visit by the Health Visiting team within 14 days of birth. A high percentage is good. Data shown is for North Yorkshire, Darlington, Co. Durham, Middlesbrough, Stockton, Gateshead and Sunderland. A high percentage is good.	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 regeusted earlier than 48 hours before Case Conference.)	Green if latest month >=95%, Red if <95%.	Contractual requirement
4.20	Responsive	Children's Services - staff compliance with Safeguarding Supervision.	% of community staff achieving 80% compliance for Safeguarding Supervision.	Green if latest month >=90%, Red if <90%.	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

Indicator number	Domain	Indicator	Description	Traffic light criteria	Rationale/source of traffic light criteria
6.5	Efficiency and Finance	Occupied bed days	Total number of occupied bed days in the month.	tbc	Locally agreed targets.
6.6	Efficiency and Finance	Delayed transfers of care	The proportion of bed days lost due to being occupied by patients who are medically fit for discharge but are still in hospital. A low rate is preferable. The maximum threshold shown on the chart (3.5%) has been agreed with HARD CCG.	Red if latest month >3.5%, Green <=3.5%	Contractual requirement
6.7	Efficiency and Finance	Length of stay - elective	Average length of stay in days for elective (waiting list) patients. The data excludes day case patients. A shorter length of stay is preferable. When a patient is admitted to hospital, it is in the best interests of that patient to remain in hospital for as short a time as clinically appropriate – patients who recover quickly will need to stay in hospital for a shorter time. As well as being best practice clinically, it is also more cost effective if a patient has a shorter length of stay.	Blue if latest month score places HDFT in the top 10% of acute trusts nationally, Green if in top 25%, Amber if within the middle 50%, Red if in bottom 25%.	Comparison with performance of other acute trusts.
6.8	Efficiency and Finance	Length of stay - non-elective	Average length of stay in days for non-elective (emergency) patients. A shorter length of stay is preferable. When a patient is admitted to hospital, it is in the best interests of that patient to remain in hospital for as short a time as clinically appropriate – patients who recover quickly will need to stay in hospital for a shorter time. As well as being best practice clinically, it is also more cost effective if a patient has a shorter length of		
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 the utilised (using elective theatre sessions (i.e. those planned in advance for waiting list patients). The utilisation calculation excludes cancelled sessions - operating lists that are planned not to go ahead due to annual leave, study leave or maintenance etc. A higher utilisation rate is good as it demonstrates effective use of resources. A utilisation rate of around 85% is often viewed as optimal.	Green = >=85%, Amber = between 75% and 85%, Red = <75%	A utilisation rate of around 85% is often viewed as optimal.
6.11	Efficiency and Finance	Day case rate	The proportion of elective (waiting list) procedures carried out as a day case procedure, i.e. the patient did not stay overnight. A higher day case rate is preferable.	Blue if latest month score places HDFT in the top 10% of acute trusts nationally, Green if in top 25%, Amber if within the middle 50%, Red if in bottom 25%.	Comparison with performance of other acute trusts.
6.12	Efficiency and Finance	Outpatient DNA rate	Percentage of new outpatient attendances where the patient does not attend their appointment, without notifying the trust in advance. A low percentage is good. Patient DNAs will usually result in an unused clinic slot.		
6.13	Efficiency and Finance	Outpatient new to follow up ratio	The number of follow-up appointments per new appointment. A lower ratio is preferable. A high ratio could indicate that unnecessary follow ups are taking place.		
7.1	Activity	Outpatient activity against plan (new and follow up)	The position against plan for outpatient activity. The data includes all outpatient attendances - new and follow-up, consultant and non-consultant led.		Locally agreed targets.
7.2	Activity	Elective activity against plan	The position against plan for elective activity. The data includes inpatient and day case elective admissions.		Locally agreed targets.
7.3	Activity	Non-elective activity against plan	The position against plan for non-elective activity (emergency admissions).		Locally agreed targets.
7.4	Activity	Emergency Department attendances against plan	The position against plan for A&E attendances at Harrogate Emergency Department. The data excludes planned follow-up attendances at A&E and pateints who are streamed to primary care.	Green if on or above plan in month, amber if below plan by < 3%, red if below plan by > 3%.	Locally agreed targets.

Data quality assessment

Green	No known issues of data quality - High confidence in data
Amber	Ongoing 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

Board Committee Report to the Board of Directors

Committee Name:	Quality Committee
Committee Chair:	Laura Robson
Date of meeting:	2 September 2020
Date of Board meeting this report is to be presented	30 September 2020

Summary of key issues

- The Quality Committee met via teleconference. The meeting was observed by Clare Cressey Lead Governor.
- Representatives from the Supported Discharge service attended the meeting to give a report on the improvements implemented as a result of the changes required to manage the impact of the COVID-19 pandemic. The service had undergone a significant expansion and was able to ensure patients were returned to their own home and supported there, rather than be in hospital. The service had implemented a 'pull system' which had worked well in difficult times. Staff from various hospital services had relocated to work in the team and this had been difficult but they had managed very well and many enjoyed the experience. Now that they were returning to the hospital setting a business case is being developed to ensure this valued service could continue, saving hospital beds and enabling patients to return to their homes as soon as safely possible. The presentation was enlightening and the team is to be congratulated for their innovation in care. Patient evaluation had been very positive.
- No hotspots were raised from committee members or attendees.
- The Clinical Advisory Group minutes from 25th June to 20th August were considered. Attendance at the meetings is reducing due to members returning to normal working and not being available to attend, also the urgency for immediate clinical decisions is reducing. The Medical Director is reviewing the Clinical Governance structure and will be considering how this important decision making forum is incorporated into the future structure. There were no particular issues arising from the meetings to bring to the attention of the Trust Board. The minutes give the Quality Committee significant assurance regarding clinical input into key decisions.
- The Medical Director gave an explanation of the new Patient Experience and Safety Huddle (PESH). The meetings are designed to be inclusive and open to ensure that safety issues can be discussed and actions agreed in an open and transparent forum. There were no immediate issues to report to Quality Committee from PESH.
- All three, quarter one Directorate governance reports were considered. The

reports gave a lot of detailed analysis of all governance issues from the Directorates. No issues of serious concern were noted and good practice was acknowledged.

- Quality items from the IBR were discussed in detail. The A&E performance remains below standard at 91.3% for July. Complaints remain below average but have increased in July. The threshold for Staff Compliance with Safeguarding supervision has been increased to give greater stretch.
- The Quality Dashboard was received. Appraisal figures remain red. Discharge before midday remains very low at 16.4%.
- The CQUIN scheme for 2019/20 was received for information. The financial impact of not achieving the targets was not realised due to the Aligned Incentive Contract however the Quality Committee agreed that progress to achieve the targets should be continued as they demonstrate vital improvements in patient care.
- The revised Quality Report 2019/20 was approved and new quality priorities agreed. A baseline position will be reported to the committee.
- The committee received a presentation and analysis of lessons learned from the management of COVID-19 in the Trust and the next steps in case of a second spike. This was a comprehensive analysis of the challenges that colleagues had experienced and the ways in which they felt improvements could be made. The importance of face to face communication, acknowledgement from managers and induction and training in new areas were detailed in the report. An action plan is not being developed however there are many lessons to learn that are being widely communicated. The full report and a short video are available if Board members wish to read it.

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

None to note.

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

The Quality Committee recommends the Quality Report to the Board for approval.

The Quality Committee is assured that a thorough assessment of lessons learned from COVID 19 has been undertaken and approves the way forward in case of a second spike.

Harrogate and District NHS Foundation Trust

Board of Directors Meeting (held in Public)
30 September 2020
Report of the Chief Nurse

Agenda Item Number:	**10.1**
Presented for:	Information, Discussion
Report of:	Chief Nurse
Author (s):	Chief Nurse
Report History:	None
Publication Under Freedom of Information Act:	This paper has been made available under the Freedom of Information Act 2000

Links to Trust's Objectives	
To deliver high quality care	√
To work with partners to deliver integrated care	
To ensure clinical and financial sustainability	

Recommendation:
The Board is asked to note and approve this work.

10.1

Board of Directors

30 September 2020

Chief Nurse Report

1.0 Executive Summary

1.1 The Chief Nurse Portfolio at HDFT includes professional standards and workforce development, clinical governance and risk management (shared with the Medical Director), Director for Infection Prevention and Control, Executive Lead for Adult and Children's Safeguarding, Learning Disabilities and Autism, Executive Lead for Maternity and Children's Services, professional lead for nursing and midwifery education portfolio (from September 2020), Executive Lead for Allied Health Professionals (AHP's), Freedom to Speak Up Lead and Senior Information Risk Owner (SIRO).

1.2 I will be regularly reporting on the following areas of the Chief Nurse portfolio:

- Professional standards and workforce development;
- Clinical quality and patient safety;
    - Infection prevention and control
    - Fundamental care standards
    - Patient Experience
- Adult and Children's Safeguarding; and
- Nursing, Midwifery and AHP Education

1.3 The other elements of the Chief Nurse portfolio will be reported on as required.

2.0 Introduction

2.1 The Chief Nurse report provides an overview of care quality, activities underpinning care and nursing, midwifery and AHP development. This is particularly important in our continued response to the challenging and evolving COVID -19 pandemic.

2.2 More details of key performance metrics, which are proxy indicators for quality of care are provided in the Integrated Board Report.

2.3 This is a new report style aiming, in conjunction with the Medical Director report, to provide assurance for the quality of care (safety, effectiveness and experience) and professional standards at HDFT.

3.0 Proposal

3.1 To provide a high quality, regular report of the work, performance and strategy of the HDFT Corporate Nursing Directorate, with particular emphasis on the following key areas

- Professional Standards and Workforce Development
- Clinical Quality and Patient Safety
- Adult and Children's Safeguarding
- Nursing, Midwifery and AHP education

4.0 Quality Implications and Clinical Input

4.1 Better clinical engagement within the leadership of HDFT will facilitate our ambition to provide outstanding patient outcomes and experience every time.

5.0 Equality Analysis

5.1 The Corporate Nursing team are committed to equality, diversity and inclusivity.

6.0 Financial Implications

6.1 The Chief Nurse Directorate has an agreed budget.

7.0 Risks and Mitigating Actions

7.1 There is a robust corporate nursing risk register which feeds into the Corporate Risk Register, monitored by the Corporate Risk Register Group.

8.0 Consultation with Partner Organisations

8.1 The Chief Nurse engages with a wide range of internal and external stakeholders to develop work programmes.

9.0 Monitoring Performance

9.1 Professional Standards and Workforce Development

9.1.1 EDS2

9.1.1.1 Implementation of the Equality Delivery System (EDS2) is a requirement on both NHS Commissioners and NHS Providers. HDFT's Summary Report is the nationally recommended template and designed to give an overview of the organisations most recent EDS2 implementation.

9.1.1.2 HDFT's EDS2 Summary Report is published on the Trust Website, as recommended, and is a supplementary paper supporting the Chief Nurse report. The Board approved this iteration of the EDS2 Summary Report in January 2020, when it was agreed more work was required. Our work programme 'HDFT at it's best', the 2020 – 2023 People Plan # the best place to work, the work in relation to WRES and WDES and working toward being an antiracist organisation are the vehicles for moving our organisation from achieving to excelling.

9.1.1.3 The EDS2 Summary Report will be resubmitted to the Board in January 2021.

9.2 Clinical Quality and Patient Safety

9.2.1 The CQC Covid-19 Emergency Support Framework Engagement and Support Call Summary Record

9.2.1.1 The Care Quality Commission is not routinely inspecting services during the Covid-19 pandemic but maintaining contact through existing monitoring arrangements and engagement and support call. Through the Covid-19 Emergency Support Framework, HDFT had an engagement and support call on 31 July 2020. This was to assess how HDFT is managing the impact of Covid-19 within our services and the internal and external stresses being experienced by the organisation. The CQC is tasked with gathering information from

providers to collate and share across all partners of health and Social Care to help shape the national response to the pandemic.

9.2.1.2 The CQC has issued a Summary Record outlining what they found during our meeting and is a good reflection of how HDFT has responded to the pandemic. The full Summary Record is a supplementary paper supporting the Chief Nurse report.

9.2.1.3 The CQC were assured by the Infection Prevention and Control Board Assurance Framework (IPCBAF published by NHSE/I, May 2020) which was presented to Board in May 2020. The CQC asked the IPCBAF was refreshed and represented to the Board in September 2020. All changes to the IPCBAF have been made in line with current PPE guidelines. The revised IPCBAF is a supplementary paper supporting the Chief Nurse Report.

9.2.2 Flu Campaign 2020/21

9.2.2.1 The vaccination of healthcare workers in our Trust against seasonal flu is a key action to help protect patients, staff and their families. HDFT in 2019/20 achieved an uptake of 73.6% against a national uptake rate amongst frontline staff of 74.3%. Operational planning for 2020/21 commenced in June 2020 with an evaluation of lessons learnt from last year's flu programme to inform the forthcoming programme. The evaluation of lessons learnt from last year's flu programme is a supplementary paper supporting the Chief Nurse Report.

9.2.2.2 The flu programme planning for 2020/21 aims to achieve 100% for frontline workers and is a 100% offer to all colleagues.

9.2.2.3 In May 2020, the Department of Health and Social Care (DHSC), NHS England and Improvement (NHSE/I) and Public Health England (PHE) wrote to all trusts setting out the appropriate vaccines for adults up to 64, and those 65 and over. HDFT will be providing the egg based Quadrivalent influenza vaccine (QIVe) and the adjuvant trivalent influence vaccine (aTIV) for this year's programme.

9.2.2.4 The Flu Campaign has mobilised on 21 September 2020. The flu group is currently meeting daily.

9.2.3 Healthcare Worker Flu Vaccination – Self-Assessment Management Check List

9.2.3.1 This is a requirement of DHSC, NHSE/I and PHE (letter published 5 August 2020) to be completed and approved by the Trust Board by December 2020. The checklist is live and will be updated throughout the campaign

A	Committed leadership	Trust self- assessment
A1	Board record commitment to achieving the ambition of vaccinating all frontline healthcare workers	Yes
A2	Trust has ordered and provided a quadrivalent (QIV) flu vaccine for healthcare workers	Completed. Staggered delivery from suppliers to be delivered from September 2020. First delivery has arrived. Last drop anticipated Novemeber 2020. aTIV ordered but not arrived yet
A3	Board receive an evaluation of the flu programme 2019/20, including data, successes, challenges and lessons	Evaluation completed to be delivered to the Board in September with operational plan for this years campaign in September 2020

	learnt	
A4	Agree on a board champion for flu campaign	Agreed – Jill Foster, Chief Nurse
A5	All board members receive flu vaccination and publicise this	Agreed – to be delivered in September2020
A6	Flu team formed with representatives from all directorates, staff groups and trade union representatives	The Flu team is formed from a multidisciplinary group. It meets weekly and the unions receive an update at the partnership meetings
A7	Flu team to meet regularly from September 2020	Flu meetings commence in July meeting weekly
B	**Communications plan**	
B1	Rationale for the flu vaccination programme and facts to be published – sponsored by senior clinical leaders and trades unions	Available to all staff vis Trust intranet site
B2	Drop in clinics and mobile vaccination schedule to be published electronically, on social media and on paper	Will be published via FluTrak system and via Communication Team across all platforms
B3	Board and senior managers having their vaccinations to be publicised	Will be completed by October 2020
B4	Flu vaccination programme and access to vaccination on induction programmes	There will be a peer vaccinator at induction programmes from October 2020
B5	Programme to be publicised on screensavers, posters and social media	Flu programme publicised via comms across all platforms.
B6	Weekly feedback on percentage uptake for directorates, teams and professional groups	Weekly feedback to be provided via Flu Trak and disseminated across the organisation
C	**Flexible accessibility**	
C1	Peer vaccinators, ideally at least one in each clinical area to be identified, trained, released to vaccinate and empowered	Peer Vaccinators identified for each area and have received training materials
C2	Schedule for easy access drop in clinics agreed	Clinics, drop in clinics and roving vaccinators are planned.
C3	Schedule for 24 hour mobile vaccinations to be agreed	Coverage planned for night shifts

D	Incentives	
D1	Board to agree on incentives and how to publicise this	Small incentive of flu fighter badges ordered
D2	Success to be celebrated weekly	Colleagues will be updated on a weekly basis

9.2.3.2 The Healthcare Worker Flu Vaccination Campaign 2020/21 and operational plan went to SMT on 23 September 2020 and is a supplementary paper supporting the Chief Nurse report.

9.2.4 NHS Resolution – 10 maternity safety actions (Year 3) - update

9.2.4.1 The maternity incentive scheme applies to all acute trusts that deliver maternity services and are members of the CNST and the incentive scheme incentivises 10 maternity safety actions. NHS Resolution is operating a 3rd year of the scheme to continue supporting the delivery of safer maternity care.

9.2.4.2 In year 2 (2019) the department achieved full compliance with all 10 maternity safety actions, a significant improvement from year 1 having achieved full compliance with 5 of 10 safety actions. We remain fully compliant with year 2 safety actions but year 3 saw some changes to the standards within each requirement.

9.2.4.3 Year 3 was due to commence in March 2020 and to be completed by submission of evidence (after Trust Board sign off) by August 2020. Due to the Covid-19 pandemic the relaunch of the scheme has been delayed to October 1st 2020 in line with the Maternity Transformation Programme and submission of the board declaration form has been deferred to 2021 (submission date TBC). While the reporting requirements were paused, trusts were asked to continue to apply the principles of the 10 safety actions which the department have done. The timeframe for submission and a revised board declaration form are currently being reviewed by the advisory group and planned to be shared with trusts in the coming weeks.

9.2.4.4 We are currently awaiting the changes to the original standards (year 3) within each safety action however we have been informed that there will be no changes to safety actions 1, 3, 7 and 10. There will be additional elements within some safety actions to ensure that learning from important, emerging Covid-19 themes is rapidly implemented by maternity services, in particular safety action 8 (multi-disciplinary training).

9.2.4.5 Known changes:

9.2.4.6 Safety action two – maternity service data set

- Item 14 on the Maternity Record Standard has been removed from action two and will be progressed separately by NHSX. NHS Digital announced on 1 April 2020 that the Digital Maternity Record Standard (DMRS) compliance date had been delayed from **Monday 30 November 2020 to Sunday 28 February 2021**.

9.2.4.7 Safety action six – saving babies lives care bundle (SBLCB)

- During the Covid-19 pandemic it has been difficult to implement some elements of SBLCB, in particular carbon monoxide testing which has been suspended. Compliance with this element will therefore require an audit based on the percentage of women asked whether they smoke at booking and at 36 weeks' gestation if carbon monoxide testing has not been reinstated.

9.2.4.8 Safety action eight – multi-disciplinary training

- NHS Resolution appreciates that local face to face, multi-professional training has not been possible due to Covid-19. When it is possible to resume training, social distancing/Covid-19 precautions will still affect the ability of units to provide face-to face-training.
- As an interim arrangement, it is recognised that traditional 'hands-on' drills and skills/in situ simulations may not be possible or practical for the immediate future interim arrangements will include local multidisciplinary training being provided as a local, half-day virtual/on-line training package as an alternative option for local MIS training requirements.
- If any 'hands-on' training is undertaken, as with clinical work, teams should follow the current guidance in relation to infection prevention control procedures, social distancing and personal protective equipment requirements, to ensure staff safety.

9.2.4.9 Safety action 9 – Trust safety champions

- Escalation of locally identified issues to include change to date of continuity of carer

9.2.4.10 When we receive confirmation of the agreed year 3 10 maternity safety actions and changes we will benchmark ourselves against these and update trust board of current status and progress between October 2020 and March 2021.

9.3 Adult and Children's Safeguarding during COVID-19

9.3.1 HDFT Adult safeguarding activity during the months of April, May June and July 2020 is as follows:

	April 2020	May 2020	June 2020	July 2020
Raised by the Trust	8	8	13	12
Raised against the Trust	0	2	6	3

The average number of concerns raised by the Trust in 2019/20 was 10.5 per month. The average number of concerns raised against the Trust was 4.6 per month.

9.3.2 The safeguarding concerns raised by the Trust over the first 3 months were mainly for neglect in care home settings, domestic abuse and self-neglect. In July, there were none for neglect but there were still a number for domestic abuse and self-neglect.

9.3.3 Most concerns against the Trust were raised by ourselves for neglect. This is mainly due to omissions in care following an RCA for pressure ulcers. Others include a fall resulting in a fracture and an alleged missed fracture.

9.3.4 The usual safeguarding procedures and processes were followed during this time however for the first 3 months' external meetings including sub groups of the Safeguarding Adult Board were cancelled. Reports of domestic abuse highlighted at swabbing stations, prompted the development of information for ED re support and signposting for victims who made a disclosure during the pandemic. Safeguarding (and LD) support was made available 7 days /week initially however this was not required so the usual hours of service were resumed.

9.3.5 For the first 3 months' internal face to face level 2 training safeguarding training was paused but this was recommenced in July. E learning figures have remained consistent. The SG/LD link worker face-to-face meetings were also postponed and have been replaced with a newsletter, the first of which was well received.

9.3.6 The Adult Safeguarding Annual Report 2019/20 is a supplementary paper supporting the Chief Nurse report

9.4 Nursing, Midwifery and Allied Health Professional (AHP) Education

9.4.1 A bid had been submitted to HEE to increase nurse pre-registration places at HDFT by 20%. We have received an indication that this bid has been successful but HEE has not mobilised this at time of writing this report

9.4.2 The strategic lead for AHP's is working collaboratively with the HCV Council Faculty to increase the number of AHP students across the HCV footprint. They were successful in getting half the £250k bid so £125K – the expectation is to employ to a post that will support the roll out of a model to improve placement expansion across the patch and purchase of laptops for provider organisations. Within HCV, HDFT are only commissioned by YSJ University for OT/PT placements so we will be focussing on those professions.

9.5 Future Freedom to Speak Up Guardian (FTSUG) Arrangements

9.5.1 The move toward a new model is going well. We had 38 expressions of interest, with colleagues from most staff groups represented and a number of colleagues who identify themselves from a Black, Asian or Minority Background. The process of selection is making progress with our interim FTSUG's meeting the applicants for a short problem solving exercise to talk through a typical scenario. The FTSUG's will then make a recommendation of who to move forward in the process.

9.5.2 All colleagues, who have expressed an interest, will be asked if they would like to be a Fairness Champion.

9.5.3 The interim arrangements continue to work well.

10 Recommendation

10.1 The Board is recommended to approve the content of this report**.**

11 Supporting Information

11.1 The following papers make up and support this report:

- The EDS2 Summary Report
- The CQC Engagement and Support Call Summary Record
- The IPCBAF (September 2020)
- The Safeguarding Adults Annual Report 2019/20
- The evaluation of lessons learnt from last year's flu programme

Equality Delivery System for the NHS
EDS2 Summary Report

Implementation of the Equality Delivery System – EDS2 is a requirement on both NHS commissioners and NHS providers. Organisations are encouraged to follow the implementation of EDS2 in accordance with the '9 Steps for EDS2 Implementation' as outlined in the 2013 EDS2 guidance document. The document can be found at: **http://www.england.nhs.uk/wp-content/uploads/2013/11/eds-nov131.pdf**

This *EDS2 Summary Report* is designed to give an overview of the organisation's most recent EDS2 implementation. It is recommended that once completed, this Summary Report is published on the organisation's website.

NHS organisation name:

Harrogate and District NHS Foundation Trust

Organisation's Board lead for EDS2:

Jill Foster, Chief Nurse

Organisation's EDS2 lead (name/email):

Angie Colvin, Equality, Diversity and Inclusion Lead (angie.colvin@nhs.net)

Level of stakeholder involvement in EDS2 grading and subsequent actions:

Stakeholders invited to review, comment and agree EDS2 grading included this year:

HDFT Learning from Patient Experience Group - includes members of staff across Directorates.
HDFT Stakeholder Equality Group - includes stakeholders representing protected characteristics and from disadvantaged groups.
HDFT Workforce Equality Group.
HDFT Council of Governors.
HDFT Youth Forum.
Trade Union Representatives.

Organisation's Equality Objectives (including duration period):

These are our objectives for 2018-2020:
1. To ensure that our services provide effective and safe treatment and care that is sensitive to people's personal and cultural needs as well as appropriate to their clinical condition.
2. To strengthen our systems and processes to meet the requirements of the Accessible Information Standard, to continue to work with patients with learning disabilities to provide even better patient access and experience, and to introduce the Patient Participation Strategy.

Headline good practice examples of EDS2 outcomes (for patients/community/workforce):

We have this year progressed work in relation to:
Launched Policy for supporting Transgender patients, service users and staff, quick guide poster and resources on the intranet and staff training.
Launched NHS Rainbow Badge to promote HDFT as an open, non-judgemental and inclusive place for people that identify as LGBT+.
Ongoing work to progress a consistent process to meet all requirements of the Accessible Information Standard. Outpatient letters available in Braille and other languages as required.
Video remote interpreting for British Sign Language and ten core languages.
Evidence of learning from complaints related to protected characteristics.

Publication Gateway Reference Number: 03247

Date of EDS2 grading January 2020 **Date of next EDS2 grading** January 2021

Goal	Outcome	Grade and reasons for rating	Outcome links to an Equality Objective
Better health outcomes	1.1	**Services are commissioned, procured, designed and delivered to meet the health needs of local communities** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: ✓ Age; ☐ Disability; ✓ Gender reassignment; ☐ Marriage and civil partnership; ✓ Pregnancy and maternity; ✓ Race; ☐ Religion or belief; ✓ Sex; ✓ Sexual orientation Evidence drawn upon for rating: Evidence from previous years and: Work progressing with meeting all requirements of the Accessible Information Standard. Outpatient letters available in Braille and other languages as required. Video remote interpreting for British Sign Language and ten core languages. Launched Policy for supporting Transgender patients, service users	✓
	1.2	**Individual people's health needs are assessed and met in appropriate and effective ways** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: ✓ Age; ☐ Disability; ✓ Gender reassignment; ☐ Marriage and civil partnership; ✓ Pregnancy and maternity; ✓ Race; ☐ Religion or belief; ✓ Sex; ✓ Sexual orientation Evidence drawn upon for rating: Evidence from previous years and: As above	✓
	1.3	**Transitions from one service to another, for people on care pathways, are made smoothly with everyone well-informed** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: ✓ Age; ☐ Disability; ✓ Gender reassignment; ☐ Marriage and civil partnership; ✓ Pregnancy and maternity; ✓ Race; ☐ Religion or belief; ✓ Sex; ✓ Sexual orientation Evidence drawn upon for rating: Evidence from previous years and: Regarding young people entering adult health services - Commenced 'Ready Steady Go' programme (initially introduced at University Hospital Southampton NHS Trust) - a suite of resources designed to deliver high-quality transition for young people across all sub-specialties. Children's Community LD Team hold regular transition meetings	✓

Goal	Outcome	Grade and reasons for rating	Outcome links to an Equality Objective
Better health outcomes, continued	1.4	**When people use NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: ✓ Age; ☐ Disability; ☐ Gender reassignment; ✓ Marriage and civil partnership; ✓ Pregnancy and maternity; ✓ Race; ✓ Religion or belief; ✓ Sex; ✓ Sexual orientation Evidence drawn upon for rating: Evidence from previous years and: All patient safety work - safety alerts; Datix RPIW; learning from events and deaths; ChatterMatters - safety focused newsletter for staff published regularly. New and updated policies Policies on a page Work to integrate Human Factors into patient safety work.	✓
	1.5	**Screening, vaccination and other health promotion services reach and benefit all local communities** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: ✓ Age; ✓ Disability; ✓ Gender reassignment; ✓ Marriage and civil partnership; ✓ Pregnancy and maternity; ✓ Race; ✓ Religion or belief; ✓ Sex; ✓ Sexual orientation Evidence drawn upon for rating: Evidence from previous years and: Public health work continues to reduce inequalities in health with Gypsy, Roma and Traveler population with specialist health promotion. Active community health promotion at community events.	✓
Improved patient access and experience	2.1	**People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: ✓ Age; ☐ Disability; ✓ Gender reassignment; ✓ Marriage and civil partnership; ✓ Pregnancy and maternity; ✓ Race; ✓ Religion or belief; ✓ Sex; ✓ Sexual orientation Evidence drawn upon for rating: Evidence from previous years and: Work progressing with meeting all requirements of the Accessible Information Standard Changing Places facility Impact Assessment Policy	✓

Goal	Outcome	Grade and reasons for rating	Outcome links to an Equality Objective
Improved patient access and experience	2.2	**People are informed and supported to be as involved as they wish to be in decisions about their care** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: ☐ Age; ☐ Disability; ☐ Gender reassignment; ☑ Marriage and civil partnership; ☑ Pregnancy and maternity; ☑ Race; ☑ Religion or belief; ☑ Sex; ☑ Sexual orientation Evidence drawn upon for rating: Evidence from previous years and: Work progressing with meeting all requirements of the Accessible Information Standard Launched Patient Participation Strategy Policy to support Transgender patients, service users and staff	✓
	2.3	**People report positive experiences of the NHS** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: ☑ Age; ☐ Disability; ☐ Gender reassignment; ☑ Marriage and civil partnership; ☑ Pregnancy and maternity; ☑ Race; ☑ Religion or belief; ☑ Sex; ☑ Sexual orientation Evidence drawn upon for rating: Evidence from previous years and: Continue to analyse information from recent patient surveys - national and local	✓
	2.4	**People's complaints about services are handled respectfully and efficiently** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: ☑ Age; ☑ Disability; ☑ Gender reassignment; ☑ Marriage and civil partnership; ☑ Pregnancy and maternity; ☑ Race; ☑ Religion or belief; ☑ Sex; ☑ Sexual orientation Evidence drawn upon for rating: Evidence from previous years and: Evidence of learning from complaints related to protected characteristics RPIW Complaints process. EDI Lead available for advice and guidance.	✓

Goal	Outcome	Grade and reasons for rating	Outcome links to an Equality Objective
A representative and supported workforce	3.1	**Fair NHS recruitment and selection processes lead to a more representative workforce at all levels** **Grade:** Undeveloped / Developing / Achieving / Excelling **Which protected characteristics fare well:** ✓ Age; ☐ Disability; ✓ Gender reassignment; ☐ Marriage and civil partnership; ✓ Pregnancy and maternity; ✓ Race; ☐ Religion or belief; ✓ Sex; ✓ Sexual orientation **Evidence drawn upon for rating:** See evidence from previous years. Rapid Process Improvement Workshop to focus on recruitment and selection processes. Some improvements noted in the 2019 WRES submission in relation to BAME colleagues being appointed following shortlisting.	✓
	3.2	**The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations** **Grade:** Undeveloped / Developing / Achieving / Excelling **Which protected characteristics fare well:** ✓ Age; ✓ Disability; ✓ Gender reassignment; ✓ Marriage and civil partnership; ✓ Pregnancy and maternity; ✓ Race; ✓ Religion or belief; ✓ Sex; ✓ Sexual orientation **Evidence drawn upon for rating:** See evidence from previous years. WRES and Pay Gap information published Action plans for Pay Gap, WRES and EDS2 to be taken forward	✓
	3.3	**Training and development opportunities are taken up and positively evaluated by all staff** **Grade:** Undeveloped / Developing / Achieving / Excelling **Which protected characteristics fare well:** ✓ Age; ✓ Disability; ✓ Gender reassignment; ✓ Marriage and civil partnership; ✓ Pregnancy and maternity; ✓ Race; ✓ Religion or belief; ✓ Sex; ✓ Sexual orientation **Evidence drawn upon for rating:** See evidence from previous years. WRES data Staff survey Appraisal process and monitoring All indicate good uptake Commenced pilot of First Line Leadership Progamme with positive evaluation.	✓

Goal	Outcome	Grade and reasons for rating	Outcome links to an Equality Objective
A representative and supported workforce	3.4	**When at work, staff are free from abuse, harassment, bullying and violence from any source** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: ✓ Age; ☐ Disability; ☐ Gender reassignment; ✓ Marriage and civil partnership; ✓ Pregnancy and maternity; ☐ Race; ☐ Religion or belief; ✓ Sex; ☐ Sexual orientation Evidence drawn upon for rating: Evidence from previous years. Staff survey data Fair and Just Culture work / Fairness Champions Staff Networks being progressed. Participation in NHS England's Workforce Race Equality Standard (WRES) Experts Programme	✓
	3.5	**Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: ✓ Age; ✓ Disability; ✓ Gender reassignment; ✓ Marriage and civil partnership; ✓ Pregnancy and maternity; ✓ Race; ✓ Religion or belief; ✓ Sex; ✓ Sexual orientation Evidence drawn upon for rating: See evidence from previous years. Flexible working policy and appeal process No central data so limited evidence Bigger departments - annual review of flexible working No evidence of concerns related to protected groups	✓
	3.6	**Staff report positive experiences of their membership of the workforce** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: ✓ Age; ✓ Disability; ✓ Gender reassignment; ✓ Marriage and civil partnership; ✓ Pregnancy and maternity; ✓ Race; ✓ Religion or belief; ✓ Sex; ✓ Sexual orientation Evidence drawn upon for rating: See evidence from previous years. Staff survey results Staff FFT results Listening events Freedom to speak up	✓

Goal	Outcome	Grade and reasons for rating	Outcome links to an Equality Objective
Inclusive leadership	4.1	**Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations** **Grade:** Undeveloped / Developing / Achieving / Excelling **Which protected characteristics fare well:** ✓ Age; ✓ Disability; ✓ Gender reassignment; ✓ Marriage and civil partnership; ✓ Pregnancy and maternity; ✓ Race; ✓ Religion or belief; ✓ Sex; ✓ Sexual orientation **Evidence drawn upon for rating:** Evidence from previous years and: Fair and Just culture work Youth Forum CQC inspection Patient and Public Participation Strategy EDI role Participation in WRES Experts programme	✓
	4.2	**Papers that come before the Board and other major Committees identify equality-related impacts including risks, and say how these risks are to be managed** **Grade:** Undeveloped / Developing / Achieving / Excelling **Which protected characteristics fare well:** ✓ Age; ✓ Disability; ✓ Gender reassignment; ✓ Marriage and civil partnership; ✓ Pregnancy and maternity; ✓ Race; ✓ Religion or belief; ✓ Sex; ✓ Sexual orientation **Evidence drawn upon for rating:** Evidence from previous years and: Front sheet with impact assessment introduced October 2017	✓
	4.3	**Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination** **Grade:** Undeveloped / Developing / Achieving / Excelling **Which protected characteristics fare well:** ✓ Age; ✓ Disability; ☐ Gender reassignment; ✓ Marriage and civil partnership; ✓ Pregnancy and maternity; ☐ Race; ✓ Religion or belief; ✓ Sex; ☐ Sexual orientation **Evidence drawn upon for rating:** Evidence from previous years and: Fair and just culture work Pathway to management First Line Leadership Programme Values and behaviours embedded and linked to appraisal Managers appraisal linked to staff appraisal and pay progression Coaching support network and mentoring being developed	✓

COVID-19 Emergency Support Framework

Engagement and support call

Summary Record

Harrogate and District NHS Foundation Trust

Location / Core Service address	Date
Harrogate District Hospital Harrogate and District NHSFT Lancaster Park Road Harrogate HG2 7SX	11/08/2020

Dear Harrogate and District NHS Foundation Trust

The Care Quality Commission is not routinely inspecting services during the COVID-19 pandemic. We are maintaining contact with providers through existing monitoring arrangements and engagement and support calls covering four assessment areas:

- Safe Care and Treatment
- Staffing arrangements
- Protection from Abuse
- Assurance Processes, Monitoring and Risk Management

This Summary Record outlines what we found during the engagement and support call shown above, using standard sentences and an overall summary.

We have assessed that you are managing the impact of the COVID-19 pandemic at the above service. The overall summary includes information about the internal and external stresses you are currently experiencing, how they are being managed, and sources of support that are available.

Emergency Support Framework calls and other monitoring activity are not inspections. Summary Records are not inspection reports. Summary Records are not published on our website.

Assessment Area 1

Safe care and treatment

1.1	Are infection risks to people using the service being thoroughly assessed and managed?
Yes	Infection risks to people using the service are being thoroughly assessed and managed.

1.2	Does the service have the resources to obtain, and reliable access to, all the supplies, personal protective equipment and C-19 testing it needs, for both staff and people who use the service?
Yes	The service has reliable access to the right personal protective equipment and C-19 testing for both staff and people who use the service.

1.3	Does the location's environment and layout support preventing and containing transmission of infection?
Yes	The location's environment supports the preventing and containing the transmission of infection.

1.4	Are working arrangements and procedures clear and accessible to staff, people who use the service, their supporters, and visitors to the service?
Yes	Working arrangements and procedures are clear and accessible to staff, people who use the service, their supporters, and visitors to the service.

1.5	Are medicines being managed safely and effectively?
Yes	Medicines are being managed safely and effectively.

1.6	Are risks to the health of people using the service being properly assessed, monitored and managed?
Yes	Risks to the health of people using the service are being properly assessed, monitored and managed.

Assessment Area 2

Staffing arrangements

2.1	Are there sufficient numbers of suitable staff to provide safe care and treatment in a dignified and respectful way?
Yes	There were enough suitable staff to provide people with safe care in a respectful and dignified way.

2.2	Are there realistic and workable plans for managing staffing levels if the pandemic or other causes lead to shortfalls and emergencies?
Yes	There were realistic and workable plans for managing any staffing shortfalls and emergencies.

Assessment Area 3

Protection from abuse

3.1	Are people using the service being protected from abuse, neglect, discrimination and loss of their human rights?
Yes	People were being protected from abuse, neglect, discrimination, and loss of their human rights.

3.2	Are the service's safeguarding and other policies and practice, together with local systems, properly managing any concerns about abuse and protecting people's human rights?
Yes	Safeguarding and other policies and practice, together with local systems, are properly managing any concerns about abuse and protecting people's human rights.

Assessment Area 4

Assurance processes, monitoring and risk management

4.1	Is the provider monitoring and protecting the health, safety and wellbeing of staff?
Yes	The provider is monitoring and protecting the health, safety and wellbeing of staff.

4.2	Does the provider have effective systems and methods for monitoring the overall quality of the service and for responding to business risks and issues as they arise?
Yes	The provider's systems and methods for monitoring the overall quality of the service and for responding to business risks and issues as they arise are effective.

4.3	Is the provider supporting staff and people who use the service to raise any concerns and give feedback?
Yes	Staff are supported to raise concerns and give feedback about the service.

4.4	Is care and treatment provided to people being properly recorded?
Yes	Care and treatment provided to people is being properly recorded.

4.5	Is the provider able to work effectively with system partners when care and treatment is being commissioned, shared or transferred?
Yes	The provider is able to work effectively with system partners when care and treatment is being commissioned, shared or transferred.

Overall summary

Summary Report.

We had a meeting with the trust on 31/07/2020, during this meeting different areas of the board assurance framework were discussed in relation to infection prevention and control. The board assurance framework was presented to the trust board in

May 2020, who felt assured that the framework was appropriate and no significant changes were required.

The trust has undertaken a thorough assessment of infection prevention and control, across all services, since the pandemic of Covid 19 was declared. Appropriate systems in place include having prompt identification of people within the organisation who have or are at risk of developing an infection. Appropriate isolation facilities and cohorting areas have been established for patients across the trust.

Staff have received, and continue to receive necessary training, in line with national guidance and are updated accordingly. The trust continues to provide information for carers and the wider public through their website and social media. The trust continues to ensure that the health needs of staff are met. This is a supportive and holistic approach which considers both the physical and psychological needs of staff. All care workers, to include volunteers and external contractors, are given sufficient information to ensure that they are aware of and discharge their responsibilities in preventing and controlling infection. The trust has a system of escalation in relation to PPE should difficulties arise, which staff can access throughout the 24-hour period, across seven days a week.

Additional information.

The Trust have commenced listening forums and instigated active recruitment of BAME staff into decision making forums/command structure (bronze cells).

What's gone well?

Agile decision making which has allowed changes to be implemented much more rapidly, for example the policy covering patient demand for NIV/ITU.

Opportunities for reflection and learning.

Staff engagement has not always been sought in decision making due to the necessity to make quick decisions. The lack of engagement has led to a negative impact on staff morale as rapid changes such as staff movement to different areas has impacted on established teams affecting ward identity.

The current PPE management and acquisition was the responsibility of one member of staff, in future this would have a dedicated team to manage.

In the event of a future outbreak/pandemic the trust would task the IPC teams differently to ensure they are more visible in their role on the wards/departments.

The trust would be more effective earlier in any future pandemics as they have learnt what works.

Innovative Practice

The trust was ahead of country in re-instating visitors which had a positive effect on

staff, patients and visitors

The trust is attempting to source clear facemasks to aid hearing impaired/lip reading. The trust have introduced a risk assessment policy to allow staff to remove facemask in order to communicate with those patients who require additional communication support.

The trust has commenced a programme writing to staff members' children-thanking them for letting parents come to work.

Psychological support services being made available to staff without the need for manager referrals.

Current challenges.

Resetting services to a volume level that has sufficient impact on patients.
Ensuring all necessary facilities are appropriate for undertaking aerosol generating procedures.
Normal winter planning challenges but factoring in planning for any resurgence of covid infections.

Infection Prevention and Control Board Assurance Framework

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 checklist / pathway for both walk in and admitted patients including emergency admissions and outpatient appointments in accordance with national guidance. • 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 safety. A Discharge	• The gaps in assurance are in relation to ensuring that the rapidly changing information is noted by the teams within the Trust.	• Regular Trust News bulletins. IPC Team visited all wards and departments to inform them of the recent changes in the checklist questions as per national guidance.

	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.		
• patients and staff are protected with PPE, as per the PHE national guidance	• Appropriate PPE has been provided to all staff within the Trust with reference materials to promote the safe donning and doffing of the PPE. The Trust has provided PPE photos/posters and checklists to support this. Patients are provided with the appropriate PPE for use within the hospital site.		
• national IPC guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way	• IPC national guidance is received via the Trust Incident Command Centre (ICC). The guidance is reviewed and cascaded to hospital teams as appropriate using the covid-19 response command 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.		

• 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	• 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.		
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	• 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 with appropriate training in required techniques and use of PPE, are assigned to COVID-19 isolation or cohort areas.	• 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 and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE and other national guidance	• Decontamination of patient areas are carried out in line with PHE IPC guidelines as per the IPC policy/protocol.		
• 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	• Linen used in patient areas is processed in		

confirmed COVID-19 patients is managed in line with PHE and other national guidance and the appropriate precautions are taken	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.		
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	• 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	• 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.

• mandatory reporting requirements are adhered to and boards continue to maintain oversight	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).		
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	• 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 current national guidance.		
• areas in which suspected or confirmed COVID-19 patients are where possible being treated in areas clearly marked with appropriate signage and have	• 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.		

restricted access • information and guidance on COVID-19 is available on all Trust websites with easy read versions • infection status is communicated to the receiving organisation or department when a possible or confirmed COVID-19 patient needs to be moved	• 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 information has been made available. • Relevant information is being given to the receiving unit when a patient is discharged from the Trust.		
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	• 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.		
• 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-tested • patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately	• All inpatients are swabbed for covid-19 on admission or if symptoms develop. Elective care patients are swabbed 72 hours before admission prior to them attending the hospital for their procedure. • Patients who test negative but are 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.	• There were concerns from the CSM team that the results for NTAP patients were not coming back soon enough to support with the flow of patients through the hospital.	• A flow cart to support with the testing and moving of patients was pulled together by the clinical director to support the clinicians on the wards.
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 team as required.		
• appropriate arrangements are in	• An SOP has been drafted by the Trust to		

place that any reuse of PPE in line with the CAS alert is properly monitored and managed	support in the reuse of visors. 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	• An audit was undertaken in September to review compliance with PPE a part of a QIP initiativie on PPE and Monthly audits (IPQAT) have re-commenced which include 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 use of PPE.		
• staff regularly undertake hand hygiene and observe standard infection control precautions	• 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 and on all soap dispensers.		

• 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.	• 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 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 Trust's bulletins. 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 were not able to launder their uniforms appropriately.	• The offer of scrubs was made to certain members of staff as these can be laundered though the Trust linen contract.
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	• 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 paediatrics have developed		

• 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	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.		
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	• 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. Guidance for swabbing was produced by IPC. • Patients are swabbed at the point of admittance into the Trust. Testing of symptomatic staff is in accordance with national guidance and advice provided to all		

national guidance • screening for other potential infections takes place	line managers of the procedure. • Patients are still screened for other potential infections whilst admitted in the Trust and these are being managed as per normal IPC guidelines.		
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-	• 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		

19 cases is handled, stored and managed in accordance with current national guidance • PPE stock is appropriately stored and accessible to staff who require it	intranet. • PPE supplies are managed centrally by the PPE Team. A Trust sitrep of stock levels is provided to the PPE team daily and supplies provided to wards/departments as appropriate. There is a dedicated number for wards to call if there is a shortage of supplies.		
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 Trust bulletins and is on the front page of the website. 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	• Staff who require the use of FFP respirators have undergone training. Staff in key areas have been trained to undertake fit testing of staff in their area. All training is logged via the ESR portal so that compliance can be		

record of this training is maintained • staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing • staff that test positive have adequate information and support to aid their recovery and return to work.	monitored and a certificate given to staff. • Staff absence and wellbeing is monitored through the covid-19 HR inbox and wellbeing advice is regularly circulated. • The staff member's line Manager will make contact as per the HR sickness policy, provide advice and maintain contact with the member of staff during their period of sickness.		

FLU CAMPAIGN REPORT 2019/2020

The annual flu vaccination campaign aims to offer and promote flu vaccination to all staff, however particular emphasis is placed on encouraging and monitoring uptake amongst clinical staff and other frontline support staff in line with NHS England requirements. Uptake amongst clinical/frontline healthcare workers is monitored at regional and national levels.

This report is compiled without the background information usually available from regional or local post campaign review due to the emergence of the coronavirus pandemic in the UK. This exercise aims to summarise the preceding year's progress and future areas for improvement, benchmarking against national performance. The following report therefore represents key points taken from information available in the previous flu campaign report of 2018/19, minutes of steering group meetings and that from national and Trust metrics for 2019/20.

The scope of the annual campaign covered provision of flu vaccination for all staff groups in all areas through a combination of:

• drop-in vaccination sessions provided by the Trust's Occupational Health (OH) team at Harrogate District Hospital and a number of community locations
• drop-in sessions delivered by our OH service partners in other regional trusts
• trained peer vaccinators located in both the hospital and community
• employee reports of vaccinations accesses elsewhere e.g. by GP service and, when requested, via individual appointment in an OH unit

A significant amount of time and resource is required to plan, organise and implement the campaign - effort shared by a multi-disciplinary staff team. This work was undertaken without additional backing to support extra seasonal activity.

Seasonal Flu Vaccine Uptake (Frontline Healthcare Workers)

2018/19 was the second year of a CQUIN[i] scheme relating to the uptake of flu vaccination by clinical/frontline healthcare workers. The target for 2018/19 was 75%. HDFT uptake in this group was 61.7% (n=2308)

During 2019/20 the uptake of vaccination by frontline healthcare workers in Harrogate at 73.6% represents the highest level since records commenced - an increase from 61.7% in 2018/19. The 2019/20 national uptake was recorded at 74.3%.

Flu vaccination % uptake for all Harrogate staff* as of 26th February 2020

Number Vaccinated	Headcount	% Vaccinated
Including HIF 3,047	4,736	64.34%
Excluding HIF 2,900	4,404	65.85%

*Including bank only contracts, but excluding employees on career breaks, maternity leave, external secondment, suspension and LTS over 3 months.

2019/20sef

Flu vaccination as of 9th March 2020 Harrogate Vaccination Uptake % - Clinical Staff

HEE Grouping	Vaccinated	Headcount	% Vaccinated
Medical and Dental	284	369	76.96%
Qualified Nurses	1,193	1,628	73.28%
Other Qualified Clinical Staff	387	484	79.96%
Support to Clinical Staff	883	1,249	70.70%

TOTAL CLINICAL	2,747	3,730	73.65%
Non Clinical	215	317	67.82%

To achieve 75% uptake of clinical staff, a further 50 clinical employees required vaccination.

Peer Vaccinators

For 2018/19 the Trust had 49 trained peer vaccinators in a variety of locations, both Acute and Community. In 2019/20 records indicate a significant increase in the number of listed peer vaccinators by 53 to 102 for both community and hospital sites.

Communications

Communications about the campaign, availability of vaccination sessions and peer vaccinators were issued via email Staff Bulletins and a dedicated Flu Vaccination intranet page.

The free NHS Flu campaign promotional posters/leaflets and imagery were used to create a single recognisable theme used on all communications relating to the flu campaign. A number of the Executive team were photographed having their vaccinations at the launch of the campaign and social media was used to encourage staff further to access the vaccination.

Communications were sent from the senior leadership team – the Chief Executive, the Chief Nurse and the Medical Director, encouraging staff to have the vaccination.

A flu 'totalizer' was also sent out weekly with an update of how many vaccinations had been issued across the Trust and within individual Directorates.

2019/20sef

Future Considerations for 2020/21 flu campaign

Planning	• Timely development of a project management plan (defining team responsibilities, key stakeholders, objectives and milestones) • Present strategy paper for the forthcoming flu campaign to the Executive team following completion of the previous year's campaign
Resource Requirements	• Consider the value and use of incentives in future campaigns (employees and peer vaccinators) • Equipment: establish requirement for vaccine administration packs also storage (fridges and cool bags) in community locations • Distribution and control of vaccine stock – hospital and community sites.
Peer Vaccinators	• Minimum requirement for peer vaccinators per headcount. • Recruitment methods for peer vaccinators across HDFT • Training requirement: Face to face/e-learning package – time to attend. • Clear information available about role expectation. • Designated responsibility for coordinating peer vaccinations: site locations, anticipated vaccination numbers, stock storage (fridges) and collection points. Data collection and management • Visibility of peer vaccinators i.e. badges & laminated information posters
Communications	• Communications plan as part of overall project plan with key messages to engage all stakeholders • Use of a variety of formats in which to deliver key messages i.e. intranet pages, social media, posters with clear & consistent branding • Consider the key messages – how these are perceived by employees • Communicate detail for peer vaccinators – sessions, name etc. • Communications to focus on outcomes from analysis of reasons for declining vaccination
Recording & Inputting of data	• Data management as part of project plan (electronic and/or paper based capture) • Dedicated resource – IT systems and admin support • Agreeing what/when data is needed • Guidance/principles for recording (confidential) information
Contingency plans for outbreak	• Agree principles with exec team of how to manage an outbreak • Swabbing • PPE • Redeployment

[i] https://www.england.nhs.uk/nhs-standard-contract/cquin/cquin-17-19/

2019/20sef

Harrogate and District NHS Foundation Trust

Board of Directors (held in Public)
30 September 2020
Flu Campaign 2020/21

Agenda Item Number:	**10.2**
Presented for:	Discussion, Information
Report of:	Chief Nurse
Author (s):	Chief Nurse
Report History:	Senior Management Team (23 September 2020)
Publication Under Freedom of Information Act:	This paper has been made available under the Freedom of Information Act 2000

Links to Trust's Objectives	
To deliver high quality care	√
To work with partners to deliver integrated care	
To ensure clinical and financial sustainability	

10.2

Recommendation:
The Board is asked to discuss and note the information in this paper.

Healthcare Worker Flu Vaccination Campaign 2020/21

1.0 Introduction

1.1 The purpose of this report is to inform SMT about the progress of the Trust Healthcare Worker Flu Vaccination Campaign 2020/21 assessed against the national best practice management checklist produced by NHS Senior Leaders on 5 August 2020 and the lessons learnt from HDFT's Flu Campaign in 2019/20.

1.2 This year's campaign will commence on 21 September 2020.

2.0 Background

2.1 The vaccination of healthcare workers in our Trust against seasonal flu is a key action to help protect patients, staff and their families. HDFT in 2019/20 achieved an uptake of 73.6% against a national uptake rate amongst frontline staff of 74.3%. Operational planning for 2020/21 commenced in June 2020 with an evaluation of lessons learnt from last year's flu programme to inform the forthcoming programme. See supporting paper in Appendix 1.

2.2 The flu programme planning for 2020/21 aims to achieve 100% for frontline workers and is a 100% offer to all colleagues.

2.3 In May 2020, the Department of Health and Social Care (DHSC), NHS England and Improvement (NHSE/I) and Public Health England (PHE) wrote to all trusts setting out the appropriate vaccines for adults up to 64, and those 65 and over. HDFT will be providing the egg based Quadrivalent influenza vaccine (QIVe) and the adjuvant trivalent influence vaccine (aTIV) for this year's programme.

3.0 Challenges

3.1 The greatest challenges of the 2019/20 campaign were

- Uncertainty, staggered and late delivery of supply of vaccine
- Lack of control of stock of vaccine
- Recording and reporting vaccination administration

4.0 Operational Plan

4.1 The operational planning for this year's campaign had been focused on learning from our previous campaigns.

4.2 The Trust has invested in the Flu-Trak management system.

Flu-Trak is a flu vaccination campaign management tool specifically designed to drive improved uptake of annual flu vaccinations by systematically managing the communication, delivery and reporting of the Trust flu campaign. It is a user friendly cloud based software reduces the need for manual, paper based processes by consolidating staff data into one system, reducing hand-offs and errors.

We know to have an effective flu vaccination campaign requires significant coordination and resource management including:

* Identifying frontline workers requiring vaccination
* Planning and adapting vaccination capacity
* Effective communication to staff
* Real time performance reporting

This system has gone live in the Trust.

4.3 Actions Completed

- Start date agreed
- Flu-Trak purchased and mobilised
- Publicity Campaign commenced
- Vaccine ordered and first delivery received
- Frontline colleagues identified
- Groups of colleagues to target in first 3 weeks agreed
- Control of stock and distribution agreed via pharmacy
- Peer vaccinator training materials agreed and distributed
- PGD agreed
- Peer Vaccinator resource pack agreed
- Peer Vaccinators identified for all areas and training commenced
- Delivery and storage of vaccine to areas outside of HDH agreed

4.4 Actions to be completed

- Internal and external reporting
- Groups of colleagues to be targeted for next vaccine deliveries

The Flu Group will be meeting on a twice-weekly basis throughout the campaign.

5.0 Healthcare Worker Flu Vaccination – Self-Assessment Management Check List

5.1 This is a requirement of DHSC, NHSE/I and PHE to be completed and approved by the Trust Board by December 2020. The checklist is live and will be updated throughout the campaign.

A	**Committed leadership**	**Trust self-assessment**
A1	Board record commitment to achieving the ambition of vaccinating all frontline healthcare workers	Yes
A2	The Trust has ordered and provided a quadrivalent (QIV) flu vaccine for healthcare workers	Completed. Staggered delivery from suppliers to be delivered from September 2020. First delivery has arrived. Last drop anticipated November 2020. A TIV ordered but not arrived yet
A3	Board receive an evaluation of the flu programme 2019/20, including data, successes, challenges and lessons learnt	Evaluation completed to be delivered to the Board in September with operational plan for this years campaign in September 2020
A4	Agree on a Board Champion for flu campaign	Agreed – Jill Foster, Chief Nurse
A5	All Board members receive flu vaccination and publicise this	Agreed – to be delivered in September2020

A6	Flu team formed with representatives from all directorates, staff groups and trade union representatives	The Flu team is formed from a multidisciplinary group. It meets weekly and the unions receive an update at the partnership meetings
A7	Flu team to meet regularly from September 2020	Flu meetings commence in July meeting weekly
B	**Communications plan**	
B1	Rationale for the flu vaccination programme and facts to be published – sponsored by senior clinical leaders and trades unions	Available to all staff via Trust intranet site
B2	Drop in clinics and mobile vaccination schedule to be published electronically, on social media and on paper	Will be published via Flu-Trak system and via Communication Team across all platforms
B3	Board and senior managers having their vaccinations to be publicised	Will be completed by October 2020
B4	Flu vaccination programme and access to vaccination on induction programmes	There will be a peer vaccinator at induction programmes from October 2020
B5	Programme to be publicised on screensavers, posters and social media	Flu programme publicised via comms across all platforms.
B6	Weekly feedback on percentage uptake for directorates, teams and professional groups	Weekly feedback to be provided via Flu-Trak and disseminated across the organisation
C	**Flexible accessibility**	
C1	Peer vaccinators, ideally at least one in each clinical area to be identified, trained, released to vaccinate and empowered	Peer Vaccinators identified for each area and have received training materials
C2	Schedule for easy access drop in clinics agreed	Clinics, drop in clinics and roving vaccinators are planned.
C3	Schedule for 24 hour mobile vaccinations to be agreed	Coverage planned for night shifts
D	**Incentives**	
D1	Board to agree on incentives and how to publicise this	Small incentive of flu fighter badges ordered
D2	Success to be celebrated weekly	Colleagues will be updated on a weekly basis

Harrogate and District NHS Foundation Trust

Board of Directors (held in Public)
30 September 2020
Quality Report 2019/20

Agenda Item Number:	**10.3**
Presented for:	Information and Approval
Report of:	Chief Executive
Author (s):	Deputy Director of Governance
Report History:	Senior Management Team Quality Committee Audit Committee
Publication Under Freedom of Information Act:	This paper has been made available under the Freedom of Information Act 2000.

Links to Trust's Objectives	
To deliver high quality care	√
To work with partners to deliver integrated care	√
To ensure clinical and financial sustainability	

Recommendation:
The Board is asked to approve the Quality Report.

Harrogate and District NHS Foundation Trust

Board of Directors (held in Public)
30 September 2020
Medical Director Report

Agenda Item Number:	**10.4**
Presented for:	Discuss/Information
Report of:	Executive Medical Director
Author (s):	Executive Medical Director
Report History:	None
Publication Under Freedom of Information Act:	This paper has been made available under the Freedom of Information Act 2000

Links to Trust's Objectives	
To deliver high quality care	√
To work with partners to deliver integrated care	√
To ensure clinical and financial sustainability	√

10.4

Recommendation:
The Board is asked to discuss and note this paper and its contents.

Board of Directors Meeting (held in Public)

30 September 2020

Medical Director Report

1.0 Executive Summary

Included within this report are updates on items relevant to the Medical Director Portfolio including national, regional and local information and performance. The report also includes standing items which cover the breadth of the Medical Director portfolio, with signposting to areas which are shared across a number of Executive colleagues, most frequently the Chief Nurse for Clinical Quality and Safety items, the Chief Operational Officer for Medical Workforce and Operational items and the Director of Human Resources for Medical Education items.

2.0 Introduction

This is the second report of the new Medical Director since taking up the position in June 2020. Working in partnership with the Chief Nurse and Chief Operating Officer, we will ensure our reports are aligned whilst covering the depth and breadth of our respective portfolios.

3.0 Proposal

To provide a high quality regular report on the work, performance and strategy of the HDFT Medical Directorate, with particular emphasis on the following key priority areas:

- *Professional standards and workforce development*
- *Clinical quality and patient safety*
- *Research and Development*
- *Quality Improvement and transformation*
- *Medical Education*
- *Digital and IT Services*

4.0 Quality Implications and Clinical Input

Better medical colleague engagement within the leadership of HDFT will facilitate our ambition to provide outstanding patient experience, outcomes and excellence every time.

5.0 Equality Analysis

The new Medical Directorate team are committed to equality, diversity and inclusivity. A priority action for the new team is identifying barriers to considering, applying and taking up a medical leadership position at HDFT.

6.0 Financial Implications

On completion of the initial review of medical leadership requirements at HDFT, a suggested model for the senior leadership will be circulated and any financial implications will be outlined at that stage.

7.0 Risks and Mitigating Actions

A Medical Directorate Business Meeting has been initiated to identify and mitigate potential risks. A Medical Directorate Risk Register is being created and will feed into the corporate risk register via the Trust's corporate governance processes.

8.0 Consultation with Partner Organisations

The Medical Director is currently undertaking a widespread listening and engagement exercise with a wide range of stakeholders. The views of internal and external stakeholders will be reflected in the 100-day report out by the Medical Director (published early October 2020) and in the future shape and work plan of the Medical Directorate.

9.0 Monitoring Performance:

1. National Update

The focus for NHS Medical Directors remains, as with other NHS Executive colleagues, on recovery planning and infection prevention and control for the COVID19 pandemic. A number of Learning from Covid reports have been published relevant to the medical workforce, which focus on the impact the pandemic has had on the continuing education of medical students and delivery of training programmes for doctors in training and the learning we have gained from different ways of delivering teaching and training in a more distanced and/or virtual way.

The Royal College of Physicians have recently published results of a survey under the banner of: "Research for all: Developing, delivering and driving better research" The findings are highly relevant to the medical workforce at HDFT:

- Physicians have a very positive attitude towards research, with approximately 60% wanting to be more involved.
- A lack of time was the biggest barrier to participation, cited by over half (53%) of respondents, with funding, a perceived lack of skills and supportive culture in their organisations reported as other key challenges.
- Unequal access to research opportunities. Women and physicians in rural hospitals participated in research in disproportionately lower numbers, despite a strong interest in being more research-active.

The resulting strategy recommends several measures to improve access and equity of opportunity in research:

- Develop and support the workforce to become research active and innovative
- Deliver a system that enables physicians to do research as part of improving care
- Drive new collaborative ways for physicians to accelerate research for patient and public benefit.

The recommendations will be reviewed at the HDFT Research Committee and a local action plan developed. **RCPresearchreport**

2. Regional/Local Update

Humber, Coast and Vale Health and Care Partnership (HCV HCP)

The HDFT Medical Director has recently been asked by Stephen Eames, System Lead and Independent Chair of HCV HCP, to lead a piece of work to consider developing a Partnership approach to innovation and improvement. An options appraisal will be conducted for the development of a single framework for innovation and improvement, to continue to support the learning from COVID currently being spread and adopted and to develop a Partnership Innovation Strategy. This will allow the Partnership to address the challenges all NHS organisations face in our approach to innovation and improvement i.e. what innovations should we consider implementing, how should we spread and adopt learning from each other across the Partnership and how can we adopt and spread innovation at pace and scale across the partnership. Member organisations of the HCV HCP are being tasked with

identifying a senior leader to represent their organisation on a working group that will be chaired by the HDFT Medical Director, reporting to the HCV HCP Chair.

Harrogate and Rural Alliance (HARA) Update
The Medical Director at HDFT has recently taken up a position on the Board of the Harrogate and Rural Alliance (HARA). Since 2019, HARA has brought together NHS commissioners, NHS service providers and North Yorkshire County Council with the aim of transforming the way community health and social care services are provided for adults in Harrogate District. Oversight is provided by the Harrogate and Rural Alliance Board (HARAB) which is comprised of senior leadership from each member of the Alliance and provides strategic direction, oversight of governance and risk and holds the Alliance Leadership Team (ALT) to account for delivery. A number of workstreams are currently in place, with HDFT colleagues involved across the programme of work. Current HARA workstreams are: Estates, Co-production, Communications, Population Health Management, MDT bookings and referrals process, Governance, Workforce, Culture and OD, Finance, Performance and benefits, Admission avoidance, Primary care integration.

3. Professional standards and workforce development

The Responsible Officer (RO) - a brief background to the role and revalidation
The Responsible Officer (RO) is a statutory role set down in an act of parliament and is responsible for establishing and maintaining systems to enable doctors connected to her/his designated body (ie HDFT) to complete annual medical appraisal as required by the General Medical Council (GMC). The RO is required to make a recommendation to the GMC on a doctor's suitability to be revalidated every 5 years. This recommendation is an assessment of a doctor's "Fitness to Practice". The RO is also responsible for raising concerns about a doctor's fitness to practice promptly with the GMC via the employment liaison service. This should happen at the time that concerns are raised and not left until the moment a recommendation for revalidation is due. The RO for HDFT is Mr David Lavalette (Consultant Orthopaedic Surgeon).

Appraisal update
The requirement for doctors to complete annual medical appraisal was suspended by the GMC in March 2020 due to the COVID19 pandemic. All revalidation recommendations due between March 2020 and March 2021 have been moved on by one year. For some doctors at HDFT the change in working pattern during the pandemic provided an opportunity to catch up on non-clinical tasks, such as mandatory training, and we therefore allowed doctors and appraisers to undertake appraisal and submit it in the usual manner if they were able to. A noticeable number of doctors used this opportunity. The GMC and NHSEI have determined that annual medical appraisal should re-start on October 1st 2020 for those organisations where there has been a return to more normal activity. Appraisal for 2020 and 2021 will have a significant emphasis on individual's welfare during the pandemic and how doctors have managed their own wellbeing as well as that of their patients during this time. In normal years there is a requirement to submit an Annual Organisational Assessment to NHSEI which details appraisals completed, appraisals missed (with RO approval) and appraisals missed which were not pre-approved. The assessment also looks at other aspects of the appraisal and revalidation process of the organisation including appraiser numbers and training. This year, there was no requirement to submit the AOA to NHSEI, however NHSEI have requested that ROs collect this information anyway and submit it to the Boards of their organisations for review (to be submitted for HDFT November Board meeting).

Clinical Services Review and Future Strategy
We have recently commenced a review of clinical services at HDFT, utilising the intelligence we gained from the Carnall Farrar report "Review of the Harrogate Health

System" published in October 2019. SWOT analysis of a wide range of services from our 3 clinical directorates has been performed, with the next steps being a deeper dive to better understand the future model required for each clinical service and gaining further understanding of an optimal future partnership model within the local Harrogate and District and also WYAAT (West Yorkshire Association of Acute Trusts) culminating in the development of a HDFT Clinical Services Strategy. The timeline for the development of the Clinical Services Strategy is currently being discussed, with the new Deputy Medical Director for Operations and Workforce (a new post in the Medical Directorate due to be advertised next month) providing a clinical leadership role for the project.

Medical Consultant appointments since July Board
Emergency Medicine – Two substantive posts successfully appointed to on 08/09/2020 (Dr Jen Lockwood and Dr Gaynor Creaby).

4. Clinical quality and patient safety

Medical Examiner Office HDFT

Dr Dave Earl, Consultant Anaesthetist and Deputy Medical Director has been appointed as the first Lead Medical Examiner for the Trust. The new role of Medical Examiner is being rolled out nationally and will ensure there is independent medical scrutiny of all deaths in hospital with the aim of improving the quality of death certification and mortality data and to oversee the learning from deaths framework within NHS organisations. Dave will oversee a small team of Medical Examiners and a Medical Examiner Officer at HDFT, these new posts will also be appointed over the next few months. Further information about the Medical Examiner system can be found here. https://www.england.nhs.uk/establishing-medical-examiner-system-nhs/

The new Lead ME will play a critical role in our Mortality/Learning from Deaths trust wide work programme of work, which will be embedded within our refreshed clinical quality and safety framework. Work is underway to review our clinical governance structure at HDFT, with numerous touch points build in to ensure colleagues are engaged in the reshape through work streams within the culture programme. An initial project has been around the adoption of the Respect (Recommended Summary Plan for Emergency Care and Treatment) Form as part of advanced care planning at HDFT. Agreement has now been secured for roll out of this nationally approved advanced care project Trust-wide during Q3 20/21.

Patient Safety

The implementation of the NHS Patient Safety Strategy (launched in July 2019) is underway. The next key milestone for HDFT is identifying one or more patient safety specialists for the organisation. These will be key leaders within the safety system, highly visible to the organisation and its partners and able to support the organisations' safety work. NHS organisations have been requested to develop a role for at least one patient safety specialist by the end of November 2020. The HDFT quality and safety senior leaders are currently liaising with other Trusts and WYAAT colleagues to share learning and experience about the likely remit of these positions.

The new look PESH (patient experience and safety huddle) meeting has been running for two months. We have held two of our wider focus monthly team PESH meetings which were well attended by representatives across the organisation and directorate quality assurance leads. These already have proved to be a great opportunity for triangulation and sharing of themes/learning with a workshop approach planned and a scheduled programme of key topics to be discussed.

The Head of Risk has been working closely with the new Chief Pharmacist to ensure PESH and the Medications Safety Review Group are working seamlessly with regards to medication safety to ensure no duplication of effort. Work to refine and focus our processes for Pressure Ulcers and falls SIs is ongoing with the new Deputy Chief Nurse who is also now attending PESH as a regular member.

Clinical Effectiveness

Early this year, the Clinical Effectiveness department produced the HDFT 2020-21 annual audit and survey programme; inclusive of national, regional and trust priorities and produced in consultation with relevant stakeholders. In March, NHS England agreed that for the majority of national clinical audits, data collection could be suspended while frontline teams managed the COVID-19 response, and our priority programme was put on hold. However, many national databases e.g. The National Hip Fracture Database (NHFD) web tool, intensive care audits, child mortality database and maternity audits, continued to collect data throughout the surge as there are concerns from patients and clinicians that care might suffer while the focus moved to COVID-19. In addition, participation in various COVID-specific projects was offered, reviewed and newly-added to the programme.

In order to support NHS recovery, the Healthcare Quality Improvement Partnership (HQIP) has now begun to work with national clinical audit and outcome review programme providers to identify key data items for collection. This is in keeping with COVID-19 recovery planning, and will prioritise restarting audits linked to key aspects of delivery and clinical outcomes during, and following, the pandemic. Although data submission is not yet mandatory work has therefore recommenced to support the delivery of the HDFT National audit programme, confirm and re-prioritise our local priority plan; and liaise with National Patient Survey external contractors to ensure new deadlines are met. We are actively encouraging and supporting teams to re-commit to entering data, and to restart quality improvement initiatives.

Efforts to refine and focus our team processes have also been underway, and Clinical Effectiveness has made improvements to working practices to best deliver our team values. We aim to share this widely, and raise the visibility of the department and its role within the Trust. To do this, a communication plan is being developed to ensure that Clinical Effectiveness facilitators are recognised as skilled experts in the field of clinical audit, and promote the excellent audit projects delivered by colleagues throughout the Trust. To help us achieve this, work is underway to actively promote “clinical audit awareness week” (November 2020), and submit applications to HQIP for the nationally recognised Clinical Audit Hero Awards.

Claims

We have had three recent cases investigated by HSIB (Healthcare Safety Investigation Branch), two of the cases were reported to HSIB in Quarter 1 of 2020/21. The reports have now all been received and the HDFT maternity department has found the investigations and reports to be accurate and fair with only a few points of accuracy and issues of interpretation requiring clarification for the investigating team.

The claims scorecard (a quality improvement tool to assist NHS organisations with the analysis of clinical and non-clinical claims) is expected to be published this month detailing the last five years’ worth of claims data and trends. We are keen to ensure triangulation of claims with events and complaints to maximise learning across the organisation, this work will be picked up by the PESH group over the next few months.

In recognition of the pressure on the NHS and maternity services during the COVID19 pandemic, the Royal College of Obstetricians and Gynaecologists, MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries in the UK), NHS Resolution and HSIB have been working together to reduce the obligation on Trusts to report cases that meet the Each Baby Counts (EBC) criteria and to align processes where possible. From 1 April 2020, it became no longer necessary for trusts to report Early Notification (EN) cases to NHS Resolution; this decision has been reviewed in Sept 2020 and the decision has been made to extend the current reporting arrangement until March 2021. However, it is still important to report all cases that meet the EN criteria to HSIB during this time. HSIB will triage all cases and prioritise those where there is evidence of harm (brain injury) to the baby and will share these cases directly with NHS Resolution. Reporting to MBRRACE-UK will follow the existing guidance issued on 2 April to continue all maternal and perinatal mortality notifications. Notification of maternal deaths of women with a positive test for COVID-19 infection is a priority as is notification of perinatal deaths where the baby and/or mother was COVID-19 positive.

5. Research and Development

The research teams have now started to develop a recovery plan to commence recruitment into studies that were paused to allow the COVID19 urgent public health studies to be delivered. There are currently 44 studies open across the trust. The COVID19 RECOVERY study continues and we have recruited the first patient into the new convalescent plasma arm, which aims to see whether using plasma from patients who have had COVID-19 will improve recovery of patients.

Preparing for delivery of COVID-19 vaccine research studies is now a national priority. Yorkshire and Humber have implemented a strategy to deliver these studies at scale. There is potential for HDFT to host two vaccine studies (the commercially developed Novavax and the Imperial College London vaccine), once safety studies have been completed. The trust is represented on the regional vaccine working group to identify locations for delivering vaccines to volunteers at scale. Sites have yet to be finalised but the Yorkshire Events Centre has been identified as a possible venue. Once confirmed volunteers to support the delivery of the study will be identified, with university students and schools students being actively considered.

The HDFT research and pathology teams are working together to ensure capacity is available to support national public health studies. The increasing necessity for COVID-19 testing for patients, staff and families is inevitably a conflicting pressure on our laboratories.

With the COVID19 pandemic confirming the importance of a strong NHS R&D function, the research team are actively identifying opportunities to embed research as a core function at HDFT and are exploring a new Trust-wide model of research recruitment to ensure all of our patients are given the opportunity to participate in national public health studies.

6. Quality Improvement and Transformation

Delivering the Culture Improvement Programme will be the key priority for the team in the coming year. A small number of previously agreed QI projects will also be delivered in order to support the quality, patient experience and productivity agendas. These will provide ongoing training opportunities for our current cohort of Platinum-level Quality of Care Champions. Socially distanced quality improvement training has restarted, with the first post-lockdown cohort of eleven Silver Quality of Care Champions commencing their training. Online training continues to be an important part of the QI training mix for Bronze-level candidates.

Support will also be provided to the Medical Director to perform an options appraisal around the potential to develop a unique continuous learning and improvement system at HDFT, to reduce silo working between the traditional NHS corporate functions of Research and Development, Innovation and Improvement / Transformation. The review will examine the current state, identify options for improvement and recommend a future model which best supports innovation and improvement at HDFT, taking into account opportunities, costs, risks and benefits.

7. Medical Education

We have received an update from the Yorkshire and Humber Postgraduate Dean with regards the four nation agreed principles in maintaining postgraduate medical and dental training during pandemic surges and the key learning points about the impact of COVID phase one on medical training. In particular, redeployment of doctors in training should be based on the principles described in the Health Education England Winter Pressures guidance which mandates suitable induction to prepare for altered duties and enhanced supervision at all times.

Another change brought about by the COVID19 pandemic is that junior doctors in the NHS will now be able to undertake their training in independent hospitals following an agreement reached between independent healthcare providers and the NHS. A position statement by the Independent Healthcare Providers Network (IHPN), NHS England-Improvement, Health Education England (HEE) and the Confederation of Postgraduate Schools of Surgery (CoPSS) was published on the 8th of September and set out a series of high-level principles to ensure medical trainees have new opportunities to train in elective surgery or diagnostic activities taking place in the independent sector. NHS indemnity must be in place for the doctor in training to work in the independent sector site for the NHS work undertaken and the principles will initially apply to those providers within the NHS' national hospital contract, although it is thought that the agreement will extend the framework for clinical training into the rest of the independent sector in time.

At HDFT, a number of new doctors in training have joined us in the traditional changeover period of August-September. They are being well supported by the Medical Directorate, Medical Education and Medical Staffing departments and also the independent Guardian of Safe Working (GSW) who reports directly to the HDFT Board (Dr Carl Gray: Q1 20/21 GSW report attached).

8. Digital and IT Services

The digital team continue to work on the development of an electronic patient record with the move away from paper based records being afforded the highest priority. Paperlite working has become a reality for some clinical teams through COVID-19 and over the next 3 month's WebV developments will allow it to be a reality for a broader range of outpatient and inpatient specialties/activity.

Negotiations are at an advanced stage with speech to text provider Nuance to agree a partnership arrangement that will allow access to this technology for every member of the trust easing the transition away from paper and helping productivity. Alongside this development, the team are helping to embed the technologies that have been rapidly deployed to support face to face patient activity as well as remote working.

The assessment of various patient portal products is underway. These portals allow a variety of patient facing functions such as access to and adjustment of appointments, viewing letters and key test results. Furthermore, they will move us a step closer to patient initiated follow up and collecting patient outcome data remotely to guide care.

Progress is also being made on our ability to integrate with other NHS organisations and partners across our two ICS's through the Yorkshire and Humber Care Record program. We now have the platform on site and are beginning to share patient event data (such as appointments) before we move on to consuming (accessing data) such as end of life care records, 111 and 999 information.

10.0 Recommendation

The Board is recommended to discuss and note the report.

11.0 Supporting Information

1. Guardian of Safe Working (GSW) quarterly report (Q1 2020/21)

Harrogate and District NHS Foundation Trust

Board of Directors (held in Public)
30 September 2020
Guardian of Safe Working Hours Report (Quarter 1)

Agenda Item Number:	**10.4.1**
Presented for:	Information
Report of:	Executive Medical Director
Author (s):	Guardian of Safe Working Hours
Report History:	None
Publication Under Freedom of Information Act:	This paper has been made available under the Freedom of Information Act 2000.

Links to Trust's Objectives	
To deliver high quality care	√
To work with partners to deliver integrated care	√
To ensure clinical and financial sustainability	

Recommendation:
The Board of Directors is asked to receive and note the content of the report.

10.4

Board of Directors (held in Public)

30 September 2020

Twelfth quarterly report on safe working hours for doctors and dentists in training

Guardian of Safe Working Hours Report (Q1)

1.0 Executive Summary

This is the twelfth quarterly report of the Guardian of Safe Working Hours. Its purpose is to report to the Board of Directors the state of safe working of doctors in training ('junior doctors') in relation to their working hours, gaps in rotas and their educational experience. This report covers the period 1st April to 30th June 2020, which is one quarter. The period of the COVID-19 emergency from 1st April 2020 greatly affects this report.

The orderly stream of quarterly reports was interrupted by the Board's instruction to change the periodicity of written reports to four-monthly intervals. This is out of synchronization with the regional quarterly reporting pattern. The Trust's reports were following alternately in and out of phase with the quarters.

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

The Trust now has all trainee doctors employed on the 2016 Terms and Conditions of Service (TCS) contract. These have moved to Version 5 of the contract.

Only seven (49 in Q4/2019-20) exception reports have been received from trainees and dealt with this quarter. This is a relatively low number. These have mainly concerned over-runs of working hours ('hours and rest') owing to the busy state of the wards and to individual patient matters in General Medicine. There were no reduced educational opportunity exception reports in Q1. Exception reporting remains comparatively low in this Trust although highly variable across the region.

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

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

The experience of trainee doctors – as for the whole NHS – has changed profoundly from March 2020 with the onset of the viral pandemic. Trainees were redeployed to medicine and the COVID wards on new 'COVID rotas'. They have responded positively to the experience. Remarkably, no exception reports have been received since 17th March 2020, and in the months of April and May 2020.

This is the key quality assurance statement for the Board:

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

The Trust Board has requested that the Guardian enlarges his role: in addition to the existing role to doctors in training grades, the Guardian will embrace the remaining non-training, non-career grade doctors in his system and responsibility. The Guardian has agreed to this change. The Guardian has discussed implementation of this process with the medical workforce department. There has been no progress with this implementation.

The Guardian intends to resign his office from a date to be agreed. The Trust will need to re-appoint to this role. The post-holder can hold no other managerial office in the Trust and should be independent of management.

2.0 Introduction

This is the twelfth quarterly report of the Guardian of Safe Working Hours which presents the Trust's statistics in brief form: more detailed data are held in the DRS computer system and are available on request. The DRS application happens to be malfunctioning currently and support has been requested.

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

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

3.0 High level data

In September 2020

Trainee posts: the position is similar to previous reports. At any time there are rota gaps around 5% in established NHS training posts. These from time to time include maternity and other leave, resigners and vacant posts not filled. The Medical Workforce Department continuously seeks recruitment to vacant posts.

The current position is seven gaps [4.6%) of which four posts are in recruitment, one awaits departmental action and two posts have departmental decisions not to fill currently.

4.0 Exception reports

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

Clinical supervisors are in most cases poor at responding to exception reports. This task was dropped on consultants without their agreement by the 2018 Trainees new contract and has never had an enthusiastic response. The Guardian has to review and agree outstanding reports. This role change has been agreed in the V5 Terms and Conditions.

This report presents Quarter 1: 2020/21

Q1: 1.4.2020-30.6.2020 Exception reports by department: hours/rest				
Specialty[five top]	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
General Medicine	0	7	7	0
Total	0	7	7	0

There were no 'education' exceptions. Reports are greatly reduced on Q4 (49). Nearly all reports are of over-working at the end of the day when clinical workload, acutely ill patients and too few colleagues demand working beyond normal hours. This is especially true in general medicine. [Exception reports are known to under-report over-working]. Exception reports reduced almost to nothing in all hospitals in the region.

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

The months of April, May and June 2020 have greatly been affected by the COVID-19 pandemic. The FY1/2 doctors were redeployed from their day jobs to join the front-line clinical teams on the COVID-19 wards. They responded magnificently and in return gave very positive feedback on their experiences. Despite being potentially exposed to infection, they were placed on single wards in larger stable teams with senior support constantly available. They generally left on time.

I have enquired about the trainees who have tested positive for COVID during the period 1st April 2020 until 30th June 2020. There were 29 trainees who tested COVID-19 PCR positive during that period and a further five who had to self-isolate for various reasons but didn't go on to have COVID. There were no cases of severe viral illness amongst trainees.

The worst single reported experience of a trainee was of a four-hour delay in going home owing to severe clinical pressures and colleagues missing from the rota on that day.

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

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

5.0 Work schedule reviews and interventions

5.0a Work schedule review

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

5.0b Interventions

No specific issue has arisen in this last quarter. There have been various enquiries about rota details which have been addressed with the medical workforce department.

6.0 Vacancies

The vacancies are not significantly changed at 4.6% of established training posts. Of seven vacancies, four are in recruitment, one awaits decision and two are dormant posts which the Trust has decided not to fill currently.

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

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

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

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

There are also 12 Trust posts for doctors not in training schemes who participate in the same rotas as trainees. There are about 60 SAS grade doctors in the Trust.

7.0 Fines

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

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

Working time rules may of course change after BREXIT.

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

8.0 Meetings

The Guardian has had no regional or national meetings to attend in the quarter. There has been a regional meeting of guardians held by MS Teams in September. The general experience across the region has been of trainees rising to the challenge, following the rules for self-isolation and of greatly reduced exception reporting owing to temporary working arrangements.

9.0 Trainees' Forum

Trainees' fora have increased to monthly in the viral pandemic. The importance of exception reporting has been canvassed to the trainees.

It is clear that the COVID-19 emergency has greatly affected post-graduate medical training. Educational opportunities, assessments, course and examinations have been discontinued

and the amount of clinical experience in their home specialties has been curtailed. On the other hand, trainees understand that they have participated in front-line service in the national emergency, greatly appreciated by the public at large and educational in its own way. They will each have something impressive to put on application forms and to discuss in future interviews. Some trainees will have delayed completion of examinations and completion of training programmes.

10.0 Disclosure

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

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

11.0 Confidentiality

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

12.0 Care Quality Commission

The Guardian has had no contact with CQC inspectors in this quarter.

13.0 Inclusion of SAS doctors within the scope of the Guardian

The Trust Board has requested that the Guardian enlarges his role: in addition to the existing responsibility to doctors in training grades, the Guardian will embrace the remaining SAS (non-training, non-consultant grade) doctors within his system and responsibility. Strictly, this has no contractual or statutory basis, but the Trust has agreed – in an exchange of letters with the Medical Director - that it will honour agreements and determinations made by the Guardian as if these doctors were training grade doctors covered by the 2016 TCS V5. The Guardian has agreed to this change. The Guardian has discussed implementation of this process with the medical workforce manager. The workload and IT implications of this change are still to be determined.

14.0 Change of Guardian

The Guardian intends to resign his office from a date to be agreed. A new guardian will need to be appointed. Naturally, the Guardian will assist in the induction of the new guardian when appointed.

15.0 Issues arising

a. The Trust continues in comparatively good standing. We have had a below-average rate of exception reporting especially during the COVID-19 emergency.
b. There is an on-going problem of sporadic over-work for trainee doctors owing to colleagues off sick and rota gaps. This is especially true in general medicine. The clinical directorate is actively managing the situation.
c. Reluctance in trainees to report exceptions exists regionally and nationally.
d. Exception reports are being received and processed.
e. There are gaps in rotas but recruitment is likely for five of seven vacancies. This a worsening issue throughout medical specialties especially in the North of England, but this Trust is doing relatively well.

f. No national Guardian meeting has yet been announced for 2020.
g. The Trust Board has requested that the Guardian enlarges his role in relation to SAS doctors. This is agreed in principle: the Guardian will discuss implementation of this process with the medical workforce department as becomes possible.
h. The Guardian intends to resign his office from a date to be agreed.

16.0 Actions taken to resolve issues

a. No fine has been necessary this quarter.
b. No intervention has been necessary this quarter.
c. At the date of reporting, the Board of Directors is assured from the evidence available that:
   i. The exception reporting system is operational for all trainees; they are now all to be converted to 2016 TCS Version 5.
   ii. Overworking owing to pressure of work and rota gaps is a chronic problem in medicine. This is under active management by the directorate.
   iii. The Guardian can only intervene on notified problems.
   iv. The Guardian will continue to attend regional and national meetings.

17.0 Questions for consideration by the Board of Directors

a. The Board is asked to receive the quarterly report and to consider the assurances provided by the Guardian.
b. There are presently no issues outlined in the report which are not being (or cannot be) tackled.
c. The Guardian makes no request for escalation, internally, externally or both, which might be recommended in order to ensure that safe working hours would not be compromised in the future.
d. Issues of medical [and indeed all healthcare professional] workforce planning are an urgent strategic challenge to the Trust and to the entire NHS. The Trust always has vacancies gaps in trainee doctor posts; these currently run at 4.6 per cent.
e. The Guardian intends to resign his office and therefore will need replacing this year.