NHS
Harrogate and District
NHS Foundation Trust

Board of Directors Meeting (to be held in Public)
will be held on Wednesday, 25 November 2020 from 9.00am
in the Boardroom, Trust Headquarters, Harrogate District Hospital, Harrogate
via virtual arrangement

AGENDA

Item No.	Item	Lead	Action	Paper	Time
1.0	**Welcome and Apologies for Absence**	Chairman	Note	Verbal	9.00
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 30 September 2020**	Chairman	**Approve**	**Attached**	
4.0	**Matters Arising and Action Log**	Chairman	Discuss	Verbal **Attached**	
5.0	**Patient Story**	Lesley Danby, Matron	Note	Verbal	9.10
6.0	**Overview by the Chairman**	Chairman	Discuss/ Note	Verbal	9.40
7.0	**Chief Executive Report**	Chief Executive	Discuss/ Note	**Attached**	9.50
7.1	**Board Assurance Framework/Corporate Risk Register**	Chief Executive	Discuss/ Note/ **Approve**	**Attached**	
7.2	**Senior Management Team Chair's Report**		Note	**Attached**	
8.0	**Resource Committee Chair's Report**	Resource Committee Chair	Note/ Discuss	**Attached**	10.05
8.1 **8.1.1**	**Recovery/Restoration of Services** **Operational Update – Emergency Care Improvement Support**	Chief Operating Officer	Note/ Discuss	**Attached**	
8.2 **8.2.1**	**Finance Report** **Appendix 1. Treasury Management Policy**	Deputy Chief Executive/Director of Finance	Note/ Discuss	**Attached**	
8.3	**Integrated Board Report**	Executive Directors	Note/ Discuss	**Attached**	
9.0	**Quality Committee Chair's Report**	Quality Committee Chair	Note	**Attached**	10.45
9.1 **9.1.1**	**Medical Director Report** **Learning from Deaths Q1 Report**	Executive Medical Director	Discuss/ Note	**Attached**	

9.2 **9.2.1** **9.2.2** **9.2.3**	**Chief Nurse Report** **(Appendix 1)** Phase 2 Ward Establishments **(Appendix 2)** Healthcare Worker Flu Vaccination – Self Assessment Checklist **(Appendix 3)** Cyber Operational Readiness Support (CORS) Remediation Report	Chief Nurse	Discuss/ Note	**Attached**	11.00
10.0 **10.1**	**People and Culture Committee Chair's Report** **Director of Workforce and Organisational Development Report**	People and Culture Committee Chair Director of Workforce and Organisational Development	Discuss/ Note Note	**Attached** **Attached**	11.10
11.0	**Any other Business** *By permission of the Chairman*	Chairman	Note/ Discuss/ **Approve**	Verbal	11.25
12.0	**Board Evaluation**	Chairman	Discuss	Verbal	
13.0	**Date and Time of next meeting** Wednesday, 27 January 2021 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 7. Elected Parish Councillor - Kirby Overblow Parish Council
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)
Tim Gold	Interim Chief Operating Officer	August 2020	Date	Seconded from Bradford Teaching Hospitals NHS Foundation Trust post of Director of Operations
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	1. Chief Executive of NHS Nightingale Hospital Yorkshire and Humber 2. Member of NHS England and Improvement North East and Yorkshire Regional People Board 3. Lead Chief Executive for Workforce in Humber Coast and Vale ICS
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	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)

30 September 2020 at 9am

in the Boardroom, Trust Headquarters, Harrogate District Hospital

In order to comply with the restrictions on social distancing due to the Coronavirus COVID 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 Jeremy Cross, 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 Tim Gold, Chief Operating Officer
Ms Angela Wilkinson, Director of Workforce and Organisational Development

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

Mr Simon Riley-Fuller, Deputy Chief Nurse
Dr Matt Shepherd, Clinical Director for Long Term Conditions and Unscheduled Care Directorate

Observing
Ms Clare Cressey, Stakeholder Governor for HIF and Lead Governor
Mr Steve Treece, Elected Public Governor (Wetherby and Harewood)

BoD/09/20/01 **Welcome and Apologies for Absence**

1.1 The Chairman welcomed members to the meeting, and welcomed Tim Gold to his first Board meeting. The meeting was being held by video conferencing facility to comply with the restrictions on social distancing due to the Coronavirus COVID 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 Andy Papworth, Non-executive Director.

DRAFT

BoD/09/20/02 **Declarations of Interest and Register of Interests**

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

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

BoD/09/20/3 **Minutes of the Meeting held on 29 July 2020**

3.1 **Resolved:** the minutes of the last meeting held on 29 July 2020 were accepted as an accurate record subject to a minor typographical error.

BoD/09/20/4 **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 completed actions were agreed to be closed. The open outstanding actions were discussed in turn.

BoD/07/20/6 Chief Executive's Report. Limited assurance reports that fall under the responsibilities of the Board Committees are now provided each Committee as appropriate. It was agreed to close this action.

BoD/07/20/17.7 Medical Director's Report. It was noted that QI methodology would be arranged to take place at a Board Workshop in the new year.

BoD/09/20/5 **Overview by the Chairman**

5.1 The Chairman reported on the Annual Members Meeting/Annual General Meeting that had been held via Teams Live on 29 September 2020 in order to comply with the restrictions and social distancing requirements. The Chairman explained that the meeting had been very productive and had enabled Members of the Trust to receive the Annual Report and Accounts in accordance with the requirements of good governance. It had been well attended and she thanked everyone involved in the event for all their hard work and support to enable it to go ahead live.

5.2 Members of the Board reflected on the event, which they agreed had been successful and the videos of colleagues and patients sharing their experiences of the pandemic were very powerful. The Chairman planned to write to everyone who had shared their stories to thank them on behalf of the Board.

5.3 Mrs Robson queried if it would be possible for patient stories to be presented to the Board via a similar arrangement going forward. In response, it was agreed that Mrs Foster and Mrs Hughes would look into the necessary arrangements for patient stories to be re-introduced to Board. **ACTION (J Foster, L Hughes)**

5.4 The Chairman drew reference to the Board papers, which provided evidence and drew attention to the significant areas of work that are being undertaken. She felt the papers provided good levels of assurance. The supplementary pack was provided for information to support the agenda items and thanked everyone involved for providing this information, which was greatly appreciated.

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

BoD/09/20/6 **Chief Executive's Report**

6.1 The Chief Executive's report was noted. He explained that since the last Board meeting there had been significant focus on restarting routine services, which had been paused during the first wave of the COVID pandemic. Recent days had seen a significant rise in infection rates nationally, but admissions to hospital had remained relatively low. As plans are developed for responding to the second wave the NHS is mindful of the risks related to the wholesale pausing services and this is unlikely to be the approach taken.

6.1.2 He reported that the Chairman and he had sent a personal thank you card to all colleagues throughout the Trust to recognise their commitment and resilience shown throughout the COVID pandemic.

6.1.3 Despite the national focus being weighted towards acute care he noted the importance to also support the Trust's 0-19 and community services, which is experiencing the same scale of challenge in respect of recovery. It was noted that Mr Gold planned to cover in more detail the progress against the Trust's recovery plans later in the meeting.

6.2 The Chief Executive reported that the draft People Plan had been reviewed and supported by the People and Culture Committee and further discussion would take place later in the meeting.

6.2.1 The work to address the findings of the Deloitte cultural review have finalised. This has been launched under the banner of 'teamHDFT – at our best'. Widespread engagement is planned to take place in November via virtual workshops. The workshops will follow the cultural survey that is due to close in early October. Formal investigations into Radiology and Estates continue with other priority areas of work including recruitment, creating a vision, and taking action to become an anti-racist organisation, re-considering the terms and conditions of service in HIF and improving the physical working environment.

6.3 He reported that NHS England and NHS Improvement had issued financial allocations to systems for the second half of the year. Systems are required to work together to deliver within this amount. It was noted that the Director of Finance would cover this in more detail later in the meeting.

6.4 The Board noted and endorsed the documents, which had 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.

6.5 The Chief Executive drew attention to the Corporate Risk Register summary, which had been discussed in detail at previous Board meetings during the COVID pandemic. During the pandemic focus on high level, operational risks had taken place instead of review and scrutiny of the Board Assurance Framework (BAF). Reference made to the following risks:

CR41 - Summary Referral to Treatment risk had been reduced from 15 to 12 since the last meeting due to the increased mitigating actions in place. Additional focus has taken place on the use of capacity through new governance arrangements.

CR52 - Delayed cancer diagnostics, treatment and care risk remained at 16. It was noted that the number of cases waiting over 62 days for treatment was stable and additional endoscopy capacity is planned to be introduced in October 2020 with the 5th room.

CR54 - Staff well-being and morale risk rated at 12, the score remained unchanged from the previous month. It was noted that colleagues are feeling tired following their experiences of the first wave and they are anxious of what the second wave would present. It was noted that health and wellbeing support will continue with clinical psychological support and additional resources have been put into the internal psychology services.

CR58 – Respiratory service risk rated at 12, the score remained unchanged from the previous month. The substantive recruitment campaign was unsuccessful but a locum appointment has been made. Support to enable a colleague to return to work is being explored together with alternative options to make a substantive appointment.

The Chief Executive highlighted that Phase 3 capital allocations had not been confirmed to date, which remains a key risk. It was noted this had previously been raised with NHS England's regional team and the Chief Executive and Jonathan Coulter planned to discuss further with the ICS.

6.6 With regards to the Board Assurance Framework (BAF) the Chief Executive explained that the Board at its Workshop in July agreed the risks and risk descriptions for inclusion in a revised BAF. The updated draft BAF was discussed and noted, which the Chief Executive explained required further work but he wanted to provide the Board with an update on the work in progress. Once the BAF is approved, the associated risks are planned to be reviewed at each relevant Board Committee meeting.

6.7 Ms Robson thanked the Chief Executive for a helpful, informative report. She also thanked the Chairman and Chief Executive for the personal thank you cards, which had been sent to every member of staff.

6.8 The Chairman voiced concern with regards to the capital position and queried if Board level intervention would be helpful. In response, the Chief Executive explained that further discussions are planned to take place with the ICS and the regional team and the Board would continue to be appraised.

6.9 Ms Robson queried the funding position for Active Against Cancer. In response, the Deputy Chief Executive explained the original funding had been received as part of a pilot scheme, which is due to end at the end of the year, and work is underway to assess the outcome of the pilot to build into a proposal to continue funding.

6.10 Ms Robson sought assurance around the safeguarding risk scores, noting that the scores had remained unchanged from the previous meeting despite an increase in safeguarding concerns being documented in the Board papers. In response, it was noted that this was planned to be taken forward by the Corporate Risk Review Group.

6.11 The Chairman queried how the Board can assist with improving staff morale. In response, it was noted that plans were in place for the November dates of the Listening Event meetings to be shared with the Non-executive Directors for them to join.

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

BoD/09/20/7 Senior Management Team Chair's Report

7.1 The Senior Management Team meeting Chair's Report from the meeting held on 23 September was noted. The key risks identified for Board's attention related to the recovery plan (included on the agenda later in the meeting) and the potential impact of implementing changes to the additional payments. The Chief Executive drew reference to the feedback received from Shadow SMT, which met on 22 September 2020 confirming that their feedback continues to be welcomed and provides an important different and broader voice into our decision making.

7.2 **Resolved:** the Senior Management Team Chair's log was noted.

BoD/07/20/8 **People and Culture Committee Chair's Report**

8.1 Jeremy Cross, Chair of the People and Culture Committee summarised the second meeting of the Committee. It was noted that the People Plan was received and approved, which the Committee found to be an excellent, visual and a well presented document. The next steps include finalising a list of key metrics which will be reported on a quarterly basis to gain assurance on progress. Board colleagues were encouraged to consider championing one of the Network groups (BAME, LGBT+ and Disability). It was also noted that the updated Conflict of Interest and Relationships at Work policy was received and reviewed and following comment would now be considered for approval via the standard internal process.

8.2 **Resolved:** the People and Culture Committee Chair's Report was noted.

BoD/07/20/9 **Conflict of Interest including Relationships at Work Policy**

9.1 The Chairman explained that the updated policy was included in the supplementary pack, which was evidence of a huge piece of work that had taken place to update the policy to implement the recommendations following the independent cultural review report and Audit Committee recommendations. She thanked everyone involved in this piece of work.

9.2 Richard Stiff, Chair of the Audit Committee explained that the updated policy had not been presented to Audit Committee to date but the actions had been discussed at Audit Committee meetings previously with regards to concern overs raised around gifts and hospitality reporting by members of staff. He queried the implementation of the updated policy. In response, the Chief Executive explained that it had previously been agreed by the Board that the updated policy would be reviewed by the People and Culture Committee prior to the Board and this process had now taken place. It was noted that colleagues are personally responsible for declaring interests. The roll-out of the revised policy will include manager briefings, information and advice provided at induction. Colleagues will be required to declare any offers of gifts and hospitality with line manager sign off required and registers will be maintained and publicised for all decision making staff. With regards to loyalty interests, it was noted that an additional risk assessment process was planned to be implemented to support recruitment processes. Communication of the updated requirements was planned along with training to support the successful implementation of the policy. Loyalty interests will be closely monitored through risk assessments by Human Resources to mitigate the risks discussed previously by the Board.

9.3 The Chairman welcomed comments from Clinical Director colleagues. In response, they agreed that they would remind colleagues of responsibilities within their directorates. The Chairman thanked colleagues for the work undertaken and for the commitment to implement this.

9.4 **Resolved:** i) the updated policy was noted to include the additional requirements for the management of relationships at work/loyalty interest for all staff;

ii) the processes to support successful implementation was noted;
iii) recommendations made by internal audit following their 2019 audit of gifts and hospitality were noted had been taken into account when updating the policy and supporting procedures;
iv) the plans in place for a register to be maintained and published for decision making staff was noted.

BoD/07/20/10 **People Plan**

10.1 The People Plan was received and noted. Discussion took place around the content and it was agreed that the graphics would be updated to represent all colleagues of the Trust. Wallace Sampson explained that it would be helpful to strengthen the commitment to diversity employment processes and practices. Ms Armstrong reported that a lengthy discussion took place at the People and Culture Committee covering similar themes raised by the Board.

10.2 **Resolved:** the People Plan was approved subject to adjustments around diversity graphics to represent all colleagues of the Trust and the inclusion of the HIF logo.

BoD/07/20/11 **Director of Workforce and Organisational Development Report**

11.1 Angela Wilkinson spoke to the report, which was noted. She drew reference to the launch of a new recruitment system, 'TRAC' Recruitment. Discussion took place around the health and wellbeing support offered to colleagues throughout the Trust. She also explained that the recent data collection and analysis of the Trust's WRES and WDES data had helped to inform action plans to improve the daily-lived experience of the Trust's BAME and disabled colleagues and to ensure that all colleagues are valued and respected equally.

11.2 Sarah Armstrong queried if analysis had found that female colleagues were experiencing higher exhaustion levels. In response, Angela Wilkinson explained that the majority of the Trust's workforce were female and there had been a large number of colleagues reporting exhaustion. The Trust has in place health and well being support by provided by line managers and occupational health. Natalie Lyth reported that in the CCCC directorate colleagues were finding life dull at the moment, which also had a negative impact on how they feel at work. The Trust is working hard on its cultural programme and is providing support to all colleagues during these unprecedented times.

11.3 **Resolved:** the Director of Workforce and Organisational Development Report was noted.

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

12.1 The Audit Committee Chair's Report from the meeting held on 1 September 2020 was noted. Richard Stiff, Chair of the Audit Committee drew reference to Audit Committee's recommendation to reappointment KPMG as the Trust's external auditors for a further year, which was noted to be within the current contract arrangement. It was noted that the tendering of the contact will be carried out in 2021 The Council of Governors will have a key role in appointing the Trust's External Auditors.

12.2 He also commended the reviewed Treasury Management policy and associated Annual Report to the Board.

12.3 In response to the Chairman's request it was agreed that the procurement timetable for the appointment of the Trust's External Auditors will be shared with the Governors at the December 2020 meeting. **ACTION (J Coulter)**

12.4 **Resolved:** i) the Audit Committee Chair's report from the meeting held on 1 September 2020 was noted; and
ii) the reappointment of KPMG as the Trust's external auditors for a further year was supported.

BoD/07/20/13 **Resource Committee Chair's Report**

13.1 The Resources Committee Chair's Report from the meetings held on 24 August and 28 September 2020 were noted. Maureen Taylor, Chair of the Resources Committee referred to the business case for the Dragon Medical One Site Licence, which was proposed to the 24 August meeting. The Committee supported further discussions with the company around benefits realisation. The Chief Executive confirmed this work had been completed by Jonathan Coulter and Matt Shepherd.

13.2 She drew attention to the 24 September 2020 meeting when the financial position for August 2020 reported a deficit of £196,000 compared to a planned deficit of £314,000. The year to date COVID costs were reported as £5.46m with cumulative top-up of £11.4m. It was noted that the system of retrospective top-up will cease after month 6, and retrospective top-up claims are currently being paid one month in arrears. Phase 1, 2 and 3 COVID capital schemes have still to be confirmed. The Committee agreed that an additional meeting would be arranged in October to discuss the second half-year financial planning arrangements in order that the Committee can consider the financial plan before its submission to the ICS by 22 October 2020. All Board members will be invited to attend this meeting.

13.3 Maureen Taylor explained that the Committee approved two capital investment proposals, which included the Refurbishment of ITU/HDU at a cost of £931,000 and Emergency Department X-Ray Upgrade at a cost of £527,000. Funding was reported to be provided by HCV capital allocation and some charitable funding. She confirmed that the two risks including Phase 1, 2 and 3 capital funding not being received to date; and the risks associated with the second half year financial planning had been discussed throughout the Board meeting that day.

13.4 **Resolved:** the Resource Committee Chair's report from the meetings held on 24 August and 28 September 2020 was noted.

BoD/07/20/14 **Recovery Plan Update**

14.1 Tim Gold presented the Recovery Plan update for performance against the activity required to deliver Phase 3 against the NHS England and Improvement Plan.

14.2 He referred to the Planned Care Recovery Programme. Activity was noted to be behind plan for Day Case procedures, with endoscopy capacity the main cause of the deficit. The two issues requiring urgent attention were noted as: i) work to improve the booking effectiveness across all Points of Delivery; and ii) staff availability to open the fifth Endoscopy Room. It was noted that there were mitigations in place to manage the key risks during October to: i) Ensuring Day Surgery Units 1 and 2 open at the start of month; and ii) Maintaining planned care capacity alongside the likely increased winter and COVID pressures.

14.3 Performance against the Accident & Emergency four hour standard was below 95% at 87.2% in August, a decrease on the previous month. The Trust has invited the Emergency Care Intensive Support Team (ECIST) to assist the Trust with its work to diagnose the causality of the variance to develop the Trust's recovery plan.

14.4 The Winter Plan was noted to be under development to include the surge capacity required for winter pressures and the capacity to respond to a second COVID surge.

14.5 With regards to Cancer, achievement of the 62 day and 14 Day cancer standards in August was noted, with increased focus on addressing the 62 Day and 104 Day backlogs taking place. Plans are in place to track on a weekly basis through the Trust's Performance & Access Meeting. The Board were pleased to note that the performance for two week waiters for non-cancer related breast referrals were above the operational standard of 93% for the first time since April.

14.6 Laura Robson queried the use of the Duchy due to their CQC rating of requires improvement. She sought assurance around the quality and safety measures in place. In response, Tim Gold confirmed that the Duchy's current CQC rating remains requires improvement. To ensure the Trust's quality and patient safety standards are met the Trust has put in place Standard Operating Procedures. The risk does fall within the responsibility of the Duchy but the Trust monitors this closely through weekly meetings with the Duchy. It was agreed Tim Gold would review this. **ACTION (T Gold)**

14.7 Laura Robson queried the arrangements in place in ED during the COVID pandemic and how this affected ED performance. In response, Tim Gold explained the current arrangements with patients being assessed and triaged in ED and noted that additional funding had been provided to enhance staffing.

14.8 Sarah Armstrong queried if personal choice is included within the waiting list process. In response, Tim Gold confirmed that patients who do not wish to have treatment due to COVID19 remain on the Trust's waiting list.

14.9 The Chairman queried the use of virtual arrangements with patients and if feedback is captured. In response, Tim Gold confirmed that feedback from patients regarding their choice could be captured although this had not yet been systematically carried out.

14.10 The Board commended Tim Gold on the format of the Recovery Plan, which they found a great improvement and easy to understand.

14.11 **Resolved:** the Recovery Plan was noted.

BoD/09/20/15 Finance Report

15.1 The Finance Report was noted as at 30 August 2020 with discussion covered within the Resources Committee Chair's report at BoD/07/20/13 above.

15.2 **Resolved:** the Finance Report as at 30 August 2020 was noted.

BoD/09/20/16 Integrated Board Report

16.1 The Integrated Board Report was noted. The Chairman explained that discussions have taken place over a summary sheet to draw out key areas of note, which will be presented to a future meeting.

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

BoD/09/20/17 Quality Committee Chair's Report

17.1 The Quality Committee Chair's Report from the meeting held on 2 September was noted. Laura Robson, Quality Committee Chair explained that Quality Report and Quality Priorities were discussed and recommended to the Board approval of the Quality Report. The Committee had watched a video and following discussion were assured that a thorough assessment of lessons learned from COVID has been undertaken and approved the plans in place if circumstances result in a second spike.

17.2 **Resolved:** the Quality Committee Chair's Report from the meeting held on 2 September 2020 was noted.

BoD/09/20/18 Chief Nurse Report

18.1 The Chief Nurse Report was noted. Jill Foster drew attention to the implementation of the Equality Delivery System (EDS2), which NHS Commissioners and Providers are required to have in place. She explained that the EDS2 Summary Report would be published on the Trust website in January 2020. To support this area of work 'HDFT at its best', the 2020 – 2023 People Plan #the best place to work, the work in relation to WRES and WDES and work taking place towards being an anti-racist organisation are the vehicles to support the Trust from achieving to excelling.

18.2 With regards to Quality and Patient Safety, it was noted that the Care Quality Commission (CQC) is not routinely inspecting services during the COVID pandemic. The CQC are maintaining contact through existing monitoring arrangements and engagement and support calls. Through the COVID Emergency Support Framework, the Trust received an engagement and support call on 31 July 2020 to assess how the Trust is managing the impact of COVID. The CQC plans to share its findings from its provider reviews across all partners of health and Social Care to help shape the national response to the pandemic.

18.3 Jill Foster drew reference to the CQC summary in her report, which confirmed how the Trust had responded to the pandemic. They

confirmed that they were assured by the Infection Prevention and Control Board Assurance Framework (IPC BAF published by NHS England and Improvement in May 2020), which was presented to the Board in May 2020. The CQC requested that the IPC BAF is refreshed and represented to the Board in September 2020, which the Board received and noted, specifically the current PPE guidelines in place.

18.4 With regards to the NHS Resolution, Jill Foster provided an update on the 10 maternity safety actions (Year 3). In year 2 (2019) the Trust's maternity 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. It was noted that the Trust remains fully compliant with year two safety actions with some changes being made to the standards for year three. Due to the COVID pandemic, and in line with the Maternity Transformation Programme the relaunch of the scheme is delayed to 1 October 2020 and submission of the Board declaration has been deferred to 2021. It was noted that Trusts have yet to be notified of this date. Trusts are required to apply the principles of the 10 safety actions, which the department have done during COVID.

18.5 It was noted that there has been an increase in concerns raised in adult and children's safeguarding during COVID in comparison to 2019/20. Reports of domestic abuse were reported at swabbing stations, which resulted in the development of information for ED to support and signpost victims who made a disclosure. Safeguarding (and LD) support was offered initially on a 7 days a week basis, this was found not be required with the usual hours of service resumed.

18.6 It was noted that 38 expressions of interest had been received for the Freedom to Speak Up Guardian position from colleagues across the majority of staff groups. The process of selection includes discussions with the interim FTSUG requiring applicants to complete a problem solving exercise before moving to the next stage of the process.

18.7 The Chairman thanked Jill Foster for her comprehensive report. Laura Robson drew reference to the safeguarding risk on the Corporate Risk Register, which had been discussed earlier in the meeting noting that the risk would be further discussed and reviewed as part of the Trust's risk management arrangements in place.

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

BoD/09/20/19 **Flu Campaign 2020/21**

19.1 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. The Trust is providing the egg based Quadrivalent influenza vaccine (QIVe) and the adjuvant trivalent influence vaccine (aTIV) for this year's programme. The flu programme planning for 2020/21 aims to achieve 100% for frontline workers and is a 100% offer to all colleagues. Jill Foster confirmed that the Flu Campaign was mobilised on 21 September 2020 and progress is monitored on a daily basis by the Flu Group.

19.2 The vaccination of healthcare workers 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.

19.3 The Healthcare Worker Flu Vaccination Self-Assessment Management Check List was noted and suported, which required approving by the Board by December 2020 and was being updated throughout the campaign.

19.4 **Resolved:** the Flu Campaign 2020/21 and progress and monitoring in place was noted.

BoD/09/20/20 **Quality Report 2019/2020**

20.1 It was noted that The Quality Report/Account 2019/20 had been reviewed and approved by the Quality Committee and Audit Committee for endorsement by the Board. The Chairman queried the quality priorities and in response, the Chief Executive explained that there could be additional priorities that are agreed to be taken forward throughout the year. The quality priorities included in the Quality Report/Account were the minimum the Trust would aim to achieve.

20.2 The Board noted the Quality Priorities for 2020/21:

Effective care priorities

1. To develop an integrated clinical service for inpatient unplanned care - ensuring patients see the right clinician at the right time in the right place 7 days a week;
2. To improve the responsiveness and effectiveness of our communication with external partners and our patients by delivering a paper-light system in outpatients.

Safe care priorities

1. To embed the Medical Examiner system and refresh our learning from deaths framework;
2. To ensure quality, safety and confidentiality in virtual consultations;

Patient and colleague experience priorities

1. To ensure we provide a high quality and developmentally appropriate service for our younger patients aged 13-18 years across the organisation; and
2. To enhance the service offered to our patients and colleagues with autism and autism spectrum disorders, by appointing an autism champion, embedding learning and training, and agreeing a Trust-wide approach.

20.3 It was noted that the Quality Report/Account was excluded from the Annual Report for 2019/20, as NHS England and Improvement had changed the annual reporting requirements for providers due to the COVID pandemic. The Quality Report/Account was excluded from external audit requirements and was now required to be completed by December 2020.

20.4 Jeremy Cross drew reference to the graph on page 206 of the report, which was inaccurate. It was agreed this would be updated.
ACTION (J Foster)

20.5 Sarah Armstrong queried if the Trust was considering alternative arrangements for PPE when dealing with visually impaired patients. In response, Jill Foster explained that the Trust was pursuing this through its procurement process.

20.6 **Resolved:** the Quality Report/Account 2019/20 and Quality Priorities for 2021 were approved, subject to the graph on page 206 being updated.

BoD/09/20/21 **Medical Director Report**

21.1 The Medical Director Report was noted. Jackie Andrews explained that this was her second report since taking up the position in June 2020 and she continues to work in partnership with the Chief Nurse and Chief Operating Officer to ensure reports are aligned whilst covering the depth and breadth of our respective portfolios.

21.2 She referred to the Carnell Farrer review and the timeline for the development of the Clinical Services Strategy. It was noted that the new Deputy Medical Director for Operations and Workforce would provide clinical leadership to support this important project when an appointment has been made.

21.4 With regards to research, it was noted that teams are developing a recovery plan to commence recruitment into studies that were paused to allow the COVID urgent public health studies to be delivered. There are currently 44 studies open across the Trust. The COVID Recovery study continues with the first patient recruited into the new convalescent plasma arm, which aims to identify if using plasma from patients who have had COVID will improve recovery.

21.5 The Board were pleased to noted that Dr Jen Lockwood and Dr Gaynor Creaby had been appointed as consultants in Emergency Medicine on 8 September 2020.

21.6 It was noticed that the Medical Director 100 Days in Post Report had been shared with colleagues throughout the Trust and in response to the Chairman's request it was agreed this would be shared with Non-executive Directors. **ACTION (J Andrews)**

21.7 **Resolved:** the Medical Director Report was noted.

BoD/09/20/22 **Guardian of Safe Working Hours Report (Q1)**

22.1 The Guardian of Safe Working Hours quarter one report was noted. Jackie Andrews explained that future reports would be presented in the updated Board format.

22.2 It was noted that plans were in place for appoint a new Guardian of Safe Working Lead. The Chairman would to write to Carl Grey to thank him for his work when a new appointment has been made.

22.3 **Resolved:** the Guardian of Safe Work Hours quarter one report was noted.

BoD/09/20/23 **Any Other Business**

23.1 There was no other business.

BoD/09/20/24 **Evaluation of Meeting**

24.1 It was noted that the meeting had been most productive enabling open discussion and debate on the key operational pressures, risks, governance and strategic planning.

BoD/09/20/25 **Date and Time of Next Meeting**

25.1 The next meeting is scheduled to take place on Wednesday, 25 November 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	16 December 2020	Included on workplan for December 2020 Board Workshop	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	2021 Workshop, date to be finalised	Work in progress	Open
BoD/09/20/5.3	30 September 2020	Chairman's Overview	Patient Story to be re-introduced at the November 2020 Board meeting (held in Public) via prerecorded arrangement	Chief Nurse/ Interim Company Secretary	25 November 2020	Included on agenda	Completed
BoD/07/20/9.4	30 September 2020	Conflict of Interest/Relationships at Work Policy	R Stiff requested that he provide a form of words to be included withi the section that describes the requirements for shareholder interest declaration requirements. Policy to be presented to internal approval process to highlight changes made for approval	Director of Workforce and OD/Interim Company Secretary	09 October 2020	Completed, policy updated and gone through internal policy review approval process. Work on the implementation plan ongoing	Completed
BoD/07/20/10.1	30 September 2020	People Plan	Approved subject to changing graphics to represent all colleagues of the Trust/HIF	Director of Workforce and OD	28 October 2020	Completed.	Completed
BoD/07/20/12	30 September 2020	Audit Committee Chair's Report	Appointment Process for External Auditors. Noted process needs to be completed before Summer 2021	Deputy Chief Executive/Finance Director	14 December 2020	Proposed process to be presented to the Council of Governors meeting on 14 December 2020	Open
BoD/07/20/13.2	30 September 2020	Resource Committee Chair's Report	Agreed Extra Ordinary meeting to be arranged mid October	Deputy Chief Executive/Finance Director/ Interim Company Secretary	mid October 2020	Completed. EO Meeting held on 19 October 2020	Completed

BoD/09/20/20.3	30 September 2020	Quality Report	Report including Priorities approved subject to amendment of graph on page 206, which was inaccurate	Chief Nurse	mid October 2020	Report updated	Completed
BoD/09/20/21.6	30 September 2020	Guardian of Safe Working Quarterly Report	Medical Director 100 days in post report to be shared with Non-executive Directors	Medical Director	mid October 2020	Completed	Completed
BoD/07/20/14	30 September 2020	Recovery Plan Update	It was agreed that a review of the Quality and Safety measures in place at the Duchy would be reviewed to provide assurance to the Board	Chief Operating Officer	25 November 2020	Update to be provided at the meeting	Open

Harrogate and District NHS Foundation Trust

Board of Directors (held in Public)
25 November 2020
Report of the Chief Executive

Agenda Item Number:	**7.0**
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	√
To work with partners to deliver integrated care	√
To ensure clinical and financial sustainability	√

Recommendation:
The Board is asked to note this report.

7

Board of Directors

25 November 2020

Report of the Chief Executive

1.0 Executive Summary

1.1 Since the last Board meeting, routine activity, which was restarted as part of our Phase 3 plan has continued to rise in a number of key areas, although there remain some areas where activity is below plan, and below the level of last year. Changes to the way additional activity is remunerated have been made in order to promote a fairer approach for all Consultants, and this may reduce the degree of non-contractual (waiting list initiative) activity which historically has been high. Strategically, alternative approaches to premium activity need to be developed in order to maintain activity but also to ensure the changing work-life balance demands of colleagues can be met. We will keep the Board updated on the progress of this work, which will form an important part of our approach for 2021/22 given the impact of COVID19 on our waiting list.

1.2 Waiting times for routine care continue to be impacted by the COVID pandemic, and unfortunately despite lower activity in our emergency pathway operational performance against the four hour standard has been lower than we would have wished, and I am disappointed to report that there was an avoidable 12 hour breach in November.

1.3 Our 'at our best' work, designed to develop a consistent culture across HDFT has started and good progress is being made, albeit the pace of the work is impacted by the breadth of activities that colleagues are needing to respond to.

1.4 Much of our work is focused on the more immediate term, which is understandable in the context that we are in. However, it is important that we start to plan for 2021/22 and beyond so that we retain a degree of focus on the medium to long term.

2.0 Leadership and Culture

2.1 **At our best** is our programme of work to make HDFT a consistently excellent place to work, and in which to receive care, building on what is already positive about being part of the team.

2.2 The first stage of the work to engage colleagues to determine the HDFT values and behaviours (**Your voice, your vision, your values**) is nearly completed, with over 1,000 colleagues participating in on-line workshops to reflect on what makes a good and bad day at work and to start to build a framework for recognising colleagues, and giving feedback.

2.3 Feedback has been largely positive, and although the workshops are due to complete by the time the Board meets, we are considering whether to commission a small number of further workshops to ensure sufficient balance of engagement across all directorates.

2.4 There has been positive progress with the HR workstream with the launch of the recruitment improvement work, and training for clinical leads and managers on disciplinary investigations; the Equality, Diversity and Inclusion workstream with the further development of the approach to becoming an anti-racist organisation and with the HIF workstream on terms and conditions and the improvement of the working

environment. Although not due to commence in earnest until January, there had been strong early progress with the Clinical Governance workstream.

2.5 Whilst the demands on teams act as a constraint to the pace of progress, we are seeking to maintain momentum whilst taking a balanced approach to the demands on colleague's time.

2.6 The People and Culture Committee have received an update on status of the formal investigations that were commissioned following the Deloitte review.

3.0 Partnerships

3.1 The Humber Coast and Vale (HCV) Partnership has been focused on collaborative planning for the second wave of COVID19 and the preparation for a possible vaccine, which are covered later in the paper.

3.2 The partnership has been awarded £0.5m of funding to support health and wellbeing. The deployment of this funding will be overseen by the Partnership's People Board.

3.3 The current position on COVID19 is covered in more detail in the following section, but to date HDFT has been less impacted by admissions to hospital compared to other Trusts in the West Yorkshire Association of Acute Trusts (WYAAT). We have therefore provided some modest mutual aid to partner Trusts and will continue to do so, whilst ensuring sufficient capacity for any local surge in activity.

3.4 Across WYAAT an escalation framework has been agreed as a common approach to managing increased demand in a consistent way. To date, the Trust has not required to implement higher levels of escalation, which involve reducing planned activity.

3.5 North Yorkshire is home to 130,000 children and young people and the Trust provides the Healthy Child Programme as part of helping to ensure children in North Yorkshire get the best possible start in life. North Yorkshire County Council, as the commissioner of the service is currently undertaking a public consultation on the proposed model, which the Trust and the Council have developed to respond to a reduction in the public health grant. This model has previously been considered and endorsed by the Board.

3.5.1 The consultation lasts for 10 weeks beginning on Monday 26 October 2020 and ending on Monday 4 January 2021. The responses received during this public consultation will be considered by North Yorkshire County Council's Executive, as well as its Scrutiny of Health Committee, and by Harrogate and District NHS Foundation Trust Board, before any final decision is made. Subject to the outcome of the consultation, it is anticipated the new service will be in place on 1 April 2021.

4.0 COVID-19

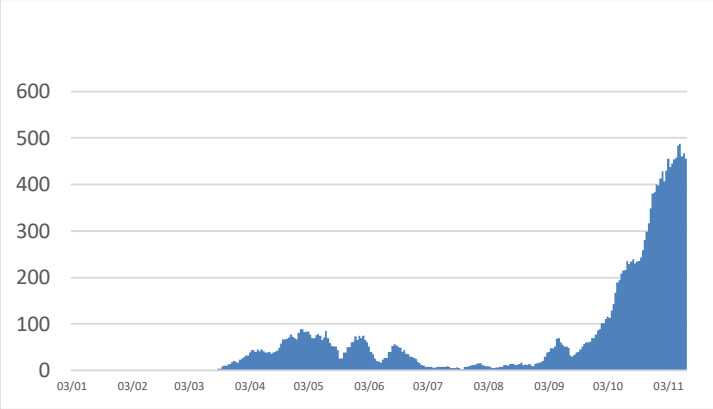
4.1 The NHS is now in the second wave of COVID19. The Trust has a surge plan, which has been refreshed for the second wave.

4.2 To date, although there has been a rise in cases being treated at HDFT, the pressure has been less significant than for surrounding Trusts, with c13% of the Trust's bed base currently occupied by patients with COVID19.

4.3 However, the number of positive community cases in Harrogate has risen, and this may impact on hospital admissions.

4.4 As at 13th November, the 7 day rolling rate per 100k residents was 283. The table below (source gov.uk) shows the number of daily cases reported for Harrogate (Lower

Tier Local Authority level). There is a generally accepted lag between positive cases in the community and hospital admissions indicating that the Trust may come under increased pressure in the coming period.



4.5 On Friday 13th November it was confirmed that Trusts would be expected to roll out lateral flow testing (LFT) for all patient facing colleagues which is expected to be undertaken twice a week. The supporting information was provided on 16th November and is due for implementation by 20th November. This is a significant task, and at the time of writing good progress is being made in being ready to provide LFT to colleagues across our services. Testing is not mandatory, and it is likely that absence will rise initially as it is implemented.

4.6 The NHS has been asked to prepare to undertake vaccination of staff and vulnerable patient groups in the event that a vaccine is approved. The Chief Nurse is the Trust's Executive Lead, and the Chief Pharmacist is the Operational Lead. The Trust's work on flu vaccination is being transitioned into planning for the vaccination of staff, which may be required to be delivered in a short space of time. There is therefore additional focus on concluding the flu vaccination programme by the end of November.

4.7 The Trust has received a summary of the expectation on Boards in terms of measures to minimise the risk of nosocomial transmission in NHS settings (17th November) and further information and assurance will be provided by the Chief Nurse/DIPC.

4.8 Whilst we continue to prepare for any surge in demand, we continue to focus on maintaining routine services in line with our recovery plan. The detail of progress is set out in the Chief Operating Officer's report.

4.9 As part of implementing new ways of working during the pandemic, our Breast team have implemented Magseed. This replaces guidewire treatment for patients with non-palpable breast cancers. Patients were previously not able to be treated on our green pathway due to the need for them to go to radiology prior to surgery, whereas Magseed can be injected 30 days prior to surgery and means patients can now be managed on our green pathway.

5.0 Use of Resources

5.1 The Trust performed in line with plan in Month 7, which was the first month of the new financial regime. An efficiency requirement of c£2m is required between Months 7 and 12 in order to live within the financial envelope.

5.2 The transition from the current level of expenditure, which includes a significant level of non-recurrent COVID19 allocation and centrally determined block payments, to the new financial year is an emerging area of focus for the Trust.

5.3 The Trust has continued to progress the dialogue about historical planned loans, and the in year capital requirement associated with Phase 3 recovery with the ICS, and whilst no conclusion has yet been reached, the ICS is engaging in a very supportive way with the Trust.

5.4 The capital scheme to upgrade ITU is on track, and due to complete prior to Christmas.

6.0 Caldicott Guardian and Senior Information Risk Owner

6.1 The Trust has made changes to its Caldicott Guardian and Senior Information Risk Owner (SIRO) Board designates. The Trust's Caldicott Guardian role is carried out by Jackie Andrews, Medical Director who is responsible for protecting the confidentiality of people's health and care information and making sure it is used properly.

6.2 The Trust's SIRO is carried out by Jill Foster, Chief Nurse who has overall responsibility for the Trust's information risk policy. The SIRO is accountable and responsible for information risk across the organisation. The SIRO is required to ensure that everyone is aware of their personal responsibility to exercise good judgement, and to safeguard and share information appropriately. The SIRO is also responsible for user access into Systems and Service Delivery (SSD) systems.

7.0 Board development

7.1 The Board undertook a development workshop on 28 October 2020, which was very positively evaluated. With a number of new appointments to the Board having taken place, it focused on developing a deeper understanding of the styles and preferences of individual Board members, and the collective team preferences in order to further strengthen an already effective Board. A follow up will take place in

8.0 Development of Board Assurance Framework and Risk Register

8.1 The Board Assurance Framework (BAF) aims to record 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. The BAF is supported by the Corporate Risk Register, which records the most serious operational risks, these risks are scored by consequence x likelihood of 12 to 25.

8.2 **Board Assurance Framework -** The BAF was paused during the first phase of the COVID-19 pandemic with the main focus on operational risk management. At the Board Workshop in July, proposed risks were presented to the Board, which were agreed would be added to a revised BAF. Following the Workshop a draft BAF has been developed by Lead Executive Directors and reviewed by the Board at its last meeting on 30 September 2020, noting that this is work in progress.

8.2.1 Since the last Board meeting the draft BAF has been reviewed by the Corporate Risk Review Group on 13 November 2020 and reviewed and updated by Executive Director leads.

8.2.2 The Board is asked to consider and approve the BAF (Appendix A), and note that it is planned to be further 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 will be highlighted and brought to the attention of Board Committees/Board meetings going forward.

8.3 **Corporate Risk Register -** The full Corporate Risk Register (CRR) has been reviewed by the Corporate Risk Review Group and Senior Management Team during November 2020 and a summary is attached at Appendix B.

9.0 Recommendation

9.1 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.

10.0 Supporting Information

10.1 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. Due to inadequate systems to support health and well-being, there is a risk that staff engagement and team performance is compromised and could impact detrimentally on patient care and 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 EAP service Enhanced H&WB programme designed around Maslow Hierarchy of needs Leadership Circles	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 changes to risk description and additions to key controls	People and Culture Committee	A Wilkinson, Director of Workforce and OD	22.09.20 15.11.20	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 19.11.20	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 19.11.20	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 19.11.20	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 19.11.20	to be populated once risk accepted

Board Assurance Framework

4. STRATEGIC OBJECTIVE: ENSURE CLINICAL AND FINANCIAL SUSTAINABILITY

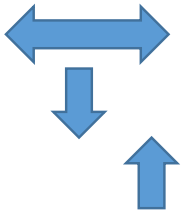
Risk ID	Principle Objective	Principle Risk to the Delivery of Objective	Residual (Current) Risk Rating			Target Risk Score	Target Date Risk Score will be met/closed	Change since last Report	Existing Key Controls	Assurances in Controls		Gaps in Assurances/ Controls	Latest Update	Responsible Committee	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	Due to a prolonged recovery from CoVid-19 there is a risk that the focus on the Trust's strategic ambitions is compromised, which will Impact upon 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 13/11/20	to be populated once risk accepted
BAF#4.2	To provide high quality care and to be a financially sustainable organisation	Due to the difficulty of generating sufficient internal funds through inward investment or additional cash releasing savings, there is a risk to long term financial sustainability and ability to invest in capital, which will impact upon the quality of care that can be provided.	4	4	16	4x2=8	Mar-23	↔	Captial asset register and planning process; financial plan; currrent financial regime	Capital Oversight Group Resource Committee and Board of Directors oversight		**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 the creation of a capital oversight group, financial plan agreed for M7-M12, which delivers the necessary efficiency programme; and PA consulting work in respect of productivity	Resource Committee	J Coulter, Deputy Chief Executive/ Finance Director	22.09.20 13/11/20	to be populated once risk accepted
BAF#4.3	To provide high quality care to children and young people in adults community services	There is a risk that the Trust places insufficient focus on early years services and adult community based services **because** of the historic dominance of hospital services which will **impact** on the transformation opportunities and miss opportunities for long term outcomes and integrated care.	4	4	16	3x3=9	Apr-22	↔	financial plan agreed for Oct 20 to April 21	Adult and Young People Safeguarding Reports	CQC Outstanding Report OFSTED Reports JTAI Reports	No Transformation Team in-house to support and drive this Lack of tangible metrics	risk, controls, assurances and gaps in controls added following Board discussion and approval at Board Workshop		J Foster, Chief Nurse	22.09.20 19.11.20	to be populated

BAF#4.4	To be financially stable to provide outstanding quality of care	**Due to** the allocation formula not providing sufficient resources to meet the needs of the unique demography of the local area, there is a risk that standards of care are compromised which will **impact** on the Trust's ambition to provide outstanding care and its reputation for quality	3	4	12	3x3=9	Apr-21	↔	Quality governance arrangements; Contracts with commissioners; Annual audit cycle; PLACE Assessments ICS and Place based networks	Integrated Board Report Chief Nurse Report Quality Committee minutes Clinical Audit Reports SMT, Resource Committee and Board reports and oversight	CCG Meetings CQC inspection reports Memorandum of Understanding with CCG Memorandum of Understanding with ICS's HARA engagement Relationships with Local Authorities Ongoing dialogue Chief Executive and Deputy Chief Executive/Finance Director has with ICS's and regulators		risk, controls, assurances and gaps in controls added following Board discussion and approval at Board Workshop		J Coulter, Deputy Chief Executive/ Finance Director	22.09.20 13.11.20	to be populated

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

Summary of Corporate Risk Register (Risks Rated 12-25 as at November 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	**Autism Assessment Service** 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 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)	↔	• 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. • Ongoing risk that managing Covid surge could mean postponement of non urgent electives • Significant additional focus on effective use of capacity has been introduced through new governance arrangements.	• Requirement for social distancing in recovery and ward areas is limiting pace of recovery.	Chief Operating Officer
CR49	**ED Imaging** Risk to patients and service when ED X-ray room fails due to age, breakdown or failure to get parts. Equipment now 12 years old and the supplier cannot guarantee parts. Risk to staff due to handling difficulties with aged equipment	12	4 (February 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.	• Completion of works approved in ED	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 has improved in October. • The number of cases waiting over 62 days for treatment is now reducing • Additional endoscopy capacity is being introduced in November with the 5th room and through using Medinet insourcing capacity. • 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 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	**Risk to patient safety, quality of care and staff welfare** Risk 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	12	8 (January 2021)	↔	• There has been no change to this risk. The additional safeguarding support remains in place.	• Availability of specialist expertise	Chief Nurse

New Risks Added (since last reported to Board on 30 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**
CR59	**Cancer IT Services** Risk to patient safety due to lack of automated system for tracking Risk to patient safety from missing relevant / important information due to difficulties with multiple electronic record systems. The inability to scan patients records on to WebV	12	1	New Risk since last reported to Board on 30 Sept 2020	IT requested to prioritise as part of WebV developments - anticipate the project to take at least12 months to complete	Lack of automated system for MDT tracking highlighted in several incidents	Chief Operating Officer
CR2	**Rota gaps in Medical Staffing** Risk to the quality of service delivery in Medicine due to unfilled and vacant rota gaps across grades; reduction in trainee numbers; agency cap rate; variable allocation from deanery; medium term sickness; availability and quality of locums; no-deal EU Exit (added 08/03/2019; impact of Covid-19 (added 13/03/2020).	12	9	New Risk since last reported to Board on 30 Sept 2020		1. Lack of availability of alternative workforce. 2. Development of alternative acute care model. 3. Ability to fill in line with current Agency Cap rate. 4. Respiratory consultant vacancies & LTS cover 5. Recruitment of substantive Acute Oncology, Respiratory, Acute Medicine, Cardiology Consultants 6. Consultant capacity for acute services	Medical Director
CR5	**Nursing shortage** Risk to the quality of service delivery and patient care due to failure to fill registered nurse and health visitor vacancies due to the national labour market shortage and local shortages in some areas e.g. Stockton, and impact of Covid-19 (added 13/03/2020)	12	9 (November 2020)	New Risk since last reported to Board on 30 Sept 2020		1. Current vacant Registered Nurse posts across the in-patient ward areas. 2. Inability to fill Registered Nurse and Health Visitor posts in a timely way due to national (and local in some areas e.g. Stockton) labour market conditions. 3. Trust inpatient ward turnover of registered nurses 15% 4. Lack of available alternative workforce 5. Increased gaps at CSW level 6. Unable to recruit substantively to escalation beds as funding only available part year. 7. Possible increase in sickness due to Covid	Chief Nurse

CR61	**ED 4 hour standard**
	Risk of failure to meet 4 hour ED standard with resultant risk to patient experience and increased concerns and complaints associated with long waits
		12	8	New Risk since last reported to Board on 30 Sept 2020	• Performance has improved
					• Data to be updated to start reporting waits of over 6 hours
					• Improved governance processes & Emergency Care Recovery Plan in place:
					  • Urgent Care Improvement Board established
					  • Updated action plan reflecting pressures within ED and covering gaps in control
					  • ECIST review completed
					  • New weekly breach meeting established to review breaches/ lengths of wait/any extended waits (beyond 6 hours). Meeting will look to triangulate risk of long waits with any harm.
							Chief Operating Officer

CR62	**Special School Nursing** Risk to quality of care and patient safety for Special School nursing patients due to increased demand on provision.	20	6	New Risk since last reported to Board on 30 Sept 2020			Chief Nurse

Risks Removed since last reported to Board on 30 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**
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	9	8 (April 2021)	↓ (previously 12)	• 3 Consultants now in post, recruited to vacancy and one Consultant returned from long term sick leave.		Chief Operating Officer

Harrogate and District NHS Foundation Trust

Board of Directors Meeting (held in Public)
25 November 2020

Committee Name:	Senior Managers Team Chair's Log
Committee Chair:	Chief Executive
Date of meeting:	21 October and 18 November 2020
Date of Board meeting this report is to be presented	25 November 2020

Summary of key issues

The Shadow SMT met on 20 October and 17 November 2020 and provided comments, advice and their own recommended decisions in respect of the items SMT considered at the meetings on 21 October and 18 November 2020. Their feedback continues to be welcomed and provides an important broader voice into our decision making.

21 October, the key issues discussed by SMT were as follows:

- Your Voice/ Vision/Values Culture Programme - Tim Keogh joined the meeting and delivered a presentation on the forthcoming culture workshops and the 'At our best' work. Tim Keogh advised to encourage colleagues to attend by any number of means. The programme would enable those who do attend to skill-up, motivate and share their learning and experiences. The more that join the greater collective learning is achieved.

- Disciplinary Training Programme for managers – colleagues were encouraged to attend the training and cascade amongst their teams to encourage attendance.

- Leadership Support Circles – to support the well-being of colleagues across the Trust. All colleagues were encouraged to sign up to the programme.

- Reciprocal Mentoring – an introduction to the Trust's inclusive mentoring programme, which is planned to be delivered in partnership with Shapiro Consulting was discussed.

- Proposals to Become an Anti-Racist Organisation were discussed and supported.

- Recovery/Operational Performance update was received.

- Continuity of Carer (Maternity) – the future plans for the provision of Maternity services with regards to implementing the Continuity of Carer model was discussed with E Fisher and M McCaul joining the meeting to provide a most informative presentation.

- Flu Campaign - an update on the Trust's healthcare worker flu vaccination campaign for 2020/21 was received.

- Month 6 Financial Performance positon was noted.

- North Yorkshire County Council's 0-19 Service consultation updated plans were received and noted.

- Corporate Risk Register was reviewed and noted.

18 November, the key issues discussed by SMT were as follows:

- COVID Recovery/Operational Performance update was discussed in detail.
- Your Voice, Vision, Values and Culture Programme Update was provided and excellent feedback received following the workshops facilitated by Tim Keogh to date.
- Health and Well-being offer to all Trust colleagues was reported to be developing very well. Shirley Silvester provided an update on the enhanced plan to improve even further going forward.
- Doing it Differently COVID – Natalie Lyth delivered an insightful presentation on the key themes that had been identified from a series of listening events, which involved around 300 colleagues in CCCC using MS Team Live Events with an additional 11 smaller workshops. Natalie, John Haigh and Richard Chillery were recognised for this area of work, which will complement the Trust's overall health and wellbeing offer.
- COVID workforce update and an update on the disciplinary training was received.
- UKVI and Brexit update was provided. The Trust employ approximately 126 EU citizens across the Trust and HIF with some of these staff required to apply to the EU Settlement Scheme by 30 June 2021. To continue living and working within the UK, staff must have arrived in the UK before January 2021 to apply.
- Additional Payment Recommendations update was provided.
- Month 7 Financial Performance positon was noted.
- CQC Action Plan update was provided.
- Quality Priorities and Corporate Risk Register update were received and noted.
- WYAAT Aseptic Collaboration Project update was provided by Kate Woodrow.

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

There were no risks raised in addition to those included on the risk registers.

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

An update from Natalie Lyth on 'Doing it Differently COVID' is recommended to be provided to the next People and Culture Committee meeting.

Board Committee Report to the Board of Directors

Committee Name:	Resources Committee
Committee Chair:	Maureen Taylor, Non-executive Director
Date of last meeting:	19 October, 26 October and 23 November 2020
Date of Board meeting for which this report is prepared	25 November 2020

Summary of key issues:

19 October 2020 – Additional Meeting – Financial Plan

1. The current financial regime came to end at the end of September with new arrangements from October. The committee received information on the new financial regime and the second half year financial plan developed at organisational and local system level.
2. The system is required to produce a financial plan contained within the resources available. At a system level there is a deficit of £17.8m with mitigations in place to manage this; £10.98m will be an allowable deficit (in respect of non-achievement of non-NHS income and annual leave accrual), £3.6m centrally funded and £4.3m through cost reductions throughout the year.
3. The Trust has developed an organisational plan to fit with the system plan. The system and organisational plans assume a break-even position (after allowing for non-achievement of non-NHS income and the annual leave accrual) resulting in the Trust setting a plan at a deficit of £5.4m.
4. An efficiency programme of £2.1m has been developed for delivery by Directorates and Trust-wide.
5. A capital plan has been developed for the remainder of the financial year. Resources of £13m are available with schemes totalling £15.8m. Schemes of £2.68m have been deferred. The programme has no contingency and there is a small element of slippage to manage throughout the year.
6. A Capital Oversight Group has been established to provide more oversight and monitor the delivery of the programme.
7. The plan assumes that cash payments will continue to be received in advance and that cash to support the capital programme matches expenditure.

26 October 2020

8. The committee received information on the financial position for September. The 'true' variance, excluding plan and Covid adjustments was a deficit of £1.3m compared to a planned deficit of £314k. This position recognised an historic accrual relating to hours owed to the Trust and costs associated with payments required to LTHT. Year to date Covid costs amount to £6.2m with cumulative top-up of £14.9m. The system of retrospective top-up will cease after month 6.
9. After adjusting for CoVid costs and material underspends, all directorates are underspent or at break-even.
10. There has been significant progress in planned care recovery, with improvements in day cases and endoscopy. Elective inpatients are also improving whilst outpatients are behind plan. The Emergency Care Intensive

8

Care Support Team is supporting our team to review performance against the Urgent Care Standard and the Urgent Care Improvement Board will be launched in November.

11. The workforce position in September showed substantive staffing behind plan by 54.32 whole time equivalents (wte) whilst bank and agency staff were behind plan by 13.92 and 2.20 wte respectively. The use of Agency staff is below the NHSI cap. The trust vacancy rate is 4.16% down from 4.31% in August.
12. There continues to be a strong pipeline of staff in a number of areas.
13. The consolidated cash position (Trust and HIF) was very healthy at the end of September with a balance in excess of £25m. Excluding top-ups and payments in advance, the underlying cash position is estimated to stand at £6.2m. Retrospective top-ups are running at one month in arrears.
14. Performance against the Better Payment Practice Code is significantly improved. 75% of all invoices are paid within 30 days. There are some delays in validating payments which need to improve. Work is continuing with the CCG on collecting outstanding receivables.
15. The capital programme update previously received at the 19th October 2020 meeting was included for the Committee's assurance.
16. The Q2 financial performance of the WYAAT trusts was noted. The HDFT spend on Covid-19 costs is in line with other trusts.
17. The Committee received a report setting out details of grant funding opportunities for the reduction carbon, energy and backlog maintenance. Two applications for grant funding were approved.
18. Approval was given to a letter of support provided by HDFT to HHFM Ltd, to enable HHFM Ltd to provide assurance to its auditors in respect of being a going concern.
19. The work-plan was reviewed and it was agreed to include a section on post-project evaluation reports which should be provided 12 months after business case approval.

23 November 2020

20. **Month 7 – October**, is the first month of the new financial regime. Prospective and retrospective top-up funding has been replaced with prospective top up and a Covid costs allocation. The trust achieved its plan for October, reporting a deficit position of £340k against a planned deficit of £346k.
21. The only exclusions from these NHS allocations are Covid testing, Flu vaccination programmes and Nightingale costs. The significant change that results in the deficit position is the expectation that non-NHS income will recover to levels seen in 2019/20.
22. Covid costs to date total £7.05m. Greater scrutiny is being placed on Covid returns. Deloitte have undertaken an audit of some CCGs and Trusts and have reported the main reasons why adjustments to claims have been necessary.
23. After adjusting for Covid costs, all Directorates are underspent in the year to date. There is an efficiency requirement for month 7 to month 12 of £1.8m.
24. Planned activity continues to improve. Day case and endoscopy continue to perform strongly against plan, inpatients hit target in October and are expected to be close to target in November. Outpatients remain slightly down on plan and a breakdown of gaps was presented.
25. The 62-day cancer standard was met in October, patients waiting 62 days and 104-day long waiting patients for treatment continue to reduce.
26. ED attendances continue to track the 2019/20 attendance pattern, performance against the 4-hour standard was below 95% in October. Non-elective admissions are at around 80% of 2019/20 levels.

27. The waiting list at the end of October was 7% up on September.
28. Following the ECIST review, an urgent care improvement programme is being scoped.
29. The workforce position in October showed substantive staffing behind plan by 63.67 whole time equivalents (wte) whilst bank and agency staff were behind plan by 13.05 and 3.58 wte respectively. The use of Agency staff is below the NHSI cap. The trust vacancy rate is 4.12% down from 4.16% in September.
30. The biggest vacancy rate is in Children's and County Wide Care Directorate at 6.17% (59.49 wte variance to plan in October). Vacancies in qualified community nursing is the main gap. There is a strong pipe-line of staff particularly in nursing and support to clinical staff.
31. The consolidated cash position (Trust and HIF) was very healthy at the end of October with a balance in excess of £25m. Excluding top-ups and payments in advance, the underlying cash position is estimated to stand at £8.2m. Progress is being made with aged receivables particularly in relation to GP Out of Hours costs.
32. The Committee received a confidential report relating to the opportunity to acquire premises currently owned and managed by NHS Property Services. It was agreed to continue to work with NHSI on this.
33. The Committee approved a loan agreement on behalf of the Board relating to a loan being made available to Harrogate Integrated Facilities for capital schemes.
34. A business case for the introduction of a new Rostering and Job Planning system and process was considered and noted. The Committee would re-visit this to track benefits realised.
35. The Committee received the ECIST report and noted the key areas for focus during the next few months.

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

- Increasing waiting lists and the impact in specific specialties.

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

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Harrogate and District NHS Foundation Trust

Board of Directors (held in Public)
25 November 2020
Operational Update

Agenda Item Number:	**8.1**
Presented for:	Discussion, Information
Report of:	Chief Operating Officer
Author (s):	Chief Operating Officer, Deputy Director of Informatics
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	√

Please copy and paste ✓ against the relevant goal(s) - *then remove this line*

Recommendation:
The Board is asked to note the status and content of the Operational Update report and the key areas of focus for November and December 2020.

Harrogate and District NHS Foundation Trust Engagement Report

Emergency Care Improvement Support Team

15 October 2020

NHS England and NHS Improvement

Background

- ECIST was approached by the trust to undertake a review of the urgent and emergency care pathway.
- The system traditionally performs highly against the range of UEC metrics, but is aware that performance has started to fall recently.
- ECIST has been asked to provide a brief report with recommendations of actions that would improve flow across the system. Any further support required will be discussed once the report is available.
- The request has been signed off by the executive team, who request that this work is completed as quickly as possible.
- The primary point of contact for ECIST is Natalie Davidson, Improvement Manager.

Harrogate Engagement Plan

22/9/20

ECIST team:

Natalie Davidson (Improvement manager)

Dr Kevin Reynard

(ED consultant)

Dr Nick Roper

(Acute physician)

Patrick Farrell (Improvement manager)

1/10/20

ECIST team:

Natalie Davidson

Dr Nick Roper

Tim Gillatt

(Senior improvement manager)

Lisa Hulme (Improvement manager)

w/c 5/10/20

A series of interviews over MS Teams, followed by a system workshop

CANCE:LLED – due to opportunity to review in week 2 and good processes demonstrated

w/c 12/10/20

A slide deck of key findings and recommendations

Data review led by Chris Green, ECIST head of informatics

Summary of recommendations and observations

- We recommend that the streaming process is simplified and redefined. This will also help increase the number of patients directed to the ART and SDEC earlier in the patient pathway.
- We recommend that the ambulance service is permitted to transfer direct to the SDEC for agreed conditions, reducing pressure on the ED.
- We recommend that there is a zero tolerance to ambulance handover delays.
- We recommend that the work in relation to frailty remains a priority, to reduce the length of hospital stay and improve patient outcomes.
- We recommend that the assessment area function is reviewed, and a capacity and demand exercise undertaken.
- We recommend that SDEC, AMU, SAU and ED teams meet to agree process to allow patients to transfer in a timely manner utilising the Harlow suite.
- We recommend that the trust site management and escalation processes are reviewed to ensure clear processes that support consistent decision making.
- We recommend the development of a system wide UEC dashboard.

Discharge processes

Observations

- The team described good use of discharge to assess pathways, with same day discharges within 3 hours of a decision being made.
- Good examples of parallel planning for discharge for frail patients.
- Strong health and social care integration.
- Pathway three at 3% for new placement and the teams were pushing to achieve the 1% standard.
- Good commissioning discussions to enhance pathway one.
- Discharge lounge open 12 hours per day, 7 days per week.
- Clinical criteria for discharge in place and examples of nurse led discharge were shared.
- Number of weekend discharges could be improved.

Impact

- Patients receive a good standard of care and a positive experience, reducing the risk of deconditioning through extended hospital delays or readmission through ineffective discharge.

Recommendations

- Management of patient & family expectations for discharge from point of admission to support “home first” ethos.
- Development of a system wide dashboard.
- Complete a case study to showcase discharge processes and integrated ways of working.

Clinical Site Management

Observations

- The clinical site team are very impressive; a team of experienced senior leaders who know the organisation and work hard to ensure safety and flow.
- There were a number of empty beds at the morning meeting and these were almost exclusively on inpatient wards, rather than acute medical unit.
- The trust has a lot of data that could be/is used to inform decisions around flow.
- Site meeting did not follow a particular agenda.
- Clinical site team take lots of actions that could be done by directorate for example COVID test results.
- Recent increased use of discharge lounge.

Impact

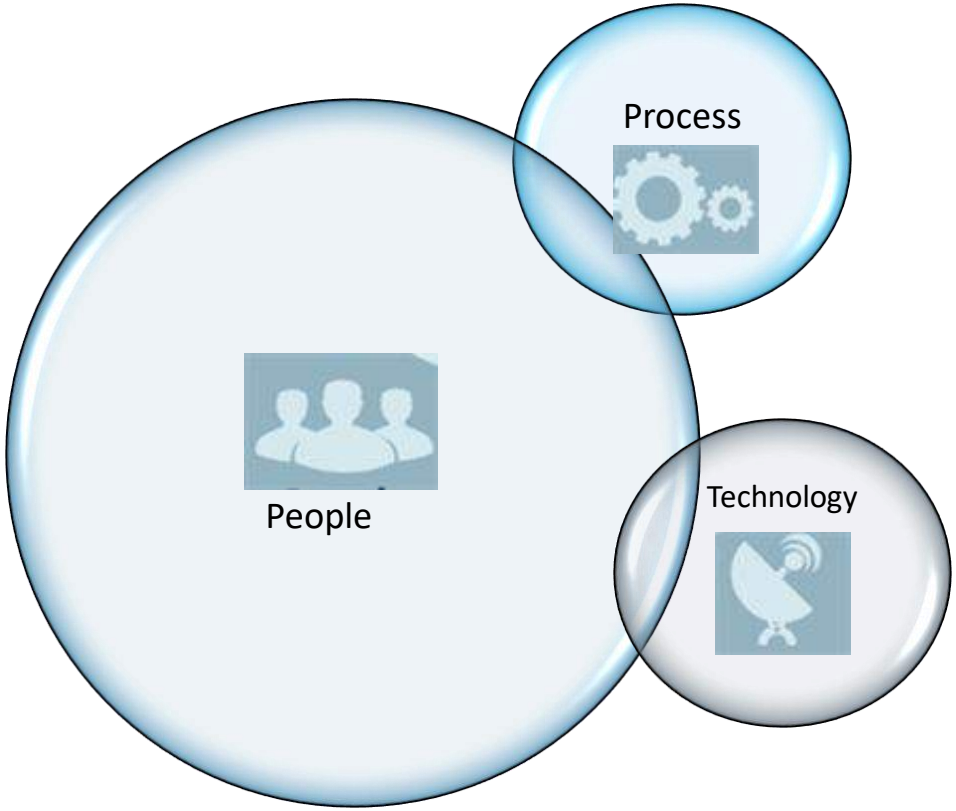
- Good site management and escalation processes provide a solid platform for daily decisions to allow consistency in application, removing person specific delivery.

Recommendations

- Redress the balance between people, process and technology.
- Clarity on relationships between clinical site team and directorate teams.
- Develop more structured site meetings.
- Develop escalation tools.

Clinical Site Management Opportunities

Current model



Best practice

FOCUS

5 Key Principles for Operational Site Management

ECIST have developed the following five guiding principles as a framework for effective operational site management:

Front door position and triggers - Current position and actions.

- Use of the trigger tool specific to site.
- Today's performance - current vs predicted
- Oversight of waits in each stream
- Speciality delays and response ED vs Professional Standards
- Next breach time and plan for patient
- Ensure all patients have a plan at two hours
- Senior nurse and medical coordination i.e. board rounds at agreed times
- Ambulance arrivals and offload position.

Operational oversight and management of whole hospital constraints.

- Outlier areas - ensure all patients have been reviewed. Prioritise which areas should be closed first
- Staffing issues
- ITU / HDU capacity and escalation plan.
- Tertiary referral and repatriation position
- Infection control i.e. side room capacity and decontamination
- Understand demand and capacity of all diagnostics
- Unresolved delays – communicate **Red** day problems and ensure action is taken
- Today's ACTUAL and POTENTIAL discharges (risks identified e.g. transport).
- Confirm that board / ward rounds happened on all wards
- Use a predictive demand model based upon previous activity

Challenge patient plans and pathways.

- Is the bed request appropriate? Has a senior review taken place?
- Can the patient be appropriately managed as short stay or do they require a speciality specific bed?
- Is the patient on the right pathway or could alternatives be suitable e.g. hot clinics, day case, AEC
- Plans for all emergency department patients at two hours with the doctor and nurse in charge
- Speciality teams who fail to respond to emergency department referrals in line with agreed internal professional standards

Understand actions required and agree accountability.

- Site meeting should generate specific actions for individuals. Actions need to be allocated to an individual with an agreed response time to ensure accountability and delivery
- Understand the actual demand against predictive demand throughout the day.
- Actions should be logged and circulated to relevant teams
- Actions should be monitored for progress and reported back to the site team
- Agree OPEL (operational pressures escalation levels) level
- Any service continuity challenges and impact on flow

Site plans, escalation and report.

- Be proactive not reactive. Always have a plan for the next two hours, eight hours and the following day
- Clear documented actions and identify responsible colleagues responsible for delivery
- Each OPEL (escalation) level should trigger specific actions to prevent further deterioration
- System wide escalation, support and response monitoring.
- Avoid 'escalitis' – use SBAR to communicate

Assessment Areas

Observations

- The assessment unit, also used as COVID assessment, COVID ward and respiratory support ward is too small to support all these functions.
- A lot of time and effort is used negotiating transactional requests such as patient moves or handover.
- There is no central system for transferring information. Oversight, command and control is undermined by lack of visible information.
- The process for requesting diagnostics is person specific.
- The SDEC model is not resilient as it is based on a single consultant run service.
- The AMU consultant working and board round seemed overly complex.

Impact

- Having high functioning assessment areas and SDEC will have a significant positive impact on flow and ED performance.

Recommendations

- There is a need to review capacity versus demand, by time of day and day of week.
- There is opportunity to implement a consistent process for requesting diagnostics.
- Consider splitting the assessment ward between the two acute consultants. If there is a need for speciality advice then this should be readily available.
- The SDEC model needs to focus on the key business. This is a good resource, but needs some role clarity as its currently a mix of new, elective, day case and a some “long term” patients which dilutes the service effectiveness in relation to emergency care.
- Review the function and timing on the AMU board round. Aim for genuine MDT working and prioritisation of early discharges and moves

Streaming and Pathways

Observation

- There is no real clinical streaming process in place at ambulance handover or walk in, in accordance with the RCEM & RCN guidelines (simple, complex)
- The streaming process observed gathers an array of more detailed information than is required to undertake streaming and triage. For example, full triage of minor injury patients
- Effectiveness is limited by variation in pathways and acceptance practices by assessment area staff, specialities and ART.
- The frailty pathway could be enhanced to increase the number of patients who are able to be discharged on the same day or after a short stay in hospital.

Impact

- The impact of clinical streaming is limited by variable access to alternatives to ED, such as SDEC. This is playing a key role in the increasing time to bee seen metric, percentage within the hour.

Recommendation

- Run small scale tests of change (PDSAs) at walk in and ambulance handover points to understand opportunities to improve patient safety, experience and flow whilst developing the future 'business as usual' model. Redefine streaming with clear objectives to develop a rapid timely service with a range of disposal destinations.
- Think of triage as a dynamic process
- Test pathways and processes to allow direct streaming to all assessment areas to ensure direct and immediate access to agreed receiving streams
- Continue to develop frailty service working with the acute frailty network
- Participation in ECIST webinars – both STP and national forums are available
- Understand current and potential streaming flows.

Emergency Care
Intensive Support Team

Safer, faster, better care for patients

NHS

Ambulance handover and Fit2Sit

Observations

- The ambulance handover is performed by the clinical co-ordinator which can delay the handover process, particularly at times of surge of ambulance arrival.
- There is no prehospital or effective streaming at handover for ambulance patients, therefore all patients are processed first in the ED.
- The principles and benefits of Fit 2 Sit are not widely understood resulting in variation in application
- It is imperative that there is a separate streaming and triage function, working as a team, communication and leading an effective nurse led front door model.

Impact

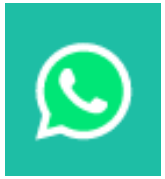
- The average ambulance handover time can extend beyond the 15-minute standard which places undue demand on the department, as well as increased risk in the community.

Recommendations

- Remodel front door handover process to aid flow, separating the triage/handover process from the further initial assessment.
- Create a new first point of contact process separate from the clinical co-ordination role.
- Develop pathways for ambulance direct to walk in, SDEC, ART etc.
- There must be a zero tolerance to handover delays and paramedic oversight of queued patients.
- Fit2Sit principle should be considered at all points within the ED pathway.

ECIST Support Offer

1. Streaming
   - To support the implementation of new streaming pathways
2. Frailty
   - To compliment the Acute Frailty Network programme of work
   - To focus on same day and short stay opportunities
3. Clinical mentoring
   - To provide 1:1 support in key areas
4. Site management and escalation
   - To review daily processes and the information available to provide effective and consistent site management (24/7)
   - To develop escalation triggers and associated actions
5. Discharge case study
   - To provide a case study to showcase the cross organisational, good practice in relation to hospital discharge



System Requirements

- The trust is asked to provide:
  - Executive and clinical sponsors for the work
  - Operational staff to accompany the ECIST team on walkthroughs
  - Local infection prevention and control policies
  - Access to appropriate clinical and managerial staff
  - Contact details for a senior analyst to work alongside the ECIST head of informatics to develop a UEC data pack
  - Space for the ECIST team to conduct interviews with staff members
  - Local data on UEC
  - Introductions to key leaders and staff in local partner organisations

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

Join the ECIST network

NHS

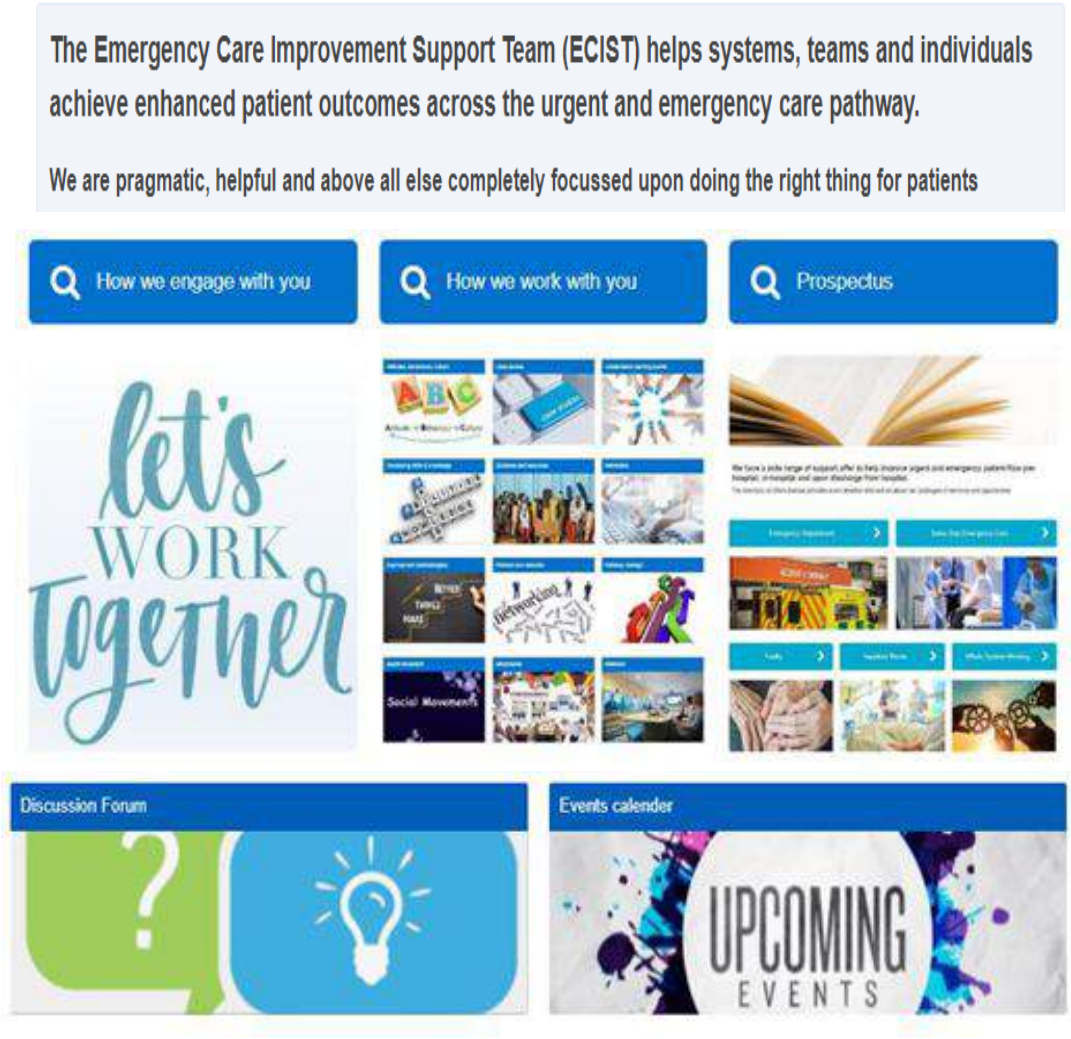
ECIST Network

The ECIST Network site has been developed to support you and your colleagues on your improvement journey, as well as giving you the ability to network and share ideas nationally and internationally.

What is available:

- Access resources including; national guidance, national websites, good practice examples, improvement guides, resources and templates, case studies, blogs, videos and much more.
- Discover more about ECIST and how we can help
- Join events and discussion forums
- Share ideas and resources

We hope you find the ECIST site useful, enjoy networking and sharing good news stories!



Join the ECIST network

This is an open network so please do share this link with your colleagues.

Harrogate and District NHS Foundation Trust

Board of Directors (held in Public)
25 November 2020
Finance Report

Agenda Item Number:	**8.2**
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:

1. receive and note the content of the report; and
2. approve the Treasury Management Policy appended to this report, which was reviewed and supported by the Audit Committee at its meeting held on 1 September 2020.

Harrogate and District
NHS Foundation Trust

Financial Position

Board of Directors – 25/11/2020

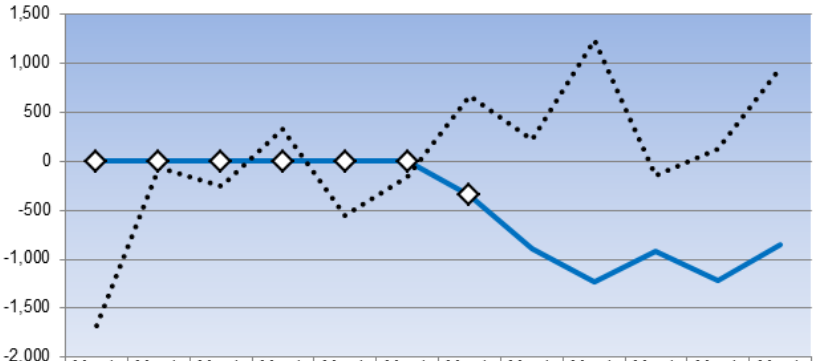
8.2

Financial Position

Harrogate and District NHS Foundation Trust

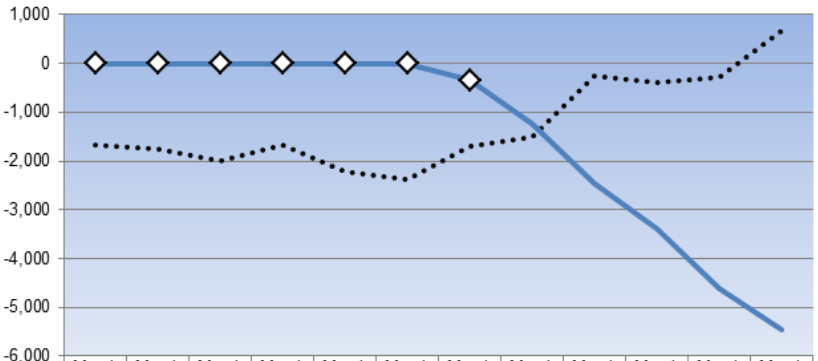
The Trust reported a deficit position in month 7 of £340k, a position closely aligned to the plan submitted to NHSEI for month 7. As this is the first month of the new financial regime, the year to date variance is the same as the in month position. The graphs below outline this.

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
Plan	0	0	0	0	0	0	-346	-892	-1,226	-920	-1,221	-845
Actual	0	0	0	0	0	0	-340					
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
Plan	0	0	0	0	0	0	-346	-1,238	-2,464	-3,384	-4,605	-5,450
Actual	0	0	0	0	0	0	-340					

To month 6 the position was supported by £1.9m and £13.0m of prospective and retrospective top up funding respectively. As previously described the funding position for month 7 onwards has moved to a prospective top up and a covid allocation. In month 7 this equates to £2.3m of support. The combined income associated with Covid and Top Ups in the position is £17.2m.

Relatively few items are excluded from these allocations for NHS income. The exclusions include Covid Testing, Flu vaccination programmes and Nightingale costs. Directorate are asked to flag anything that may be linked to the above to the finance team to ensure appropriate reimbursement.

As a reminder, the significant change that results in a deficit position relates to the national expectation that non NHS income will recover to levels seen in 2019/20. The calculation of this expectation for the Trust results in a plan that is actually greater than 2019/20, hence the material impact in plan. In October the plan for this was £4.8m and the Trust reported a position of £4.1m.

Added to the above there has been an estimate of the impact of increased annual leave provisions that will not be factored into the position until later in the year.

As previously described this position includes an efficiency requirement of £1.8m which has been shared between directorates.

Directorate Position

Harrogate and District NHS Foundation Trust

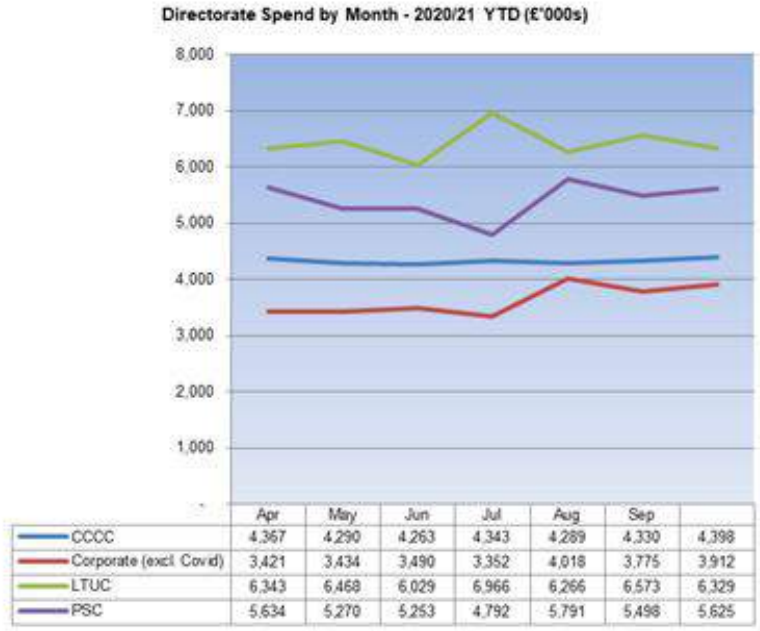
The tables below outline the in month and YTD positions for each Directorate.

Directorate	Month 7 Budget £'000s	Month 7 Actual £'000s	Variance £'000s	% Variance %
CCCC	4,549	4,398	- 150	-3%
Corporate (excl. Covid)	4,450	3,912	- 538	-12%
LTUC	6,405	6,329	- 76	-1%
PSC	6,233	5,625	- 608	-10%

Directorate	YTD Budget £'000s	YTD Actual £'000s	Variance £'000s	% Variance %
CCCC	31,052	30,280	- 772	-2%
Corporate (excl. Covid)	26,906	27,376	- 683	-3%
LTUC	45,826	45,384	- 442	-1%
PSC	40,108	37,454	- 2,654	-7%

Final Covid budgets were uploaded in month 7, effecting corporate services in particular. Covid costs in month are estimated across the Trust at £800k but the reporting is currently being finalised.

The graph below outlines spend per month by each directorate.



There is an efficiency requirement for M7 to 12 of £1.8m based upon expected winter costs, and comparing the funding available to the agreed budgets, so Directorates will need to be delivering efficiency focusing on low risk CIP plan.

Added to this, the recent PA report highlighted opportunities within temporary staffing, procurement and estates which will be explored for both this year and into 2021/22.

The temporary staffing element is connected with ensuring that we have sufficient controls in respect of rostering to establishment and use of bank and agency staff, which largely relates to nursing and medical staffing. This is particularly important now that we have implemented the agreed staffing levels for the next six months.

Whilst the planning process for 2021/22 may be challenging, it is likely that the expectations will be more simple, living within allocations pre Covid levels. The approach to this is being developed and will be discussed in more detail in future Resource Committees.

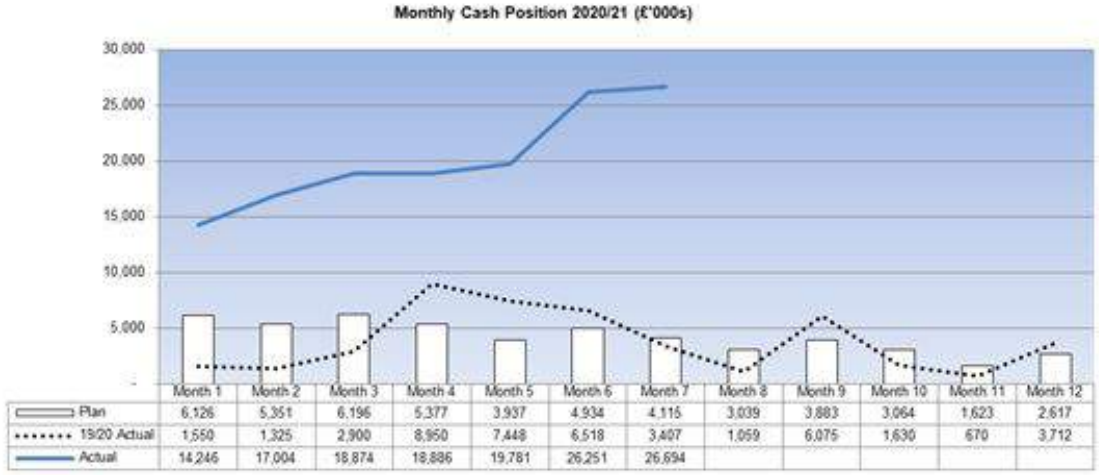
Cashflow, Debtors and Creditors

Harrogate and District NHS Foundation Trust

As outlined in the graph to the right, the Trust cash position is extremely positive. The improvement in month was again more favourable than expected, with the Trust receiving prospective payment for top up and covid for 2 months.

The finance team are currently reviewing information in relation to payment of debts. This is measured as part of the Better Payment Practice Code which requires payment within 30 days, although current expectations are 7 days. The target is 95%.

One of the main blocks to achieving 95% remains the timely receipting of goods. On a weekly basis all invoices which are validated are being paid. Budget holders have been reminded of the importance of this in order to support key suppliers to the Trust.

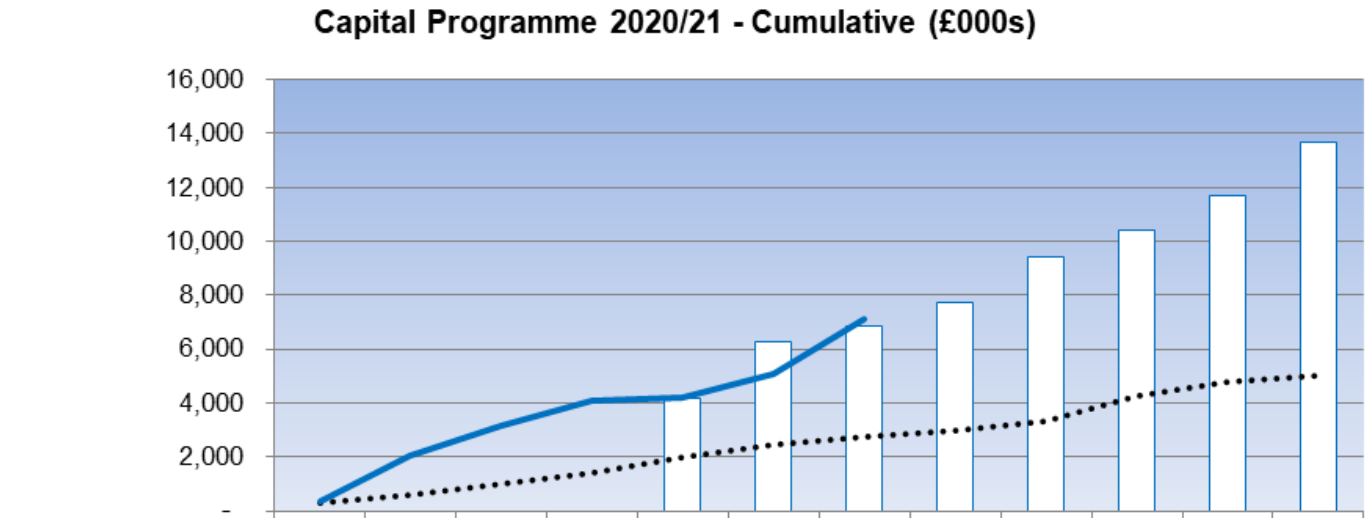


	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12
Plan	6,126	5,351	6,196	5,377	3,937	4,934	4,115	3,039	3,883	3,064	1,623	2,617
19/20 Actual	1,550	1,325	2,900	8,950	7,448	6,518	3,407	1,059	6,075	1,630	670	3,712
Actual	14,246	17,004	18,874	18,886	19,781	26,251	26,694					

Capital Position

NHS
Harrogate and District
NHS Foundation Trust

The table below outlines the cumulative Capital expenditure for 2020/21..



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2020/21 Plan					4,187	6,258	6,869	7,730	9,398	10,397	11,719	13,683
2019/20	265	581	988	1,414	1,989	2,445	2,744	2,999	3,351	4,286	4,801	5,042
2020/21	350	2,069	3,154	4,084	4,187	5,100	7,093					

As highlighted in Resource Committee, the size of the programme this year is materially greater than recent years. Whilst a significant proportion relates to investment linked to Covid-19 requirements, there is also a number of developments within this. The level of work will be challenging to complete, however, at present the Trust is forecasting that it will meet this plan.

Schemes are developed to exceed the above target, however, whilst local discussions are positive about providing CDEL cover the Trust remains in discussion about the cash support to enable further work to be progressed.

Harrogate and District NHS
NHS Foundation Trust

TREASURY MANAGEMENT POLICY

Version	Date	Purpose of Issue/Description of Change	Review Date
1-10	Jun 05 – Sep 14	Initial Issue and 12 monthly review of Policy	Jun 06 – Aug 15
11	Sept 2015	12 month review of Policy	August 2016
12	Sept 2016	12 month review of Policy	August 2017
13	Aug 2017	12 month review of Policy	July 2018
14	Aug 2018	12 month review of Policy	July 2019
15	Aug 2019	12 month review of Policy	August 2020
16	Aug 2020	12 month review of Policy	August 2021

Status	Open	
Publication Scheme	Document Library>>Policies	
FOI Classification	Release without reference to author	
Function/Activity	Treasury Management	
Record Type	Policy	
Project Name	**N/A**	
Key Words	Treasury, Management, Policy, Finance	
Standard	**N/A**	
Scope / Location	Trust-wide	
Author	Head of Financial Accounts	**Date 30 August 2019**
Approval and/or Ratification Body	Board of Directors Board of Directors Board of Directors Board of Directors Board of Directors Board of Directors	May 05 – Jan 15 Oct 2015 Sep 2016 Aug 2017 Sep 2018 Oct 2019

8.2

CONTENTS

1 INTRODUCTION

NHS Foundation Trusts are required to manage their affairs in a way that ensures they remain 'going concerns' and have access to sufficient cash and other liquid assets to meet their financial obligations. A key element of this is having an effective policy for Treasury Management.

Treasury Management includes the management of:

- Cash flow (monitoring and forecasting).
- Working capital management.
- Banking.
- Money and capital market transactions.
- Optimising returns through investment.
- Reducing financial transaction and borrowing costs.
- Minimising financial and corporate risk.

Donated funds are regulated by the Standing Financial Instructions and other guidelines relating to Charitable Funds and decisions on investments are made by the Trust's Charitable Funds Committee.

2 AIMS AND OBJECTIVES

The Treasury Management Policy aims and objectives are:

- To apply and develop professional standards and disciplines to the Treasury management function.
- To identify, manage, reduce and eliminate where possible, financial risk arising from operational and treasury management activities.
- To support the delivery of the Trust's objectives by ensuring short and long term availability of liquidity.
- To minimise costs by borrowing on flexible and competitively priced terms.
- To manage HDFT's liabilities and investment assets prudently ensuring commitments can be met as they fall due.

3 KEY RESPONSIBILITIES AND CONTROLS

The Chief Executive is the Accountable Officer for the Trust and is charged, with the Board, in ensuring probity in the use of public money. Responsibility for the day to day management of the Trust's financial systems rests with the Finance Director.

The Finance Director is responsible for the following:

- Ensuring that controls and processes are sufficient to meet the aims and objectives of the Treasury Management policy.
- Making recommendations to the Trust Board for a system of delegated authority limits and implementing and reviewing those limits on a regular basis.

- Establishing strict limitations on the types of investments for deposits of surplus cash and the circumstances in which they may be used.
- Managing daylight exposure (a limit set by a bank on its foreign-exchange dealings in a given currency with a particular counterparty) in the use of agreed counter-party limits.
- Ensuring that all moneys due from maturing or sold assets are received on time by the Trust.

4 INVESTMENTS

Cash investment decisions will be aimed at ensuring security, safeguarding liquidity and maximising income to support the financial aims of the Trust.

The Trust will only invest cash in organisations or financial institutions that offer the maximum security for the investment, in line with NHS Improvement's definition of a 'safe harbour' investment. The types of organisations that can provide this are:

- UK Government Departments and Agencies (excluding those contracted out to the private sector).
- Local Authorities.
- Banks, Building Societies and any similar institutions granted permission to trade by the FSA particularly those that are unlikely to fail).
- Approved Money Market Funds.
- Open ended investments such as unit trusts or bond funds where all elements of the investment meet NHS Improvement's safe harbour criteria.
- Revenue repurchase transactions where collateral is securities backed by the UK Government and the counterparty is a permitted institution under the NHS Improvement's definition.
- Wholly owned subsidiary companies.

5 APPROVED INVESTMENT INSTITUTIONS

The Department of Health changed the methodology for calculating Public Dividend Capital (PDC) dividends from 2013 onwards, by excluding cash from the calculation based on average daily cleared balances as opposed to opening and closing cash balance. This will have the effect of increasing the amount of PDC dividend paid annually. As the UK bank base rate is currently 0.1% and that returns from short term investment is very low, the cost of the extra PDC dividends far outweighs the benefit earned from the short term investment.

For example, on £5m there is a 3.5% saving on PDC dividend which totals £175,000 pa. Any investment made at the present time within this policy, and whilst the UK bank base rate is 0.1%, are unlikely to yield 3.5%. Therefore, the Trust does not intend to place any investment until UK bank base rate rises to 3.5% or above. At that time, the Audit Committee will consider the Investment Policy again. It is likely that some financial institutions, whilst meeting the current definitions outlined in section 4 of this policy, would be excluded because of individual credit ratings or other information.

The Trust will keep all of its cash with the Government Banking Service (GBS), the National Loan Fund (NLF) and Harrogate Healthcare Facilities Management Ltd (HHFM Ltd) until such time where base rate goes above 3.5%.

6 LIMIT PER COUNTERPARTY

GBS	Unlimited
NLF	Unlimited
HHFM Ltd	Unlimited

7 MAXIMUM INVESTMENT PERIOD

With the exception of equity held in HHFM Ltd the maximum period of 12 months will be permitted for investments. For investments with a fixed period of up to 6 months Finance Director approval is required. Board of Director approval is required for investments with a fixed period between 6 and 12 months.

8 DELEGATION OF RESPONSIBILITY FOR BORROWING

Post implementation of the Risk Assessment Framework the Trust no longer has a Prudential Borrowing Limit set annually by NHS Improvement. The Board will authorise the strategic use of all borrowing in advance; whilst delegating day-to-day responsibility for all borrowing to the Chairman and Chief Executive collectively.

One of any of the Non-Executive Directors can deputise for the Chairman. The Finance Director can deputise for the Chief Executive.

In order to carry out these duties, the Chairman and Chief Executive will request from the Finance Director as required reports on borrowing, including:-

- Performance monitoring.
- Review of borrowing requirements, funding plans and interest rate strategy.

The information included in the above reports will form part of the Trust's annual business planning process and the output of which will be approved by the Board of Directors.

9 AUDIT COMMITTEE

The Audit Committee is responsible for:

- Ensuring that public money is safeguarded and properly accounted for.
- Ensuring that the Trust's investment and borrowing strategy retains an appropriate risk profile.
- Ensuring that proper safeguards are in place for the security of the Trust's funds by agreeing the list of permitted institutions, setting investment limits for each institution and agreeing permitted investment types.

- Performing an annual review of this Policy and recommending approval to the Board of Directors.

10 APPENDICES

Appendix 1: Consultation Summary

10.1 Appendix 1: Consultation Summary

	List Groups and or Individuals Consulted
Those listed opposite have been consulted and comments/actions incorporated as required. The author must ensure that relevant individuals/groups have been involved in consultation as required prior to this document being submitted for approval.	Finance Director/Deputy Chief Executive
	Deputy Finance Director
	Audit Committee

Harrogate and District NHS Foundation Trust

Board of Directors (held in Public)
25 November 2020
Integrated Board Report (October 2020)

Agenda Item Number:	**8.3**
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:
The Board is asked to note the items contained within this report.

8.3

Harrogate and District NHS Foundation Trust

Integrated board report - October 2020

Key points this month

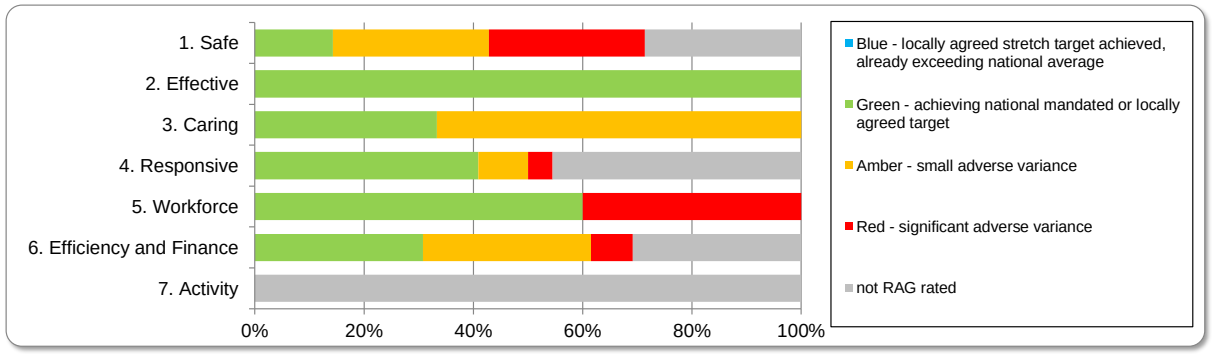
1. The Trust reported a deficit of £340k, a small favourable variance to the planned deficit of £346k. This is supported by top up and covid income of £2.2m.

2. HDFT's performance against the A&E 4-hour standard remained below 95% in October (90.9%). This is however an increase on last month. The year to date position for 2020/21 now stands at 91.4%.

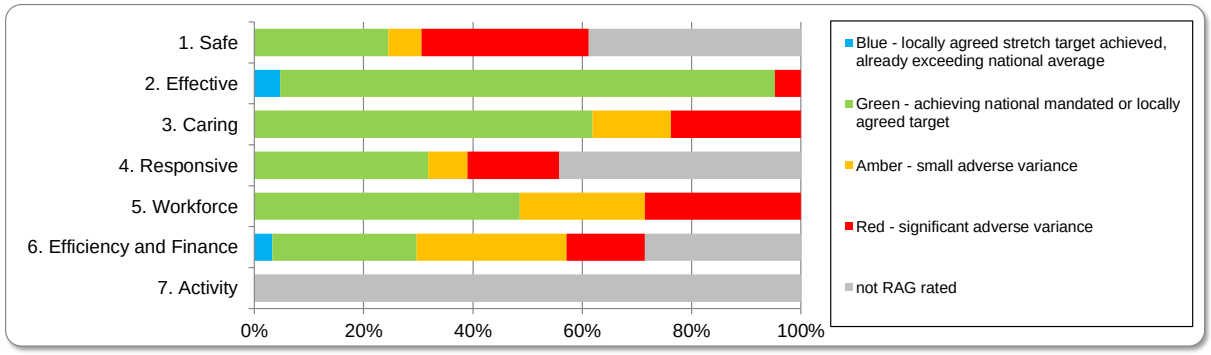
3. Provisional data shows that performance against the 62 day cancer standard was delivered in October with performance at 89.0%.

4. Both 14 day cancer standards were delivered in October, but predicted performance for November is below the 93% standard for both standards due to a significant rise in breast referrals at the end of October (further details contained in this report).

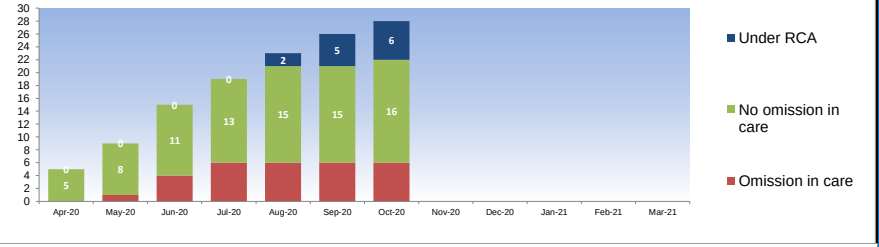
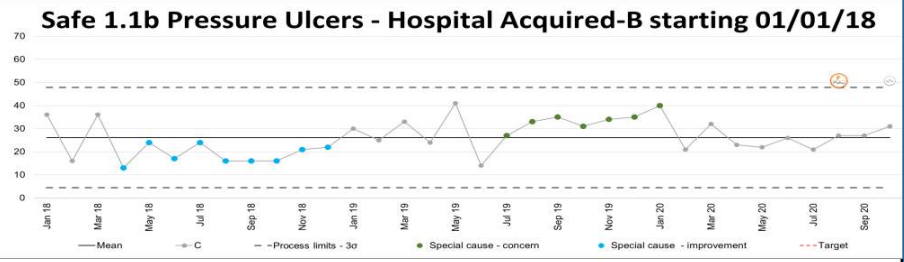
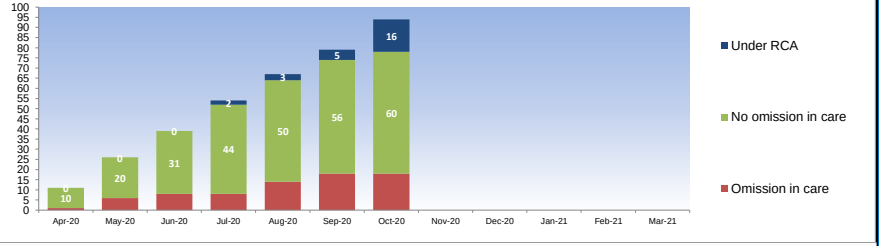
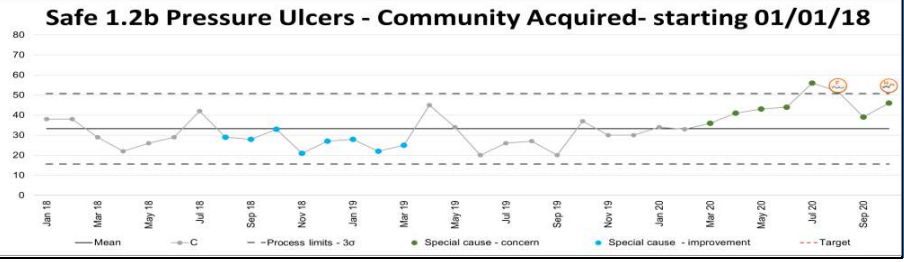
Summary of indicators - current month



Summary of indicators - year to date

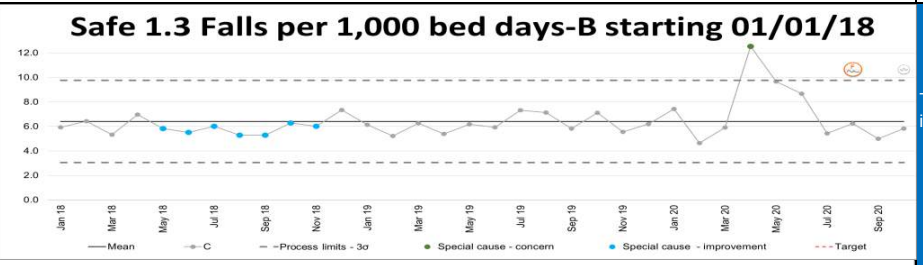
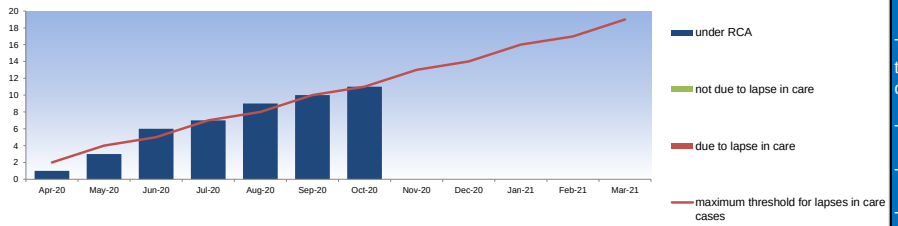
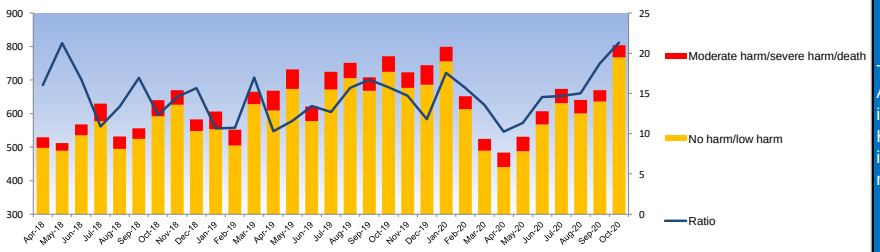
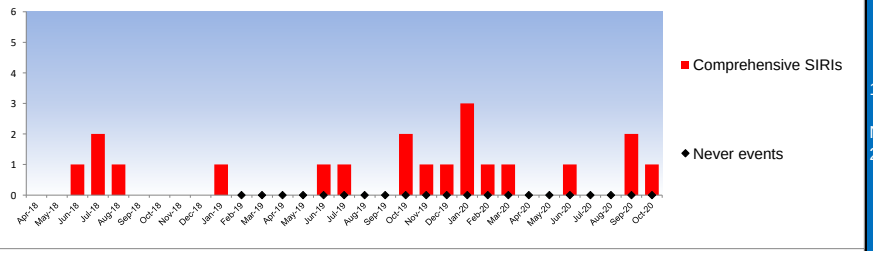


Section 1 - Safe - October 2020

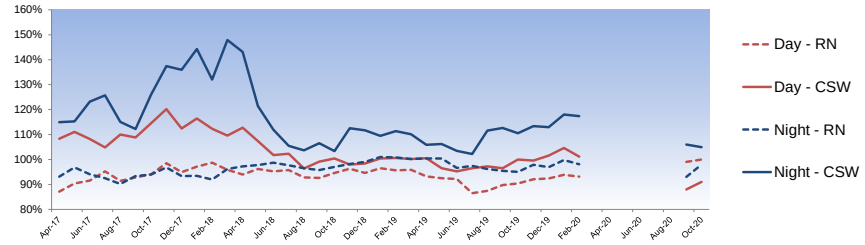
Indicator number	Indicator name / data quality assessment	Trend chart	Interpretation
1.1a	Pressure ulcers - hospital acquired		There were 7 hospital acquired category 3 and above pressure ulcers reported in October (including device related and device related mucosal). This is lower than last year with an average of 8 per month reported in 2019/20. 2 of these require RCA, taking the total requiring RCA YTD to 28. Of the 7* reported, there was 1 under RCA and 1 no omission in care. *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 October was 31. The reported number is inclusive of device related and device related mucosal pressure ulcers.
1.2a	Pressure ulcers - community acquired		There were 26 community acquired category 3 and above pressure ulcers reported in October (including device related and device related mucosal). 15 of these require RCA, taking the total requiring RCA YTD to 94. The average per month reported in 2019/20 was 14. Of the 26* reported, there were 4 with no 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 October was 46. The number reported is inclusive of device related and device related mucolsal pressure ulcers.

Harrogate and District NHS Foundation Trust

Section 1 - Safe - October 2020

Indicator number	Indicator name / data quality assessment	Trend chart	Interpretation
1.3	Falls		The rate of inpatient falls was 5.8 per 1,000 bed days in October. This is an increase on recent months but lower than the average HDFT rate for 2019/20 (6.2).
1.4	Infection control		There was 1 case of hospital apportioned C. difficile reported in October bringing the year to date total to 11 cases. 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 October gives a ratio of 21.3.
1.6	Incidents - SIRIs and never events		1 SIRI was reported in October, with the YTD position now at 4 reported cases. No Never Events have been reported YTD. No Never Events were reported in 2017/18, 2018/19 or 2019/20.

Section 1 - Safe - October 2020

Indicator number	Indicator name / data quality assessment	Trend chart	Interpretation
1.7	Safer staffing levels		After being suspended due to Covid-19, this indicator has now resumed. In October, staff fill rates were reported as follows: - Registered Nurses Day 100% and Night 98% - Care Staff Day 91% and Night 105%

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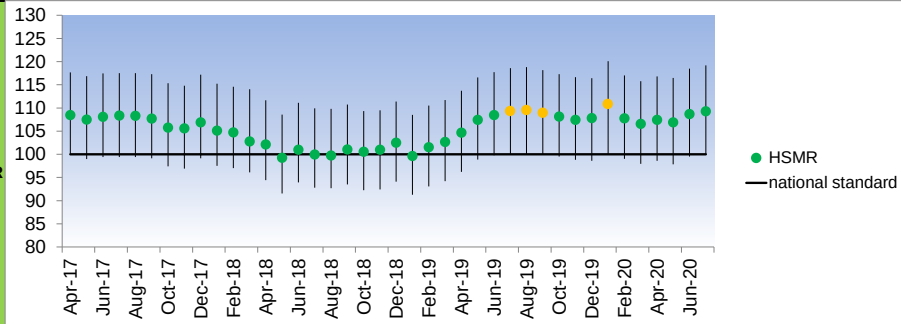
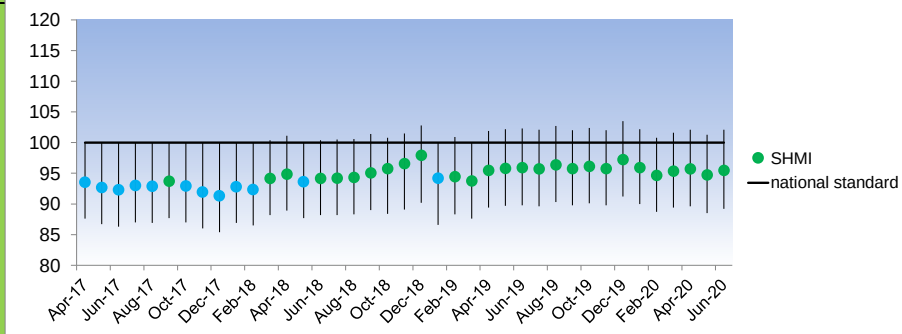
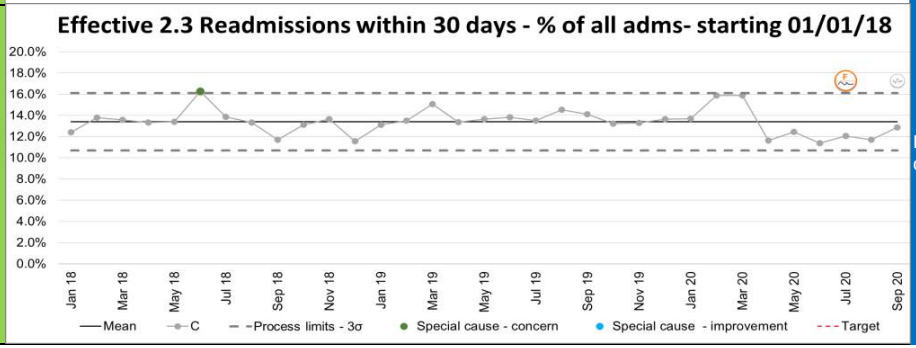
Section 2 - Effective - October 2020

Indicator number	Indicator name / data quality assessment	Trend chart	Interpretation
2.1	Mortality - HSMR		HDFT's HSMR has increased to 109.26 for the rolling 12 months ending July 2020, but remains within expected levels. At specialty level, two specialities (Trauma & Orthopaedics and Geriatric Medicine) 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.
2.2	Mortality - SHMI		HDFT's SHMI for the rolling 12 months ending June 2020 is 95.49, remaining within expected levels. At specialty level, one specialty (Gastroenterology) has a standardised mortality rate above expected levels. NHS Digital have advised that Covid-19 related activity and deaths is now excluded from the SHMI. They advised that the SHMI is not designed for this type of pandemic activity and the statistical modelling used to calculate the SHMI may not be as robust if such activity were included. *The delay in calculating and publishing is linked to the requirement that all episodes are clinically coded and therefore there is at least a 2 month delay before they can start to look at the data. SHMI is slightly later than HSMR as it includes deaths within 30-days of discharge from hospital that will cause a further delay to the publication
2.3	Readmissions		Emergency readmissions increased to 12.9% in September. This is below the 2019/20 average of 14.0%.

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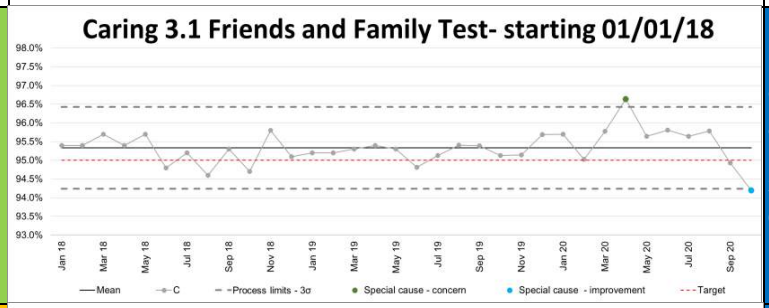
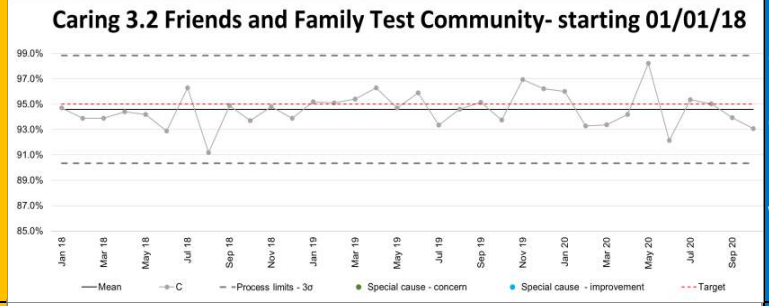
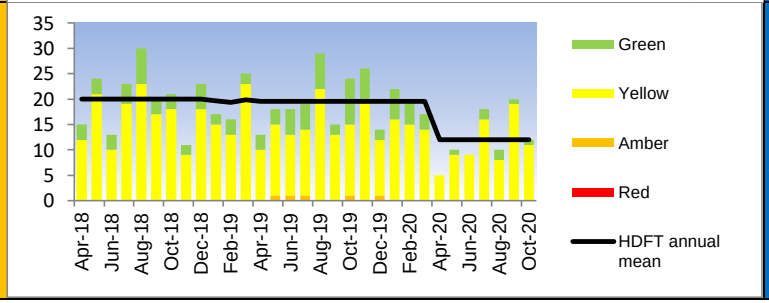
Section 3 - Caring - October 2020

Indicator number	Indicator name / data quality assessment	Trend chart	Interpretation
3.1	Friends & Family Test (FFT) - Patients		94.2% of patients surveyed in October would recommend our services remaining above the latest published national average (93.3%, February 2020). 3,566 patients responded to the survey this month, of which 3,360 would recommend our services.
3.2	Friends & Family Test (FFT) - Adult community services		93% of patients surveyed in October would recommend our services, a decrease on last month (93.9%). The latest published national data (February 2020) shows 95.6% of patients surveyed would recommend the services. 101 patients from our community services responded to the survey this month, of which 94 would recommend our services.
3.3	Complaints		12 complaints were received in October (11 yellow, 1 green) which is 8 less than September and lower than the average for 2019/20 of 20 per month.

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Section 4 - Responsive - October 2020

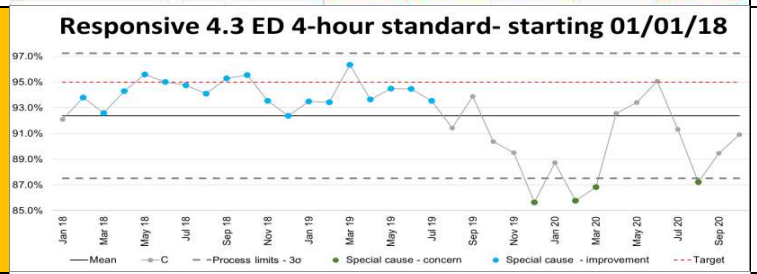
NHS Improvement Single Oversight Framework

4.1 NHS Improvement Single Oversight Framework

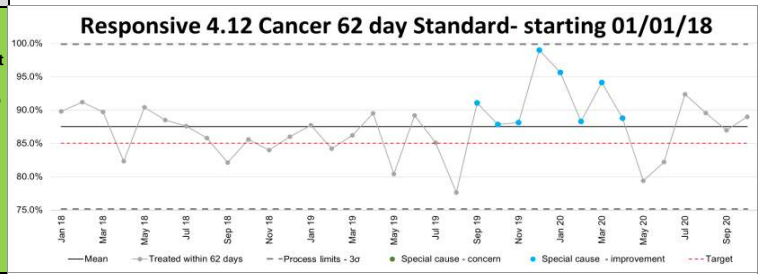
Standard	Q1	Q2	Q3 to date	Q4	YTD
RTT incomplete pathways					
A&E 4-hour standard	93.9%	89.3%	90.9%		91.2%
Cancer - 62 days	83.7%	89.6%	89.0%		87.3%
Diagnostic waits	55.5%	74.39%	79.18%		70.7%
Dementia screening - Step 1	92.2%	96.1%	95.5%		94.5%
Dementia screening - Step 2	80.0%	84.6%	100.0%		86.4%
Dementia screening - Step 3	87.0%	90.9%	100.0%		91.8%

4.2 RTT Incomplete pathways performance

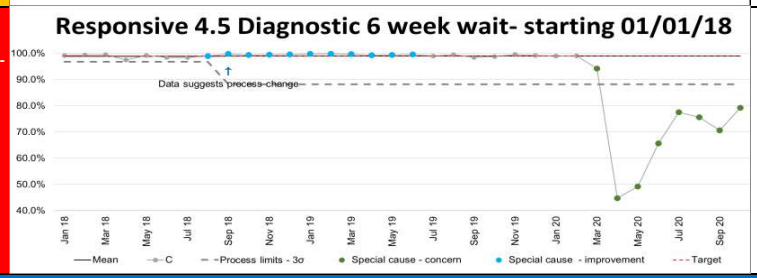
4.3 A&E 4 hour standard



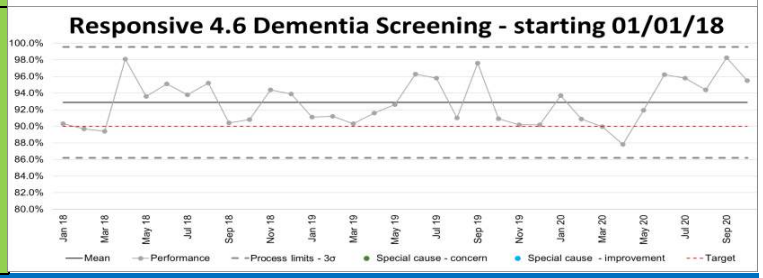
4.4 Cancer - 62 day wait for first treatment from urgent GP referral to treatment



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 October (90.9%), but an increase on last month.

Provisional data shows that performance against the 62 day cancer standard was delivered in October with performance at 89.0%. Performance for 2WW non-cancer related breast referrals was delivered for the third consecutive month, but following an upturn in breast referrals in October performance is currently below 93% for both 14 day standards in November . All other cancer standards were achieved in October with the exception of 62 day Screening and Consultant upgrades (see a more detailed summary below).

Data shows the performance on diagnostic waiting times increased with 79.2% waiting less than 6 weeks at the end of October, 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 Covid-19.

Dementia Screening - All steps have been achieved in October.

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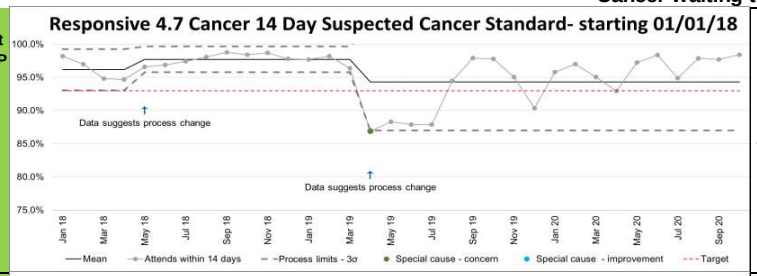
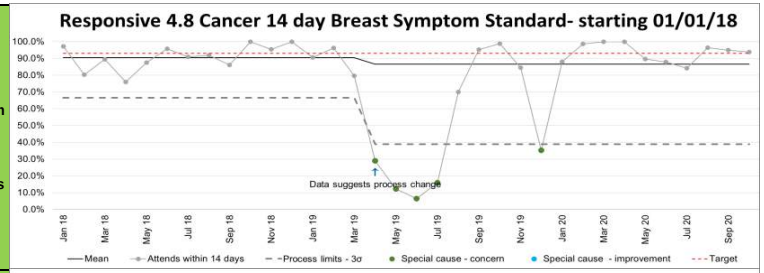
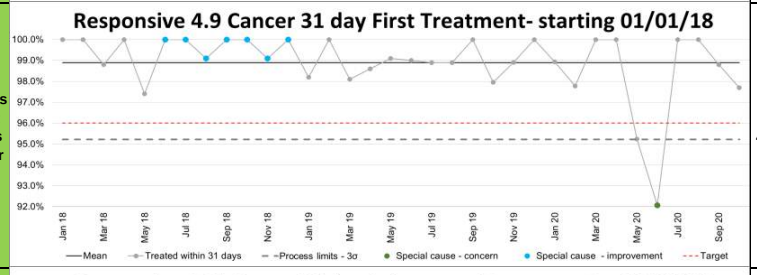
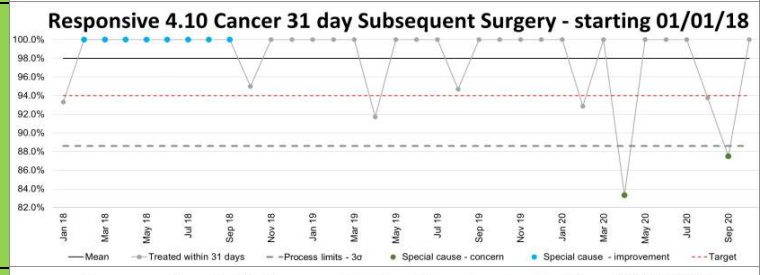
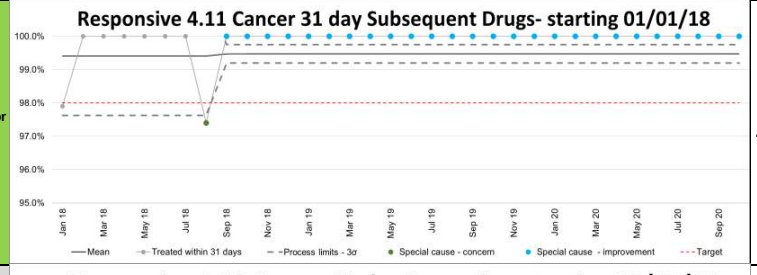
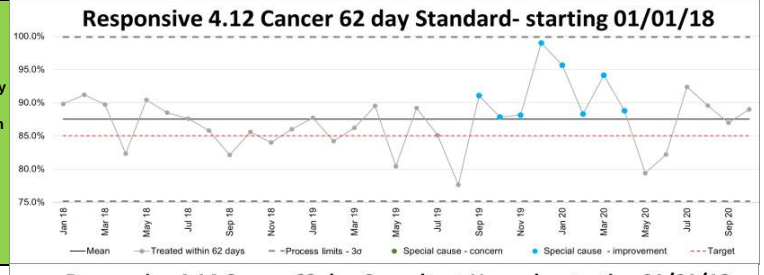
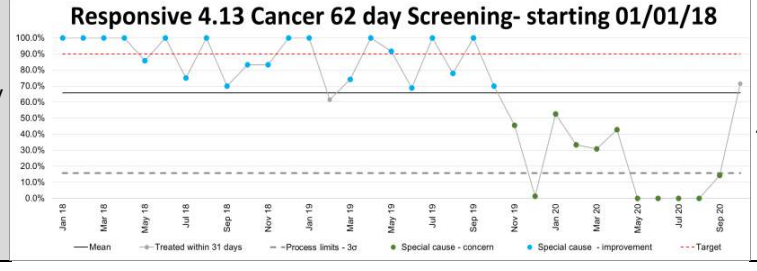
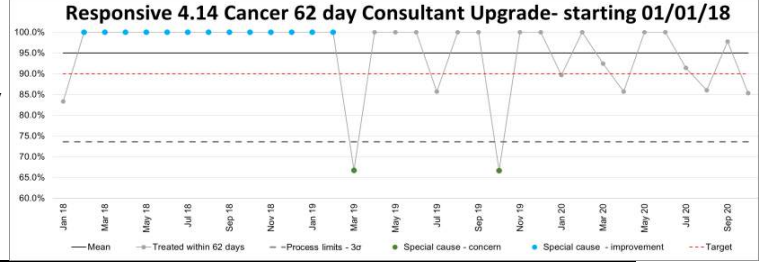
Section 4 - Responsive - October 2020

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 - October 2020

Narrative

Provisional data indicates that 6 of the 7 applicable cancer waiting times standards were achieved in October. 62 day Screening performance was below the standard of 90% with 2 patients treated after 62 days – these 2 pathways were delayed due to the suspension of the Bowel Screening service in recent months. Activity levels were below the de minimus for the month with 5 patients attributable to HDFT (equivalent to 3.5 accountable treatments).

2WW breast referrals (including breast symptomatic) rose significantly in October following a return to pre-Covid levels in September. There were 212 breast referrals in October compared to 189 in September which is a 12.2% increase. Consequently current performance for November is below the 93% standard for both 14 standards. Work is being done to understand the impact of these delays on delivery of breast services both in terms of the 62 standard and also capacity for post-surgical radiotherapy.

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. At the end of October, the vast majority of 62 day long waiters had received dates for their endoscopy procedure.

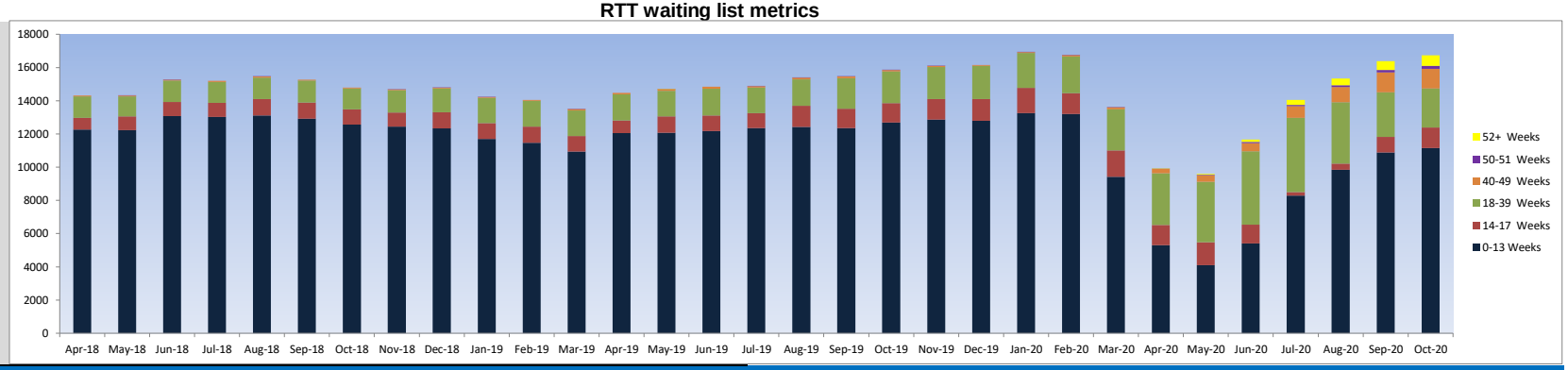
62 day standard performance is expected to be above 85% in October at 89.0%. Provisionally there were 63.5 accountable treatments in October (similar to pre-Covid levels) with 7.0 over 62 days. Of the 10 tumour sites treated in October, performance was above 85% for all but 3 (Colorectal, Head and Neck, and Upper GI – 66.7%, 33.3%, and 0.0% respectively). Colorectal and Upper GI pathways have been significantly affected by Covid-19 but performance for colorectal patients has improved in October with 4.5 accountable treatments delivered in October (5 patients) with 3.0 within 62 days (3 patients). All pathway delays will be reviewed by the breach panel at the end of November. 2 Upper GI patients waited over 104 days for treatment in October and both delays were a result of reduced diagnostic capacity in endoscopy during the summer. Current forecasting predicts that 62 day performance will be below the 85% standard in November.

Provisional data indicates that 52.6% (10/19) of patients treated at tertiary centres in October were transferred by day 38.

Section 4 - Responsive - October 2020

RTT waiting list metrics

4.15	RTT waiting list split by weeks



Narrative

Provisional data shows that there were a total of 16,730 patients on the RTT waiting list at the end of October. There were 639 patients waiting over 52 weeks at the end of the month. Extra capacity at The BMI Duchy continues to support the reduction of long-waiting orthopaedic patients who make up around 40% of the 52W total.

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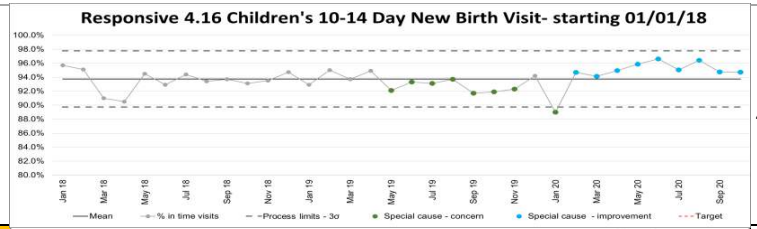
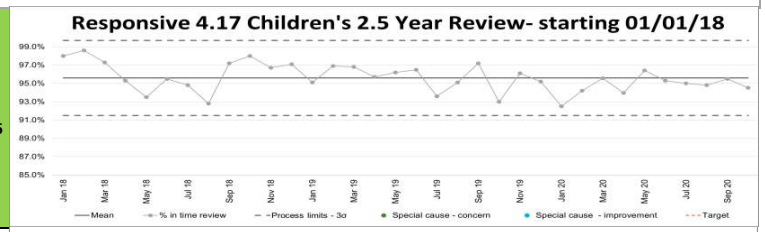
Section 4 - Responsive - October 2020

Children's Services metrics

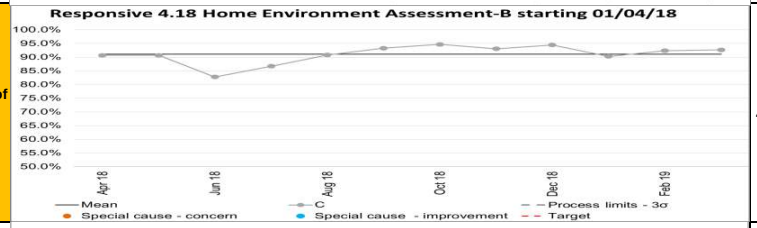
4.16 Children's Services - 10-14 day new birth visit



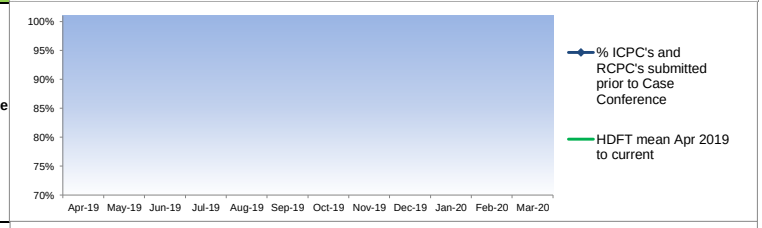
4.17 Children's Services - 2.5 year review



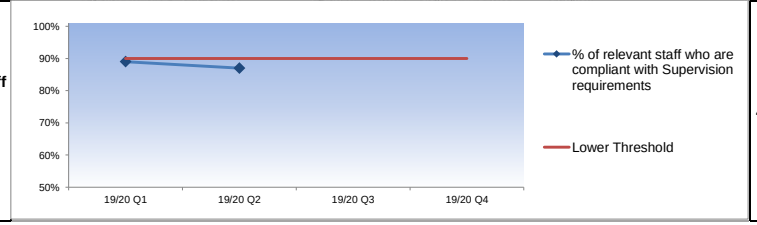
4.18 Children's Services - Use of the Home Environment Assessment Tool



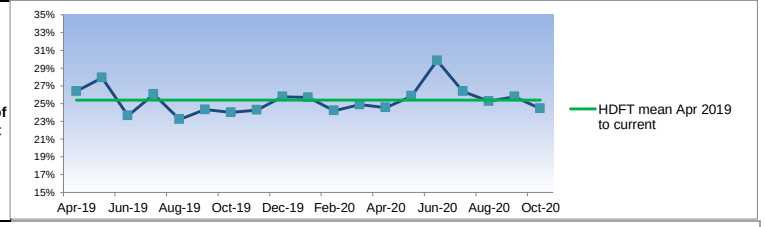
4.19 Children's Services - Reports for Initial and Review Child Protection Case Conferences



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

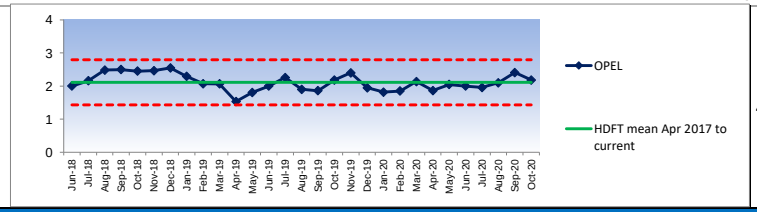


4.21 Children's Services - Reports for Achievement of KPI for Breast Feeding Prevalence.

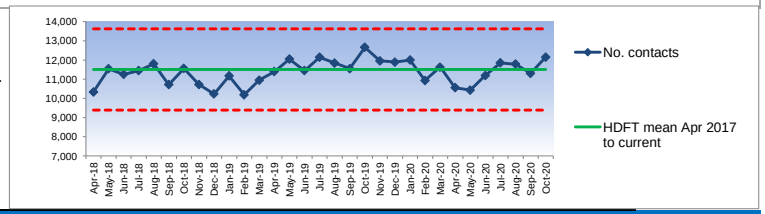


Adult Community Services metrics

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%.

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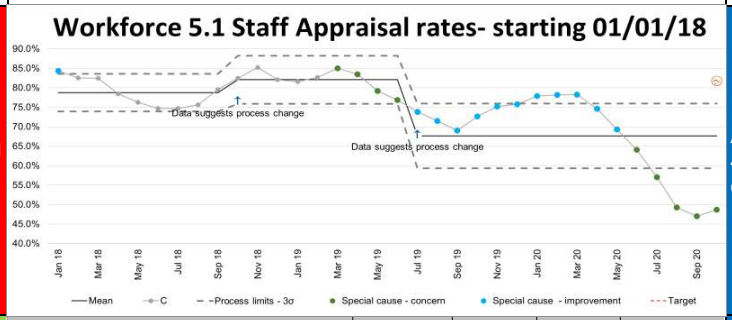
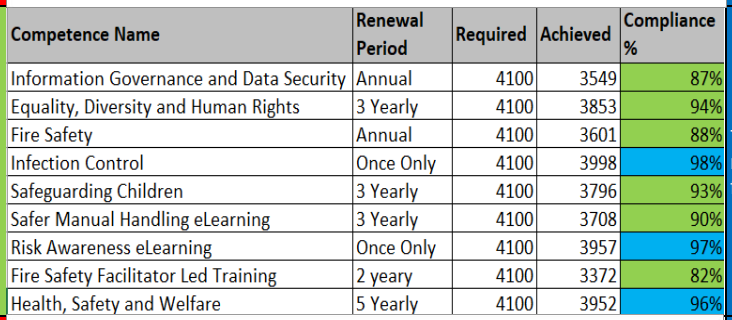
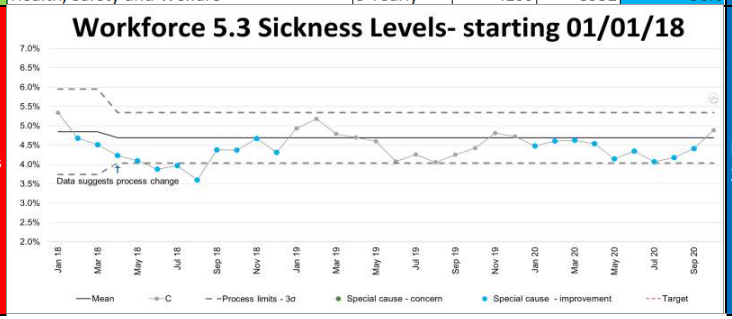
Section 5 - Workforce - October 2020

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 48.7%. 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.
5.2	Mandatory training rates		The data shown is for the end of October. Mandatory and Essential Training is currently being reintroduced and full MEST reporting has now resumed. The overall training rate for mandatory elements for substantive staff is 92% and has increased by 1% since the last reporting cycle.
5.3	Sickness rates		Non-Covid-19 related sickness has increased in October 2020 to 4.8% and is higher than September 2019.

Competence Name	Renewal Period	Required	Achieved	Compliance %
Information Governance and Data Security	Annual	4100	3549	87%
Equality, Diversity and Human Rights	3 Yearly	4100	3853	94%
Fire Safety	Annual	4100	3601	88%
Infection Control	Once Only	4100	3998	98%
Safeguarding Children	3 Yearly	4100	3796	93%
Safer Manual Handling eLearning	3 Yearly	4100	3708	90%
Risk Awareness eLearning	Once Only	4100	3957	97%
Fire Safety Facilitator Led Training	2 yeary	4100	3372	82%
Health, Safety and Welfare	5 Yearly	4100	3952	96%

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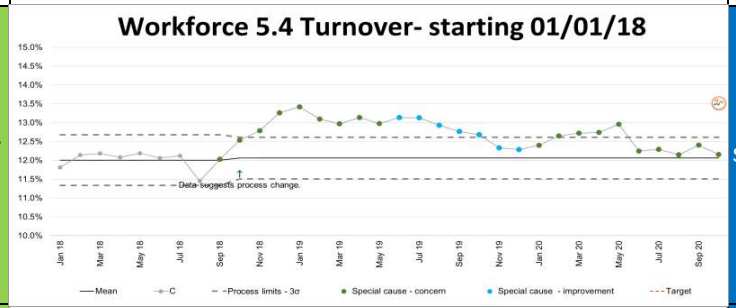
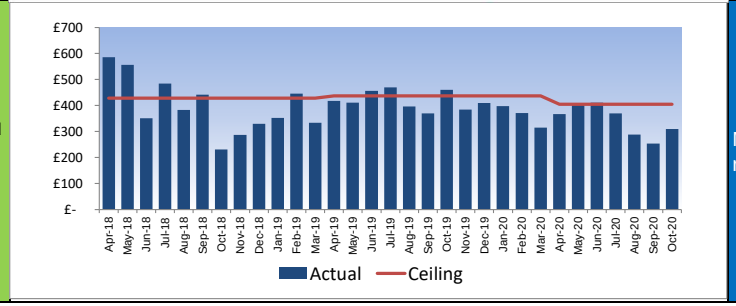
Section 5 - Workforce - October 2020

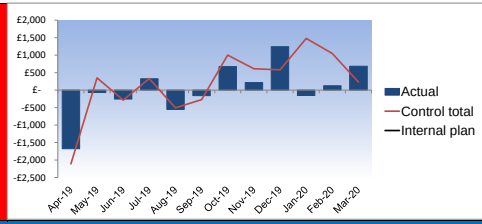
Indicator number	Indicator name / data quality assessment	Trend chart	Interpretation
5.4	Staff turnover rate		Staff turnover, both voluntary and involuntary, remains stable.
5.5	Agency spend in relation to pay spend		Month 7 agency spend increased to £310k. This is a consolidated position and specifically reflects a reduced requirement and improved controls within HIF.

Harrogate and District NHS Foundation Trust

Section 6 - Efficiency and Finance - October 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

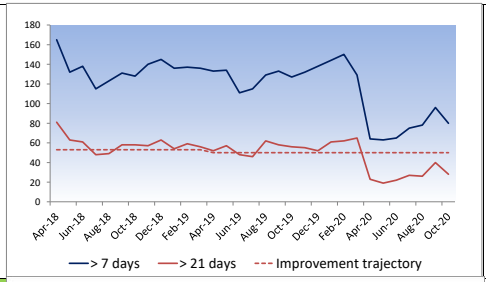
The Trust reported a deficit of £340k, a small favourable variance to the planned deficit of £346k. This is supported by top up and covid income of £2.2m.

Currently reported as a 1. It should be noted that this rating is currently not being formally reported to NHSEI.

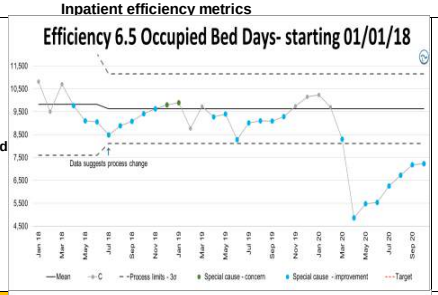
The Trust continues to be in discussion with NHSEI regarding the capital plan for 2020/21. Trust spend is outlined in the graph, with a forecast position of approx. £14m dependant on approvals.

Inpatient efficiency metrics

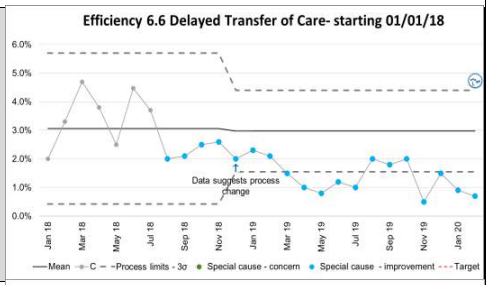
6.4 Long stay patients



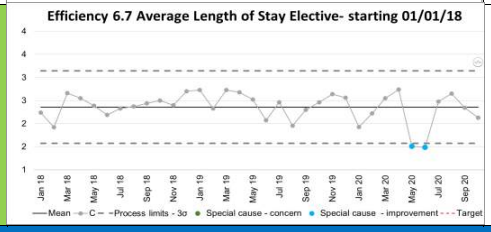
6.5 Occupied bed days



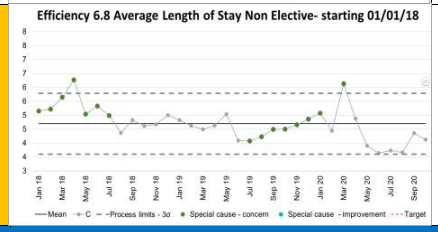
6.6 Delayed transfers of care



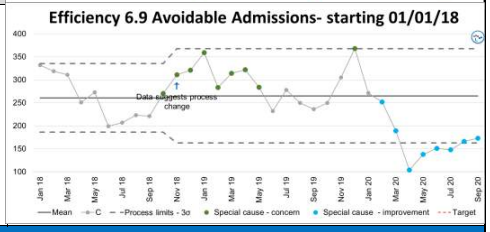
6.7 Length of stay - elective



6.8 Length of stay - non-elective



6.9 Avoidable admissions



Narrative

In October, long stay patient numbers and occupied bed days remained stable. Elective and non-elective length of stay decreased this month, with both remaining below the Trust mean. Avoidable admissions are increasing but remain below the Trust mean.

Section 6 - Efficiency and Finance - October 2020

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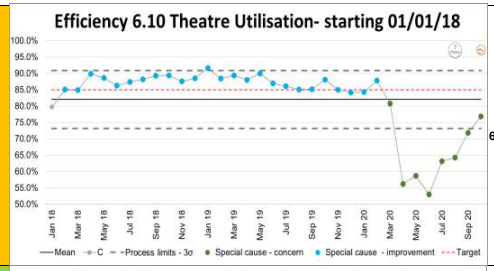
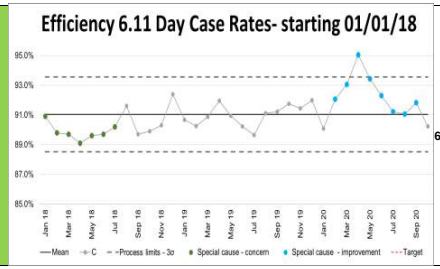
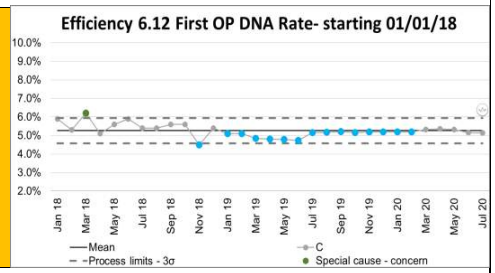
6.10 **Theatre utilisation**



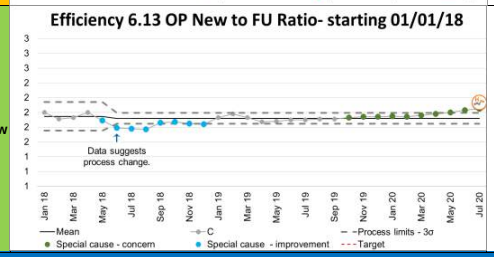
6.11 **Day case rate**



6.12 **Outpatient DNA rate**



6.13 **Outpatient new to follow up ratio**



Narrative

Theatre utilisation increased in October but remains below the target and Trust mean position. It is anticipated that theatre utilisation will continue to rise as the Trust's recovery plan comes into effect.

Outpatient DNA rates remained stable and the new to follow up ratio increased slightly.

Section 7 - Activity - October 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

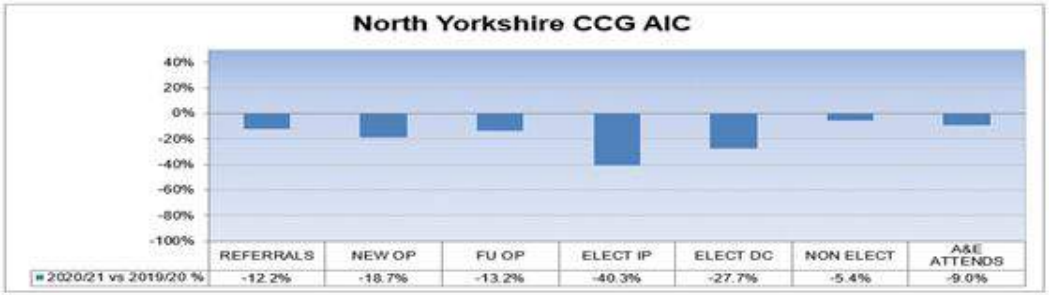
GROUP	2019/20 OCT	2020/21 OCT	2019/20 YTD	2020/21 YTD	2020/21 vs 2019/20	2020/21 vs 2019/20 %
REFERRALS	3,553	3,097	23,048	20,234	-2,814	-12.2%
NEW OP	6,219	5,393	40,014	32,529	-7,485	-18.7%
FU OP	12,974	10,970	80,168	69,602	-10,566	-13.2%
ELECT IP	174	147	1,287	768	-519	-40.3%
ELECT DC	2,005	1,709	12,951	9,360	-3,591	-27.7%
NON ELECT	1,605	1,395	10,817	10,236	-581	-5.4%
A&E ATTENDS	3,302	2,669	23,208	21,118	-2,090	-9.0%

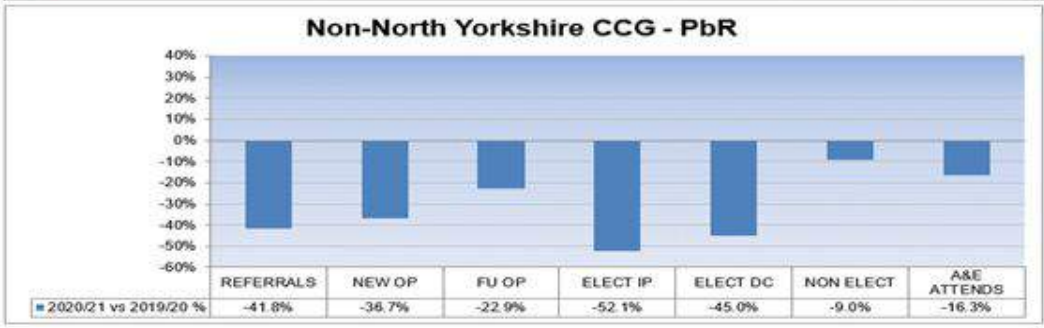
Non-North Yorkshire CCG - PbR*

GROUP	2019/20 OCT	2020/21 OCT	2019/20 YTD	2020/21 YTD	2020/21 vs 2019/20	2020/21 vs 2019/20 %
REFERRALS	1,600	1,018	11,080	6,454	-4,626	-41.8%
NEW OP	2,477	1,500	16,047	10,162	-5,885	-36.7%
FU OP	4,703	3,290	28,718	22,147	-6,571	-22.9%
ELECT IP	110	94	769	368	-401	-52.1%
ELECT DC	772	529	5,176	2,848	-2,328	-45.0%
NON ELECT	496	428	3,311	3,014	-297	-9.0%
A&E ATTENDS	1,138	881	8,416	7,045	-1,371	-16.3%

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

Activity Summary

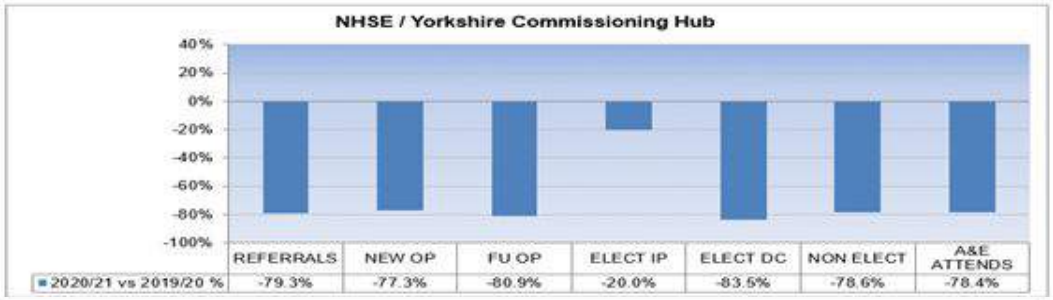




NHS
Harrogate and District
NHS Foundation Trust

NHSE / Yorkshire Commissioning Hub

GROUP	2019/20 OCT	2020/21 OCT	2019/20 YTD	2020/21 YTD	2020/21 vs 2019/20	2020/21 vs 2019/20 %
REFERRALS	201	24	1,409	292	**-1,117**	**-79.3%**
NEW OP	315	12	1,574	357	**-1,217**	**-77.3%**
FU OP	531	14	3,346	638	**-2,708**	**-80.9%**
ELECT IP	1	2	10	8	**-2**	**-20.0%**
ELECT DC	398	6	2,707	447	**-2,260**	**-83.5%**
NON ELECT	9	0	42	9	**-33**	**-78.6%**
A&E ATTENDS	32	0	148	32	**-116**	**-78.4%**



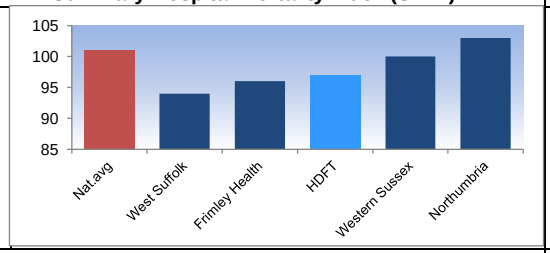
Trust Total

GROUP	2019/20 OCT	2020/21 OCT	2019/20 YTD	2020/21 YTD	2020/21 vs 2019/20	2020/21 vs 2019/20 %
REFERRALS	5,354	4,139	35,537	26,980	**-8,557**	**-24.1%**
NEW OP	9,011	6,905	57,635	43,048	**-14,587**	**-25.3%**
FU OP	18,208	14,274	112,232	92,387	**-19,845**	**-17.7%**
ELECT IP	285	243	2,066	1,144	**-922**	**-44.6%**
ELECT DC	3,175	2,244	20,834	12,655	**-8,179**	**-39.3%**
NON ELECT	2,110	1,823	14,170	13,259	**-911**	**-6.4%**
A&E ATTENDS	4,472	3,550	31,772	28,195	**-3,577**	**-11.3%**

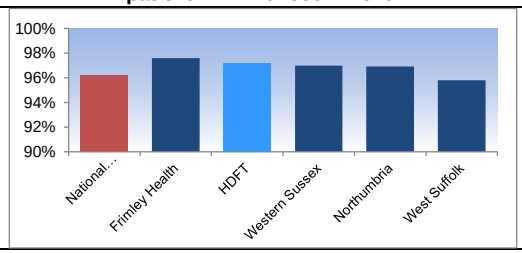
Harrogate and District NHS Foundation Trust

Section 8 - Benchmarking - October 2020

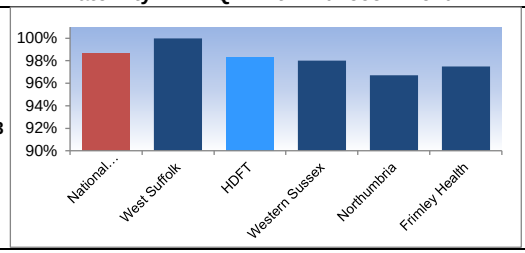
8.1 Summary Hospital Mortality Index (SHMI)



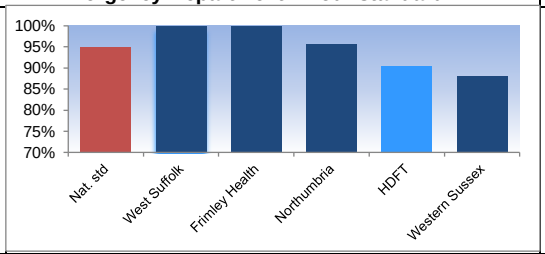
8.2 Inpatient FFT - % recommend



8.3 Maternity FFT - Q2 Birth - % recommend

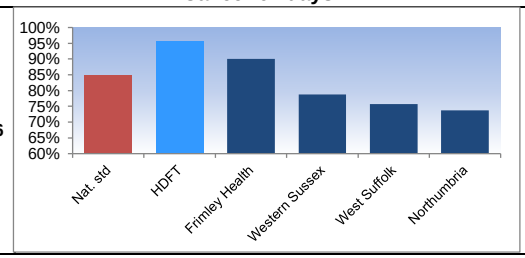


8.4 Emergency Department 4 hour standard

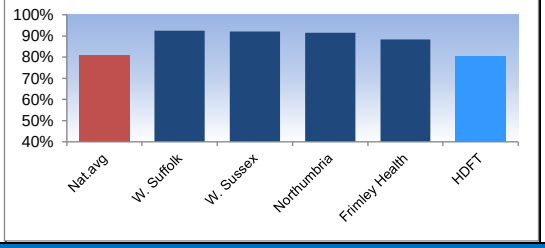


8.5 RTT incomplete pathways

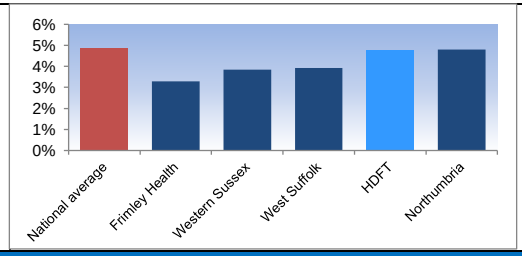
8.6 Cancer 62 days



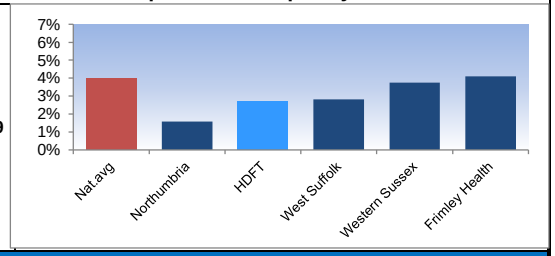
8.7 Staff FFT - % recommend (place to work)



8.8 Sickness absence



8.9 Proportion of temporary staff



Narrative

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

Harrogate and District NHS Foundation Trust

Integrated board report - October 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.

Harrogate and District NHS Foundation Trust

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 >= national average % recommended, Amber if latest month <= 5 percentage points below national average, Red if latest month over 5 percentage points below 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 daily 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, Non-executive Director
Date of meeting:	7 October 2020
Date of Board meeting this report is to be presented	25 November 2020

Summary of key issues

- The Quality Committee met via teleconference. The meeting was observed by Clare Cressey Lead Governor and Dave Stott Public Governor.
- The meeting began with a brief presentation from Charlotte Rock – Lead Macmillan Nurse, on Care after death. Charlotte gave an overview of work undertaken to improve the experience of relatives when a loved one dies in the care of the Trust. Changes have been made as a result of complaints and comments made by relatives. An RPIW has taken place and a standardised pathway has been developed. The process for care of the patient at the time of death had been standardised across the Trust, improvements had been made to the mortuary viewing room, improvements have been made to the process for issuing death certificates to ensure they are provided in a timely manner and that the family do not need to go to the ward but can deal with the central office. Nurse verification of death has been introduced and training is in process for helping nursing staff manage communications at the time of death. The committee was very impressed by the changes made and requested that Charlotte came back to the committee in a year to update us on progress with training and feedback from patients
- One hot spot was raised by committee members. This relates to a national shortage of reagents for laboratory tests. Action is being taken to mitigate the impact. The issue should be resolved very soon however if necessary then some of the tests may be restricted to high risk cases. The committee were assured that action has been taken and at the moment there was no cause for concern. The Trust internal processes will monitor and manage the situation as required.
- The Clinical Advisory Group minutes 27th August to 24th September were considered. There were no issues for the quality committee to review. The meetings had not been well attended and it was felt that the process should now change to ensure the committee was dealing with the right issues. In order to do this the group will only meet when required to provide clinical advice to the control team. They will not meet routinely. The quality committee agreed this as a sensible way to

proceed and will receive updates via the Deputy Medical Director as necessary in the future. The Committee again acknowledged on behalf of the Board the excellent work that had been undertaken by this group and the excellent leadership of Dr Hall and Dr Wood.

- The Medical Director gave an update on discussions at the Patient Experience and Safety Huddle (PESH). The meetings are improving communication and inclusion with all Patient Experience and Safety leads being invited to attend. There were no immediate issues or concerns to report to Quality Committee from PESH.
- A number of quality and safety issues were considered from the IBR. A discussion took place on the number of 'long waiters' and the impact that wait had on the health of the individual. The COO gave an update on the processes in place to ensure action was being taken to identify the patients in a priority order to minimise the impact of their wait. It was acknowledged that the length of the wait would have a detrimental impact on the health of the individual and could make managing their condition more difficult. The COO will bring a paper to the QC detailing the action being taken to minimise risk to patients. Community acquired pressure damage is rising and the Chief Nurse assured the committee that the situation was under investigation and will feedback when available.
- The Quality Dashboard was received. Little change from the figures of the previous month. The Executive present stated that a process was in place to look at the metrics being provided to the committee and these would be fed back in due course. No time scale is identified to do this so the committee will keep progress under constant review.
- No limited assurance audit reports relevant to the QC
- The Patient Experience Report Quarter 1 was received. It was noted that improvements in timescales had slipped during the pandemic but the team were analysing the reasons and will reinvigorate the drive for improvement. It was suggested that equality analysis should be considered for this report. It was noted that the PHSO was investigating one complaint from 2018/19. This is a concerning length of time for patients and the staff involved but the Trust has no feedback on progress.
- The Patient Safety Report Quarter 1 was also received. Reporting numbers have improved and the Trust is in top 5% for incident reported. Classification of the reports has been brought in line with other Trusts and this should improve the ratio of harm/no harm. A good level of investigation and feedback was reported which indicated the improvement in the process since the revision to DATIX. Document control was detailed in the report and gave the committee cause for concern. The pandemic has resulted in an increase in policies put onto the intranet and these in turn require active management to keep them up to date and current. The report detailed a rising trend in policies past their review date on the system. This has been the subject of internal audit scrutiny in the past but the committee is concerned that there is no clear way to improve management of these vitally important documents. The risk is detailed on the departments risk register but only rates as a 9

therefore not great enough to be a corporate risk. The Committee is not assured that the process for managing policies and guidelines is robust. It was highlighted that some staff working from home due to COVID may be in a position to review guidelines. This was the approach taken by the maternity department who are responsible for a large number of the policies and guidelines.

- Clinical Audit Report for Quarter 1 was received, A very detailed report with significant numbers of projects under way. The committee were concerned about the numbers of audits which were not progressing and the potential risk that may be associated with this.
- NICE Compliance report for quarter 1 was received. It was noted that NICE had been very active during the pandemic and a large amount of guidance had been received. It was noted that the reconfiguration of the Emergency department will improve the safety of staff when dealing with patients who could be potentially violent. This will remove this non-compliance.
- A report was received detailing new external reports received. This is normally a monthly report which had stalled during the pandemic. The paper highlighted that a range of feedback is still require to demonstrate compliance with the recommendations of the reports. These will be brought to the committee in due course. An update on the Learning Disability recommendations, previously reported to the board was received.

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 would draw the attention of the Board to the management of policies and guidelines on the intranet, This has previously been the subject of an Internal Audit limited assurance report and it appears that there has been little progress to improve the management of these documents, in fact the position appears to be deteriorating. The quality committee highlights the potential risk associated with this situation and seeks assurance that the Executive will give consideration to the way to ensure improvement so that we know policies procedures and guidelines are current and in line with available evidence.

The Quality Committee would also draw the attention of the Board to the work to improve care after death. The Board has heard patient stories where these issues have been raised and the QC is assured that improvements have been made for the benefit of patients and relatives.

Harrogate and District NHS Foundation Trust

Board Committee Report to the Board of Directors

Committee Name:	Quality Committee
Committee Chair:	Laura Robson, Non-executive Director
Date of meeting:	4 November 2020
Date of Board meeting this report is to be presented	25 November 2020

Summary of key issues

- The Quality Committee met via teleconference. The meeting was observed Dave Stott Public Governor.
- The meeting began with a quality improvement presentation from Jude Burden, Lead Cardiac Physiologist, who is a Silver Level Quality of Care Champion. Jude explained how she had introduced a change to continuous heart monitoring. Instead of using implantable devices as the first option at a cost of £2000 each she had introduced external monitoring systems which could be worn discretely by the patient. The change had been planned prior to the pandemic but had been introduced rapidly as a result of it. The system was much better for patients, less invasive, faster to implement and saved the Trust almost £50000 per annum. The adaptability of our staff during this time has been incredible and speed of change commendable. Jude demonstrated the essence of a good practitioner putting patients first and improving service.
- This meeting had a shorter agenda than normal. We are awaiting a review of governance processes by the Medical Director and the Chief Nurse. This will include a review of the role of the Quality Committee and focus it more to assurance. The Terms of Reference for the Quality Committee are due for review but this has been deferred until the Governance review is complete. We are also awaiting baseline reports on the quality priorities this year. An update on the progress of this review will be given in December. Any proposals to alter the role of the Quality Committee will require Board agreement and approval.
- The Clinical Advisory Group has now stopped meeting on a regular basis therefore there were no minutes for this meeting. The group will reform on an ad-hoc basis as and when required to advise on clinical issues during COVID 19 pandemic. The group has been an excellent forum for quick decisions and advice. The Quality Committee has been very impressed by the way the group has functioned and looks forward to seeing how this type of decision making forum can be incorporated into the governance structure.
- The Planned and Surgical Care Directorate presented their Quarter 2

report. There was a wide ranging discussion. The number of complaints returning to the directorate has risen and ground has been lost from the previous action to improve complaints management. The Quality Committee will receive its regular quarterly report from the Patient Experience Team and keep progress under review. There are some very good comments from patients who had positive experiences.

- The IBR and Quality dashboard were scrutinised with no particular concerns.
- The committee received a presentation on Cancelled Activity and the impact this may have on clinical quality and patient safety. The committee was informed that there is regular review of patients waiting and clinicians prioritise the patients to be seen. The Committee will continue to scrutinise this information and seek assurance that patients are receiving care in a timely manner.
- One External report was received related to the National Lung Cancer Audit. The report relates to patients seen in 2018. The Trust was meeting almost all the national standards audited by this audit. One area where we appear to fall outside of the national performance was management of small cell lung cancer. However the number of patients treated was very small. A retrospective review of the 14 patients in this audit will be undertaken by the team.

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 Board should note the excellent work by Jude Burden and the benefit this change makes to the patient and the service.
The Board should note the response to complaints work and the Quality Committee will seek to gain assurance that improvement will be made.
The Board should also note the planned changes to Governance processes and determine the timescale required for this work.

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Harrogate and District NHS Foundation Trust

Board of Directors (held in Public)
25 November 2020
Medical Director Report

Agenda Item Number:	**9.1**
Presented for:	Information
Report of:	Jackie Andrews, Executive Medical Director
Author (s):	Jackie Andrews, 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	√

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

9.1

Public Board Meeting

25th November 2020

Medical Director Report

Dr Jacqueline Andrews

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 third 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, including Information Governance*

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 proposed 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 has recently undertaken a comprehensive listening and engagement exercise with a wide range of stakeholders. The views of internal and external stakeholders were reflected in my 100-day report out published early October 2020 and will shape and inform the future clinical services strategy now being developed in partnership with the Chief Operating Officer and senior leadership colleagues.

9.0 Monitoring Performance:

1. National and Regional Update

The national focus continues to prioritise vaccine development, regulation and deployment, testing of asymptomatic NHS staff and ensuring we continue to provide urgent and elective NHS care as much as possible. In addition, a new programme of care for patients who are experiencing "Long Covid" has been launched, with £10M allocated nationally to help kick start and designate long covid clinics in every area across England, to complement existing primary, community and rehabilitation care. New guidance commissioned by NHS England from NICE has recently been published and we are working with local system colleagues to define the model for HDFT patients. Further work is also happening at pace to increase capacity to care for and monitor patients with Covid outside of an acute hospital setting, using pulse oximetry and other remote monitoring packages (COVID "Virtual Wards").

The WYAAT (West Yorkshire Association of Acute Trusts) Medical Directors are working closely together to facilitate mutual aid across our local and regional healthcare system. A number of clinical networks such as critical care and respiratory have been sharing learning and optimising the patient experience during the COVID19 pandemic, working on guidelines such as initiation of non-invasive ventilation and infection prevention control in a theatre environment. The roll out of a potential COVID19 vaccine has also ensured good multi-agency working both within our integrated care system (Humber Coast and Vale) and within our local system in Harrogate and district place (HARA- Harrogate and Rural Alliance).

2. Professional standards and workforce development

Appraisal

The focus for medical appraisal this year will be on health and wellbeing whilst ensuring the requirements for fitness to practice are met.
An internal audit is being conducted in Q3/4 of 2020/21 to review our medical appraisal process and systems. There are ambitions to better develop the link between annual job planning and appraisal and the information gained from the audit will provide useful information of how best we align these two essential processes going forwards.

Medical Consultant appointments since September Board

No new appointments during this reporting period. There are a number of appointment panels booked for the next few months, including Acute Frailty and Respiratory Medicine.

3. Clinical quality and patient safety

Medical Examiner Office HDFT

Since commencing the role last month, Dr Dave Earl, our new Lead Medical Examiner has been working with colleagues to identify suitable estate for his new team of Medical Examiners and a Medical Examiner Officer, all of these are new posts and are currently

out to advert. Dr Earl now also leads on the publication of our quarterly Learning from Deaths report, his Q1/2 report is attached to this paper.

Patient Safety

As previously advised the next key milestone for the Trust relating to implementation of the NHS Patient Safety Strategy was nominating our Patient Safety Specialists (PSS) for the organisation. I am delighted to report that our Deputy Medical Director (Quality and Safety), Deputy Chief Nurse, and Head of Risk Management have agreed to fulfil this new role. We have confirmed their acceptance with NHS England ahead of the end of November deadline for the role to be in place in provider organisations. PSS will provide senior leadership and support for the development of a patient safety culture, safety systems and improvement activity across the NHS in England. PSS will also work in networks with colleagues from other organisations to share good practice and learning. I will report more on their objectives and influence as the roles develop over the next few months.

The new look PESH (patient experience and safety huddle) meeting has now been running for 5 months and regularly achieves good representation from colleagues across the organisation, particularly at the monthly extended learning session. We are exploring a number of software options whilst we review our future needs for our HDFT clinical (and possibly corporate) governance system. A demonstration of Datix Cloud IQ is scheduled for the December 2020 monthly meeting.

Work continues on the quality improvement work around complaints and events, which has been running for the last 2 years. Although this is no longer a formal quality improvement priority, it is still very much an ongoing part of the team's focus and progress against key workstreams continues to be reported in the quarterly patient safety and patient experience reports. #ChatterMatters issue 10 is due to be published in December.

The latest NRLS (National Reporting and Learning System - a central database of patient safety incident reports) data showed that our incident reporting rate has dropped very slightly to **73.27** during the reporting period October 2019 to March 2020 compared to **75.65** for April to September 2019. We have slipped from 6th highest reporter to 7th but this still places us in the top 10% of reporters per 1,000 bed days. There has been a slight improvement in our harm ratio which has gone from **13.4** for the period April 2019 to September 2019, to **15** for the latest reporting period of October 2019 to March 2020.

Clinical Effectiveness

Following discussion at Quality Committee, the team is working with project leads to consider which audits may no longer be required this year given delays in the overall programme due to covid-19. A number of nominations were submitted to HQIP for the nationally recognised Clinical Audit Hero Awards, and we are delighted that Andy Brown, Risk Management Midwife at HDFT, has been shortlisted for the Florence Nightingale award. This is in recognition of his outstanding work implementing a new process on obtaining midwifery notes from other trusts, following a Serious Incident. Winners will be announced during national "clinical audit awareness week" (week commencing 23 November 2020).

Claims

The Trust solicitors have recently undertaken a helpful triangulation of the national claims scorecard and key points will be circulated in a future report. There is to be a re-launch of the Maternity Incentive Scheme with a deadline of May 2021. Resources are available on the NHS Resolution website.

4. Research and Development

Discussions are underway about the future strategy for R&D at HDFT, with ambitions to expand our commercial research portfolio to ensure balance in our financial planning, in view of likely reduced funding received in future years via the NIHR CRN (Clinical Research Network). We have identified there are opportunities to develop our research portfolio within our community footprint, particularly in populations with the greatest health and social care needs.

A recent survey conducted by the Medical Director confirmed that there are a number of colleagues with the HDFT medical body who have higher research degrees and/or have acted as a Principal Investigator for a research study. A similar survey is now being performed with HDFT nursing and AHP colleagues.

A new general manager for R&D has been successfully recruited and will commence in the new year. The successful applicant brings a wealth of experience and has experience of working with a wide variety of funding bodies and sponsors, including industry.

5. Quality Improvement and Transformation

A new post of HDFT **Clinical Lead (CL) for Innovation and Improvement** has been advertised, and shortlisted applicants will be interviewed the week commencing the 16th of November. This will be the first time we have had such a position which will provide an excellent opportunity for a clinical colleague who is passionate about creating a culture of continuous innovation and improvement and has experience of quality improvement methodology and/or innovation testing, adoption and spread. Reporting directly to the Medical Director, The CL will have the opportunity to shape our innovation and quality improvement programmes and develop opportunities for collaboration with colleagues within HDFT but also externally through our wider systems partnerships (particularly the Academic Health Science Network).

I am also delighted to report that HDFT's bid to host our first **HEE (Health Education England) Clinical Leadership Fellow** was successful. The Future Leaders Programme offers opportunities for Health Education England Yorkshire and the Humber medical and dental trainees to do a one year "out of programme experience" (OOPE) Leadership Fellowship to help grow and develop their personal leadership skills. Some Leadership Fellow vacancies are open to other healthcare professionals, such as nurses, allied health professionals, pharmacists, health care scientists, and SAS doctors and dentists. The HDFT Fellowship will be open to all professions and the successful applicant will participate in our "At Our Best" programme of work, performing a project within the EDI workstream around clinical recruitment processes and culture. The post will commence in August 2021.

6. Medical Education

HEE have published principles for maintaining training delivery during future COVID-related service pressures. HEE appreciated the invaluable contribution made by doctors in training during the start of the pandemic earlier this year but recognise that this has significantly impacted on their education and training. In response to this, the Postgraduate Dean for HEE Yorkshire and the Humber has issued guidance on the redeployment of doctor-in-training to support the increase in acute medical activity. This guidance will help the organisation to make further plans to respond to COVID or other pandemic-related service pressures, allowing us to maintain training, while keeping patients safe. The increase in acute admissions over the last few weeks has understandably caused anxiety amongst junior doctors and the Medical Education Department has established a number of measures to ensure trainees are well informed and have ample opportunity to voice their concerns. We shall continue to ensure that their training needs are supported over the coming months.

HDFT has been approached by the University of Leeds to develop a Foundation Year (FY) Entrepreneurship Programme in collaboration with Leeds Teaching Hospitals NHS Trust. The University have recently initiated an entrepreneurship programme for undergraduates, which has successfully afforded medical students the opportunity to undertake a Masters Degrees in Business. HDFT's undergraduate and FY programmes are highly regarded by medical students and doctors in training and Leeds University believe that Harrogate's strong business and innovation links would provide the optimal environment to ensure the programme's success. The aim would be for three Foundation Year 1 Entrepreneurship posts to commence in August 2021 or 2022.

Finally, the Medical Education Department is bidding farewell to a number of senior colleagues: Pamela Dunn, Medical Education Manager if taking up a new role at Leeds Teaching Hospitals, and Dr Shakeel Rahman, Foundation Year One Training Programme Director; Dr Will Peat, Clinical Skills and Simulation Lead; and Dr Lauren Ralston, Undergraduate Lead for Leeds University MBChB Year 3 are stepping down from their roles. We thank them all for their great contributions to medical education at HDFT. The posts will be advertised shortly with a number of interested candidates already making contact.

7. Digital and IT Services

After discussion with North Lincolnshire and Goole NHS Trust the next WebV release is scheduled for 5th January. This delivers ward and bed management functionality as well as clinical noting. These are the two remaining steps required for us to then implement paperlite working and digital handover. These two long term aims will significantly improve patient safety, reduce duplication of effort by staff as well as reduce gradually the need for paper case notes to be present on site. Our ability to move to paperlite working is further enhanced as we have now secured a site licence for speech to text with Nuance- this will come on stream over the next 2 quarters.

The digital team have continued to roll out home working to an extended group of staff supporting COVID-19 working arrangement. We have also supported a rapid roll out of devices / networking to support clinical teams on site to provide safe and effective care in coronary care, endoscopy and the critical care units.

Further digital innovation is imminent in replacing the bleep with our personal mobile devices (ASCOMs) which bring a much broader functionality to facilitate communication and access clinical information. Additionally, the team are supporting the implementation of a replacement rostering system, adoption of a variety of clinical and collaboration apps and the ongoing upgrade and improvement of our digital infrastructure, security and equipment. The focus of the digital team for the next quarter is to maximise the utilisation of WebV, embed speech to text and ASCOMs and further support paperlite working.

10.0 Recommendation

The Board is recommended to note the contents of the Medical Director report.

11.0 Supporting Information

1. Learning from deaths report (covering Q1/Q2 20/21)

Harrogate and District NHS Foundation Trust

Board Meeting (held in Public)
25 November 2020
Learning from Deaths Quarterly Report Q1

Agenda Item Number:	**9.1.1**
Presented for:	Information
Report of:	Jackie Andrews, Medical Director
Author (s):	Dave Earl, Deputy 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	

Recommendation:
The Board is asked to note the contents of this report and the processes for ensuring learning from death.

9.1

Public Board Meeting

25 November 2020

Learning from Deaths

Executive Medical Director

1.0 Executive Summary

Crude mortality rates for the Trust are mirroring the national picture, with a peak rate of 4% at the height of the first wave of Covid-19

Standardised mortality rates give a conflicting picture. Although both the HSMR and SHMI are relatively stable, the former is above expected levels and the latter below. Both indices have highlighted specific areas where more detailed work has been undertaken to provide assurance.

Annualised data from the National Cardiac Arrest Audit demonstrates that the chances of survival from a cardiac arrest at HDFT are better than predicted.

13 Structured judgement reviews have been undertaken in 2020. 11 cases had overall care described as good or excellent. 1 case was investigated further as a serious incident (SI), and a second case identified potential learning regarding multidisciplinary communication and senior clinician input.

Deaths in patient with learning difficulties undergo a second independent review as part of the LeDeR programme. Reports this year are supportive of the internal reviews and the care given

In the first wave of Covid-19, 65 patients out of 187 admissions died in hospital within 30 days of a positive test, with a further 5 dying in that time period following discharge. The overall mortality from a hospital admission with Covid-19 was 37.4%. Our Critical Care mortality was 36.4%, which is similar to the national mortality rate.

2.0 Introduction

Covid-19 has had a massive impact on this reporting period. Not only has the disease itself caused significant mortality in its own right, the necessary modifications in working practices and limitations placed on standard operating and reporting procedures has meant that the content of this report is reduced compared to previous quarterly reports. In addition, the date range of some of information provided does not fit easily into standard quarterly reporting.

3.0 Findings

Crude Mortality Data - The crude mortality rate for admissions gives a longer-term view of Trust mortality rates. This data is not risk-adjusted so takes no account of the unique characteristics of the admissions. Since April 19, we have able to view similar data for all hospitals (shown in the darker blue line on the Figure 1). This demonstrates that the peaks and troughs we see in HDFT are often mirrored at the national level. Note that the peak mortality at the time of the first Covid-19 wave mirrors the national figure at exactly 4% of admissions.

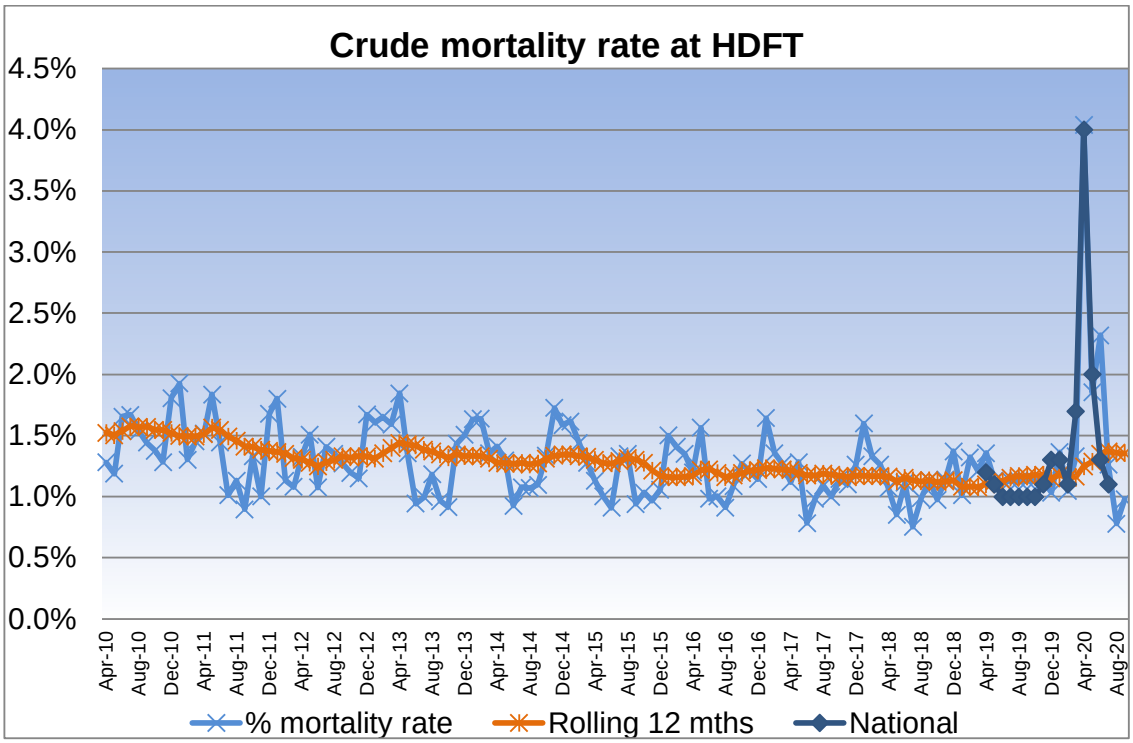


Figure 1: Crude mortality rates over the last 10 years (%deaths per hospital admission)

Standardised Mortality Rates (HSMR and SHMI) - The HSMR (Figure 2) has remained relatively constant for the last 12 months although at a level of around 105-110% predicted. This exceeded predictions during 4 months in 2019. 2 clinical areas were highlighted as areas for concern in the period July 2019-June 2020 – 3 deaths from "syncope" and 6 from "leukaemias". The syncope deaths have been examined and all were expected deaths – all presented with the symptom of syncope (fainting) but had severe underlying conditions causing the syncope. No errors in diagnosis or management were identified. The leukaemia deaths are believed to be due to patients receiving chemotherapy at the Sir Robert Ogden Macmillan Centre being classed as elective admissions, so if they are unwell and admitted they keep the original elective designation and are therefore given a lower risk of death than for emergency admissions.

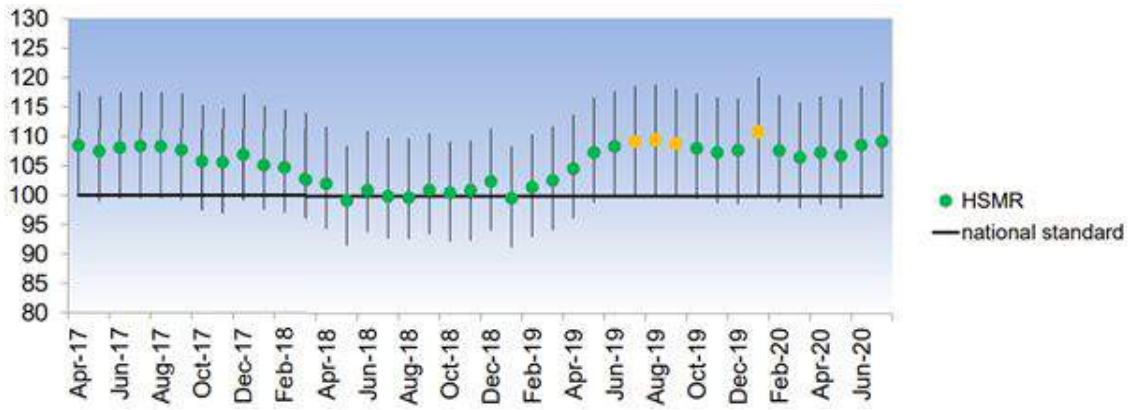


Figure 2: HSMR. Dots show the recorded values with error bars showing possible range of true values. Yellow dots indicate a deteriorating trend which is likely to be significant

The SHMI rates (Figure 3) are also stable, although in contrast to the HSMR are trending below the expected levels. One clinical area has been highlighted as a negative outlier for July 2019-June 2020 – deaths related to COPD and bronchiectasis. This has been highlighted on a previous occasion and the incumbent medical director at the time commissioned a case note review and was reassured. Due to its continued alerting, we have now commenced a further interrogation of the most recent cases, which suggest that in the 12 months up to April 2020 we had 35 deaths compared to a predicted number of 23.

There have been no highlighted alerts for HMSR between September 2019 and August 2020.

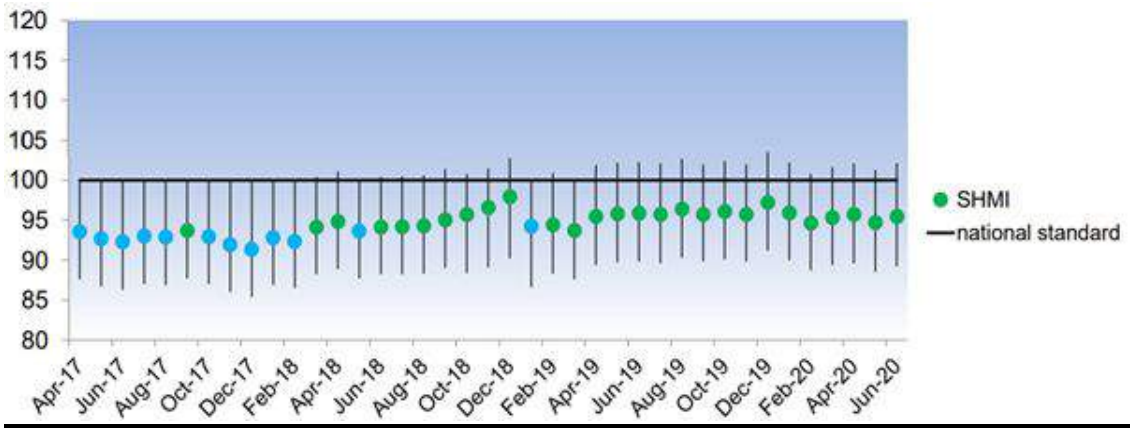


Figure 3: SHMI. Dots show the recorded values with error bars showing possible range of true values. Blue dots indicate an improving trend which is likely to be significant

National Cardiac Arrest Audit (NCAA) - The most recent report from the NCAA covers the period 01/04/2019 to 31/03/20. For this period, we had a total of 45 reportable arrests. Figure 4 below demonstrates that our rates per 1000 admissions are lower than in the majority of participating hospitals

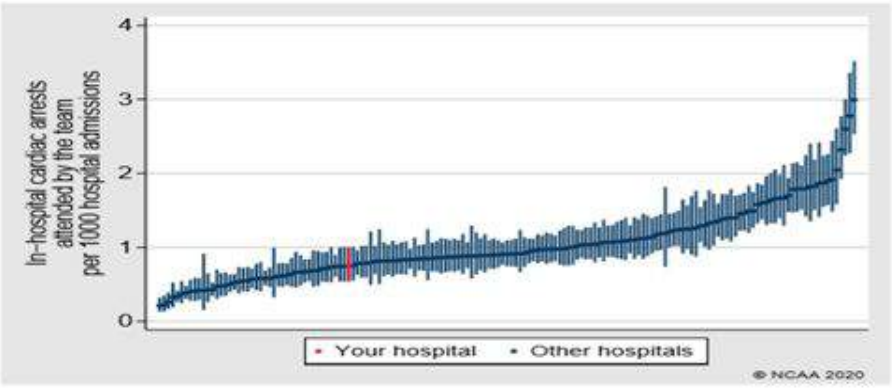


Figure 4: Rates of cardiac arrest per hospital admission for all participating UK hospitals

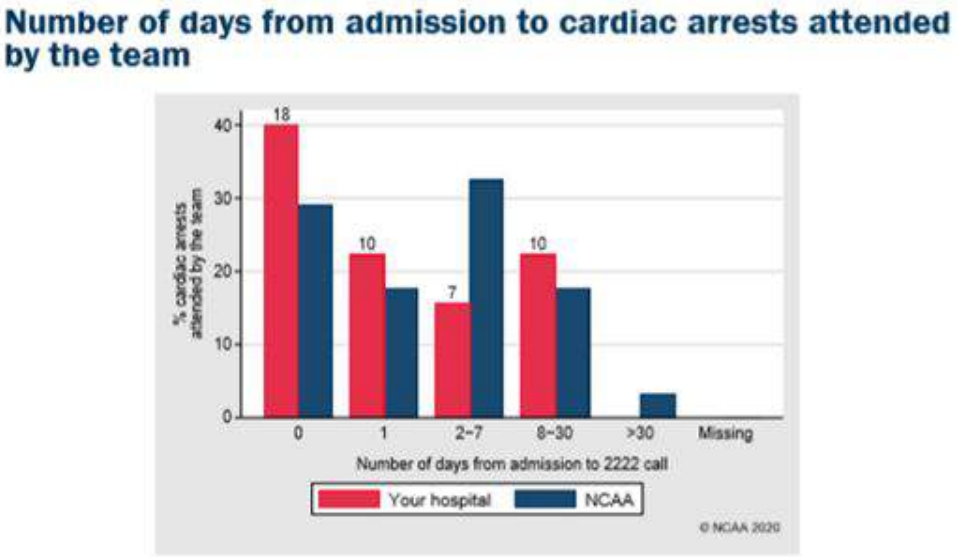


Figure 5: Time from admission to cardiac arrest

Figure 5 demonstrates that the majority of cardiac arrests occur early in a patient's admission, which is expected and broadly in line with other centres. This reinforces the importance of early discussions and decision making regarding resuscitation.

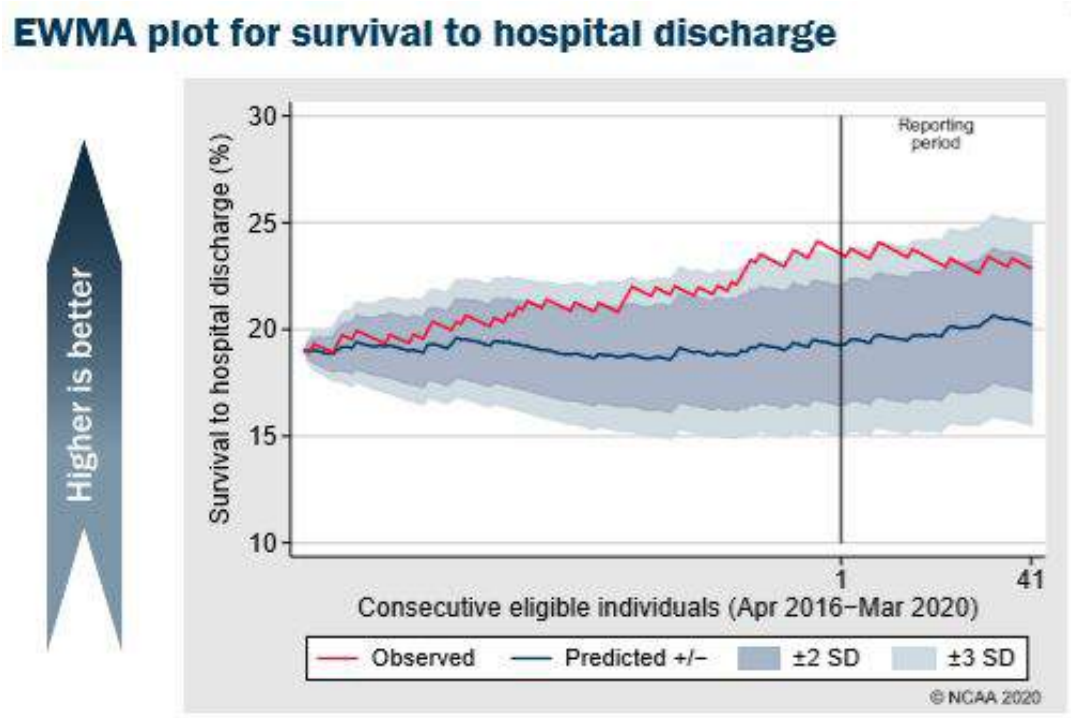


Figure 6: Actual survival from cardiac arrest in HDFT compared to predicted outcome. Each consecutive case is added to the right of the graph, with the red line rising or falling depending on survival.

Overall survival from cardiac arrests (to hospital discharge) remains above that predicted using a risk-adjusted model based on patient demographics.

Structured case reviews - Due to Covid-19 pressures, structured case reviews were temporarily reduced during the first wave. As a result, only 13 cases have been reviewed to date in 2020. All cases were reviewed by either the Medical Director in post at the time or a Deputy Medical Director

The overall assessment of standard of care is shown in Table 1:

Case ID	Evidence of Learning Difficulties?	Evidence of Serious Mental Health Issue?	Quality of Care in first 24hr (1-5)	Quality of Ongoing Care if applicable (1-5)	Quality of End of Life care (1-5)	Quality of Overall Care (1-5)	Quality of Note-keeping (1-5)
1	Y	N	4	3	4	4	4
2	Y	N	4		5	4	4
3	N	N	4	5	5	5	5
4	N	N	2		5	2	4
5	N	N	5		5	5	5
6	N	N	5	4	4	4	4
7	Y	N	4		4	4	4
8	Y	N	5	5	5	5	5
9	Y	N	5	5	4	5	5
10	Y	N	4	4	5	4	3
11	N	Y	3	2	4	2	4
12	Y	N	4	4	4	4	5
13	N	N	4	4	4	4	4
Median Score	-	-	4	4	4	4	4

Table 1: Structured Judgemental Reviews (SJR) conducted in 2020

Case number 4 was investigated as a Serious Incident (SI). Case 11 underwent a further review by a second Deputy Medical Director and a Consultant Microbiologist. Although there were learning points identified in terms of inter-disciplinary communication and senior involvement, no further investigation was adjudged necessary by the reviewers and the coroner.

Deaths of patients with learning disabilities - HDFT notified the LeDeR programme of 5 deaths in Q1 and 2 deaths in Q2.

Three patients with learning disabilities who died during Q1 and Q2 had SJRs completed. The overall assessment of care was good in two cases and excellent in one.

2 SJRs were also completed during Q1 and Q2 for two deaths that occurred in 2019/20 The overall assessment of care was excellent in one case and good in the other.

During Q1 and Q2 we received feedback from LeDeR reviews for two patients who died in 2019/20

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

The LeDeR report identified:

Areas of good practice to feedback:

- Learning Disabilities Liaison Nurse was notified of admission through a flagging system. Involved in discussions around best interest decision making
- Multiple carers were allowed to be present whilst an inpatient to meet the patient's individual needs and a side room was provided to facilitate this.
- An Independent Mental Capacity Advocate was consulted in decision making

There were no areas of identified learning for the Trust

2. The SJR done at the time identified good overall care.

The LeDeR report identified:

Areas of good practice to feedback:

- Patient had a hospital passport
- Family allowed to visit during COVID-19, due to exceptional circumstances
- Good involvement with family in decision making

There was one area of identified learning for the Trust

· No cause of death recorded in the patient notes

Covid-19 Deaths - Table 2 shows the hospital's Covid-19 mortality for Q1. In total, 65 patients died in hospital within 30 days of a positive Covid19 test, with a further 5 dying following discharge. As can be seen, the mortality rises sharply with increasing age. Please note that this data uses the current NHS definition of a positive Covid-19 diagnosis and does not include data where Covid-19 is included on a death certificate based on clinical suspicion.

NEW Confirmed Covid-19 inpatients (Apr-Jun 2020)				% (of patients)		% (of deaths)	
Age category	Total	Death within 30 days	Death in hospital	% Death within 30 days	% Death in hospital	% Death within 30 days	% Death in hospital
6-17	1	0	0	0.0%	0.0%	0.0%	0.0%
18-24	1	0	0	0.0%	0.0%	0.0%	0.0%
25-34	3	0	0	0.0%	0.0%	0.0%	0.0%
35-44	4	0	0	0.0%	0.0%	0.0%	0.0%
45-54	12	1	0	8.3%	0.0%	1.4%	0.0%
55-64	15	3	3	20.0%	20.0%	4.3%	4.6%
65-74	24	6	6	25.0%	25.0%	8.6%	9.2%
75-84	55	25	23	45.5%	41.8%	35.7%	35.4%
85+	72	35	33	48.6%	45.8%	50.0%	50.8%
Total	**187**	**70**	**65**	**37.4%**	**34.8%**		

Table 2: Covid19 deaths for admissions, either whilst still an inpatient or within 30 days of positive test. Note that "Confirmed Covid-19" relates to patients with a positive PCR test and excludes any patient with negative PCR results whose imaging and clinical impression was of suspected Covid-19.

9.1

Table 3 shows the mortality from Covid-19 amongst patients admitted to Critical Care during the first wave. The overall mortality was similar to national data (ICNARC), which showed a UK mortality of 39.4% for all admissions up to 31st August 2020.

Positive	Discharged	Transferred	Death	Total	% Death
NIV	11	0	5	16	31.3%
MV (includes I+V)	0	1	4	5	80.0%
Total	**11**	**1**	**9**	**21**	**42.9%**
Negative	Discharged	Transferred	Death	Total	% Death
NIV	8	0	1	9	11.1%
MV (includes I+V)	1	0	2	3	66.7%
Total	**9**	**0**	**3**	**12**	**25.0%**
All	Discharged	Transferred	Death	Total	% Death
NIV	19	0	6	25	24.0%
MV (includes I+V)	1	1	6	8	75.0%
Total	**20**	**1**	**12**	**33**	**36.4%**

Table 3: Covid-19 mortality from Critical Care admissions. Positive cases had a positive PCR test. Negative cases had a negative PCR test but high clinical suspicion supported by radiological imaging. NIV – non-invasive ventilation (includes CPAP); MV – mechanical ventilation (formal intubation and ventilation).

4.0 Future Plans and Learning

A review of how to maximise learning from death across the Trust in currently underway. Current proposals in this regard are:

- Establish a Medical Examiner Service. This will provide independent scrutiny of all hospital deaths and identify cases for further review, investigation and learning
- Improve the feedback given to clinical areas for dissemination through Quality of Care teams
- Internal Audit review of learning from serious incidents and complaints
- Ensuring structured case reviews are triggered and performed in a timely manner

5.0 Recommendation

The Board is asked to note the contents of this report and the processes for ensuring learning from death.

Harrogate and District NHS Foundation Trust

Board of Directors (held in Public)
25 November 2020
Report of the Chief Nurse

Agenda Item Number:	**9.2**
Presented for:	Information, Approval
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.

9.2

Board of Directors

25 November 2020

Report of the Chief Nurse

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
- 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 that feeds into the Corporate Risk Register, monitored by the Corporate Risk Register Group

8.0 Consultation with Partner Organisations

8.1 The CN engages with a wide range of internal and external stakeholders to develop work programmes;

9.0 Monitoring Performance

9.1 Clinical Quality and Patient Safety

9.1.1 Nurse Staffing Levels during Covid

9.1.2 The impact of nursing, midwifery and care staffing capability and capacity on the quality of care experienced by patients and patient outcomes has been well documented in several high profile reports on care failings. National guidance requires the Trust Board to agree and set substantive nurse staffing levels and budgets on annual basis, to maintain oversight of staffing levels and safe care delivery and review nurse staffing levels every six months.

9.1.3 I would normally be reporting to the Trust Board about the latest position in relation to Nursing and Midwifery staffing in line with the expectations of NHS England (National Quality Board – NQB's Ten Expectations 2012, 2016), NHS Improvement(NHSI, 2018) and the Care Quality Commission (CQC). However, as this year has not been normal I am using this section to inform the Trust Board of changes that have been made to the acute ward configuration and nurse staffing levels.

9.1.4 The majority of our adult in-patient areas have been repurposed. In addition, there has been a reduction in the number of beds. There has been two key drivers in the removal of beds, to maintain appropriate social distancing and the success of our discharge planning process and the Supported Discharge Service that has meant, outside of winter, our services can be provided on a lower bed base.

9.1.5 Nurse staffing levels were reviewed as we began to restore our services following the first wave of Covid - 19. The Acute Ward Configuration and nurse staffing level per shift is provided as a supplementary paper supporting this report.

9.1.6 I have met with the Heads of Nursing, Matrons and the majority of the Ward Managers to discuss their nurse staffing levels to determine if they can safely provide the services

they are expected to deliver. Whilst some concerns were discussed the staffing levels have been agreed.

9.1.7 Against the ongoing national picture of 40 000 nursing vacancies the nurse vacancy rate across the acute wards and departments at HDFT are as follows

LTUC Areas	RN Establishment	RN Vac against new Budget	Planned New RN Starters	RN ML/LTS not included in vacancy	CSW Establishment	CSW VAC against new Budget	Planned New CSW starters	CSW ML/LTS not included in vacancy
New Farndale	22.89	2.38	0.00	2.40	19.72	0.17	2.00	0.00
New Byland	14.98	-1.99	0.00	0.00	13.91	-1.73	0.00	0.00
New Granby	10.45	2.00	0.00	0.80	11.51	-1.45	1.80	0.00
New Oakdale	15.86	2.40	0.00	0.00	18.67	1.51	0.00	1.00
New Wensleydale	18.36	8.85	5.00	0.00	19.72	-1.37	0.00	0.60
New Jerv	14.09	2.00	1.00	2.00	16.91	-4.25	0.00	2.4
New Las/Rowan	9.02	0.78	0.00	0.00	10.68	1.29	0.00	0.00
Trinity	9.23	0.34	1.00	1.00	13.27	1.30	0.00	0.00
Total	**105.65**	**16.76**	**6.00**	**6.20**	**111.12**	**-4.53**	**3.80**	**4.00**
Vacancy minus planned starters	**10.76**				**-8.33**			

PSC Areas	RN Establishment	RN Vac against new Budget	Planned New RN Starters	RN ML/LTS not included in vacancy	CSW Establishment	CSW Vac against new Budget	Planned New CSW starters	CSW ML/LTS not included in vacancy
New ESU	13.11	1.88	3.00	1.00	11.51	1.93	0.00	0.45
New Nidderdale	13.50	4.62	3.00	0.00	16.72	8.77	7.00	0.00
New Littondale	13.35	1.35	3.00	0.00	16.03	2.71	1.00	0.73
New Harlow	17.31	4.32	2.00	0.00	20.06	3.94	3.61	1.00
Total	**57.27**	**12.17**	**11.00**	**1.00**	**64.32**	**17.35**	**11.61**	**2.18**
Vacancy minus planned starters	**1.17**				**5.74**			

9.1.8 The Nursing staffing establishments on the acute adult wards are set and funded to a good standard, which allows delivery of high quality care in all services and maintains patient flow throughout the acute services.

9. 2 Flu Campaign 2020/21

9.2.1 The flu programme planning for 2020/21 aims to achieve 100% (90% for external reporting) for frontline workers and is a 100% offer to all colleagues.

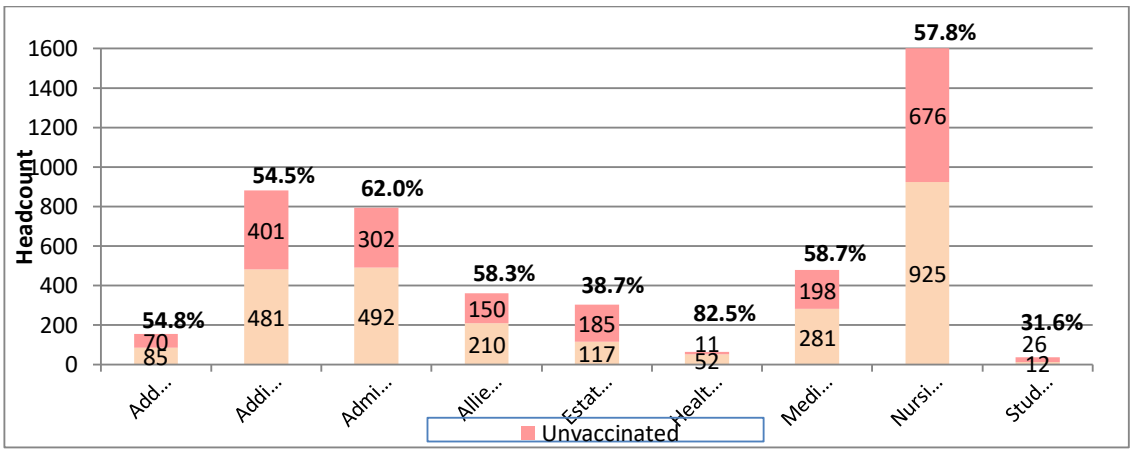
9.2.2 The aim is to complete this year's Flu Campaign by December 4th 2020.

9.2.3 Current Position – as of 16th November 2020

ALL STAFF	Vaccinated	Headcount	% Vaccinated
TRUST TOTAL (Excluding HIF)	2,506	4,337	**57.78%**
TOTAL (Including HIF)	2,655	4,674	**56.80%**

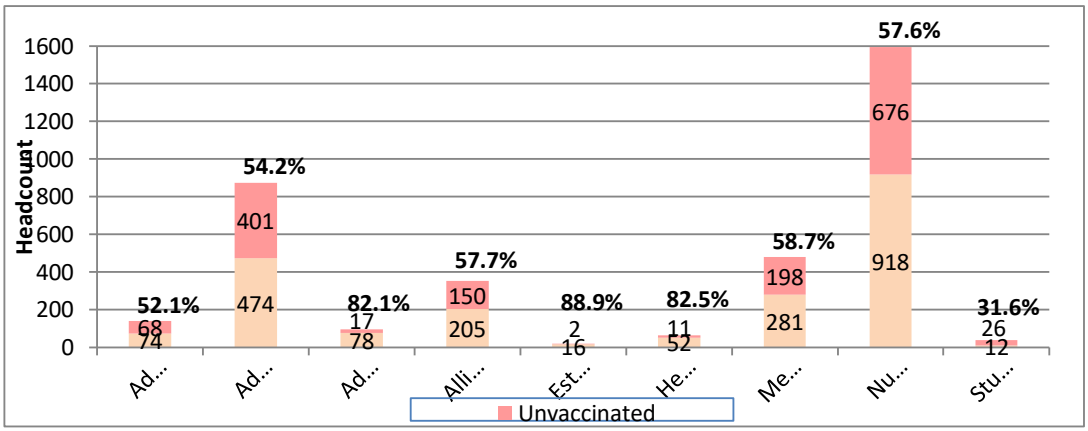
FRONT LINE STAFF	Vaccinated	Headcount	% Vaccinated
TRUST TOTAL (Excluding HIF)	2,083	3,613	**57.65%**
TOTAL (Including HIF)	2,110	3,659	**57.67%**

9.2.4 Flu Vaccination uptake by Staff Group (including HIF)



9.2

9.2.5 Flu Vaccination uptake by Staff Group – Frontline Staff (including HIF)



9.2.6 Flu Vaccination uptake by Staff Group (including HIF)

Staff Group	Vaccinated	Unvaccinated	% Uptake	Headcount
Add Prof Scientific and Technic	85	70	54.8%	155
Additional Clinical Services	481	401	54.5%	882
Administrative and Clerical	492	302	62.0%	794
Allied Health Professionals	210	150	58.3%	360
Estates and Ancillary	117	185	38.7%	302
Healthcare Scientists	52	11	82.5%	63
Medical and Dental	281	198	58.7%	479
Nursing and Midwifery Registered	925	676	57.8%	1601
Students	12	26	31.6%	38

9.2.7 Flu Vaccination uptake by Staff Group – Frontline Staff (including HIF)

Staff Group	Vaccinated	Unvaccinated	% Uptake	Headcount
Add Prof Scientific and Technic	74	68	52.1%	142
Additional Clinical Services	474	401	54.2%	875
Administrative and Clerical	78	17	82.1%	95
Allied Health Professionals	205	150	57.7%	355
Estates and Ancillary	16	2	88.9%	18
Healthcare Scientists	52	11	82.5%	63
Medical and Dental	281	198	58.7%	479
Nursing and Midwifery Registered	918	676	57.6%	1594
Students	12	26	31.6%	38

9.2.8 To encourage further uptake communication is being increased over next three weeks. Uptake by ward/department/team has been circulated for colleagues to understand how they are doing. Peer vaccinator will be encouraged to publicise flu clinics in areas where there is currently low uptake. The total number at this point (16th November 2020), does not reflect all colleagues who have received their flu vaccine elsewhere – a list of colleagues for whom we have no information about their flu vaccination status has been compiled, this is being circulated to line managers this week for follow up, it is anticipated total numbers will be boosted.

9. 2.9 Healthcare Worker Flu Vaccination – Self-Assessment Management Check List

9.2.10 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. The updated checklist is a supplementary paper supporting this paper.

9.2.11 Covid Vaccination Programme

9.2.11.1We have been asked to be prepared to commence Covid-19 vaccinating in December, provisional start date December 7th 2020. Whilst we have no further, at time of writing, confirmed details, our preparations are underway. I can confirm I am the Executive Lead for the programme and Kate Woodrow, Chief Pharmacist is the operational lead. The Flu group is the operational group tasked with delivering the programme.

9.3 Future Freedom to Speak Up Guardian (FTSUG) Arrangements

9.3.1 The move toward a new model continues to go 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 has continued with our interim FTSUG's meeting the applicants for a short problem solving exercise to talk through a typical scenario. This part of the selection process has been completed and five colleagues have been recommended by the FTSUG's for consideration as the Lead FTSUG. The FTSUG's have been in touch with the national and regional guardian offices for advice regarding assessment criteria for the final part of the selection process which will take place shortly.

9.3.2 There are a further group of colleagues who wish to be considered for a role as an Associate FTSUG. The selection for these roles will take placeafter the Lead FTSUG has been appointed.

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

9.3.4 The interim arrangements continue to work well.

9.4 SIRO Report

9.4.1 In addition to my role as Chief Nurse, I have recently become the Trust's Senior Information Risk Owner (SIRO). There is a formal delegation process by means of a letter from the Accountable Officer (CEO) that I have received and answered, accepting responsibility of the role.

9.4.2 The SIRO role summary is as follows

- The Senior Information Risk Owner (SIRO) will be an Executive Director or Senior Management Board Member who will take overall ownership of the Organisation's Information Risk Policy, act as champion for information risk on the Board and provide written advice to the Accounting Officer on the content of the Organisation's Statement of Internal Control in regard to information risk.

- The SIRO is expected to understand how the strategic business goals of the Organisation and how other NHS organisations' business goals may be impacted by information risks, and how those risks may be managed.

- The SIRO will implement and lead the NHS Information Governance (IG) risk assessment and management processes within the Organisation and advise the Board on the effectiveness of information risk management across the Organisation.

- The SIRO shall receive training as necessary to ensure they remain effective in their role as Senior Information Risk Officer.

9.4.3 I will be receiving induction and training for the role of SIRO on 20th November 2020.

9.5 The Cyber Operational Readiness Support (CORS) Programme

9.5.1 The Cyber Operational Readiness Support (CORS) programme is funded by NHS Digital, with the aim to enable NHS organisations to identify and address Cyber Security vulnerabilities and help them attain the mandatory NHS Cyber Security standards. The over-arching objective is to provide secure and sustainable patient care, against an increasingly digitised and web-enabled environment. NHS Digital has commissioned Templar Executives to work with Trusts to help deliver these outcomes.

9.5.2 The CORS engagement consists of an Outbrief Report that sets out findings and recommendations for improvement, followed by support for remediation against any issues identified.

9.5.3 HDFT has received the latest quarterly remediation progress report (to October 2020). The report is attached as a supplementary paper supporting this report. This report sets out the progress made to October 2020 against the Outbrief recommendations.

9.5.4 It is the view of the team HDFT are working with that a lot of good progress has been made but there are still some areas that need attention, particularly in procurement and the Trust's journey to CE+ (Cyber Essentials +) accreditation (or its equivalent).

9.5.5 The CORS programme comes to an end on 31 March 2021 and the Trust and NHSD will receive a final remediation report around February 2021. The team are suggesting we push to complete as many remediation tasks as possible over the next four months and suggest the key areas are:

- Procurement Workshop: to gather Trust procurement people together with IT and security/IG support functions and contract managers to raise awareness of how cyber can be made part of a collaborative Plan – Source – Manage cycle, stressing that procurement is a team sport.
- Clinician training: particularly important if Trust clinicians are working remotely.
- IAO training: completing this training across the IAO community (which is the SIRO's key risk management resource).
- CE+ assessment: Templar Executive IT expert can offer a private run through of the CE+ requirements so that the CIO and SIRO can determine how near the Trust is to compliance (NB: DSPT assessment covers the same territory as CE+ so the assessment is relevant whatever standards are ultimately used).
- SIRO KPIs: simple metrics against which SIRO can report on cyber security and information assurance (e.g. to DIGS or Audit Committee).

9.5.6 I will be working with the team at HDFT and Templar Executives to support this work.

10.0 Recommendation

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

11.0 Supporting Information

11.1 The following papers make up and support this report:

- Phase 2 Ward Establishments
- Healthcare Worker Flu Vaccination – Self Assessment Checklist
- Cyber Operational Readiness Support (CORS) Remediation Report

Appendix 1

Phase 2 – Ward Speciality and Staffing Numbers With Reduced Bed base (50 beds)

Assessment & COVID wards

Harlow/Swale – SAU/MAU/Gastro (25 beds)

	RN	CSW
Early	4	4
Late	4	4
Night	4	3

ARCU - Red ICU / HDU / NIV

	RN	CSW
Early	0	0
Late	0	0
Night	0	0

Wensleydale - Frailty/orthogeri/stroke (32 beds)

	RN	CSW
Early	4	4
Late	4	4
Night	4	3

Farndale - MAU (MAU/CCU) 23 beds

	RN	CSW
Early	5	4
Late	5	4
Night	5	3

Rowan – Rehab 12 Beds

	RN	CSW
Early	2	3
Late	2	2
Night	2	1

Maternity and Woodlands – remain mixture of Red/Yellow and no staffing changes

Non-COVID wards

Oakdale – Stroke/Neuro/Haem/ Oncology/Gastro (24 beds)

	RN	CSW
Early	4	4
Late	4	3
Night	3	3

Littondale – Gen surgery/ortho (24 beds)

	RN	CSW
Early	3	3
Late	3	3
Night	3	2

Nidderdale – Trauma Ortho (22 beds)

	RN	CSW
Early	3	3
Late	3	3
Night	3	2

Jervaulx – Medical frailty (22 beds)

	RN	CSW
Early	3	3
Late	3	3
Night	3	3

Byland – Resp/CCU/med (18 + CCU)

	RN	CSW
Early	4	3
Late	3	3
Night	3	1 +Tw

ITU Green – ICU / HDU / / NIV / CCU

	RN	CSW
Early	5	1
Late	5	0
Night	5	0

Granby Medical

	RN	CSW
Early	3	2
Late	2	2
Night	2	2

Trinity – Rehab 16 beds

	RN	CSW
Early	3	3
Late	2	3
Night	2	2

Briary - Discharge Lounge & Hub
Matron Lead – Lesley Danby

Green COVID clear wards

DSU

BMI Duchy
Staffed by Duchy staff

MSS – Green HOB (22 beds)
Early 4 2 Late 4 2 Night 4 2

Key (Based on COVID costing/numbers)
Red – increase in staffing numbers
Green – decrease in staffing numbers
Black – no change to staffing numbers
Purple – ARCU/ITU increase by 1 overall across both areas

Appendix 2

Healthcare Worker Flu Vaccination – Self Assessment Checklist

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
A3	Board receive an evaluation of the flu programme 2019/20, including data, successes, challenges and lessons learnt	Completed
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 – almost completed for all Board members
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 daily 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. Since the campaign has begun the group has met daily
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

Appendix 2

Healthcare Worker Flu Vaccination – Self Assessment Checklist

B3	Board and senior managers having their vaccinations to be publicised	Will be completed by November 2020
B4	Flu vaccination programme and access to vaccination on induction programmes	Not now necessary. All new colleagues assigned to FluTrak and invited to attend a clinic
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 and are signed off as competent
C2	Schedule for easy access drop in clinics agreed	Complete
C3	Schedule for 24 hour mobile vaccinations to be agreed	Complete
D	**Incentives**	
D1	Board to agree on incentives and how to publicise this	Complete
D2	Success to be celebrated weekly	Colleagues will be updated on a weekly basis from the end of October – process of obtaining accurate figures of staff groups by wards, departments and teams under discussion – aim to be completed by end of week

HARROGATE AND DISTRICT FOUNDATION NHS TRUST

CYBER OPERATIONAL READINESS SUPPORT (CORS) – REMEDIATION REPORT

QUARTERLY REMEDIATION PROGRESS REPORT (TO OCTOBER 2020)

Lead Author	Rob Higgins, Strategic Integrator
Date	5 November 2020

Executive Summary

This report describes the progress of the Trust as a result of its engagement with the Cyber Operational Readiness Support (CORS) programme. Funded by NHS Digital, CORS aims to enable NHS organisations to identify and address Cyber Security vulnerabilities and help them attain the mandatory NHS Cyber Security standards. The over-arching objective is to provide secure and sustainable patient care, against an increasingly digitised and web-enabled environment. NHS Digital has commissioned Templar Executives to work with Trusts to help deliver these outcomes.

The CORS engagement consists of an Outbrief Report that sets out findings and recommendations for improvement, followed by support for remediation against any issues identified. This report sets out the progress made to October 2020 against the Outbrief recommendations.

Considerable progress has been made since the previous review which was prior to the onset of Covid. A new SIRO has been appointed and, with fundamental protections now in place, the SIRO can drive further improvements over the coming months (circumstances permitting).

Key areas for SIRO and Trust consideration:

The role of the Board in promoting, supporting and demanding appropriate cyber security standards needs to be made clearer and communicated. The SIRO is currently working on this.

The Clinical workstream has shown good progress and the Trust needs to ensure that the move from paper to digital solutions is matched by parallel work of cyber security.

The Information Asset Owner community has been established and is in the middle of being trained. This community is vital for the day to day delivery of high-quality information assurance and cyber security and needs to be developed.

Comms is key to the culture change inherent in a move to the Trust's Digital Vision. Implementation of a communications plan that fosters a security culture where all staff are stakeholders should be supported.

Compliance with NHS cyber security standards is vital and support should be given to the CIO and their organisation to deliver CE+ or its equivalent by March 2021. Many solutions to identified issues are in hand but have been delayed by Covid.

In the new lockdown, it is probable that a significant proportion of staff will be working remotely. The SIRO should engage with the IG Manager to ensure that remote working policies are in place and understood and with the CIO to ensure that cyber security standards can be maintained during this difficult period. CORS will support the Trust in whatever way it can in this regard.

Finally, the status of the Trust's procurement service with regard to cyber security has been difficult to ascertain due to the ongoing merger of this function with that of Leeds THT. CORS recommends the delivery of a cyber security workshop for the Trust's ICT, procurement and contract management staff as a valuable awareness-raising tool and to promote collaborative working on cyber-sensitive procurement activities.

Detailed Progress Against Outbrief Recommendations

1. Policies (Leadership and Governance)

Recommendation	**Progress**	
Board to take regular Cyber Security briefings	SIRO to establish how and when the Board is briefed	done
Cyber NED to be appointed	SIRO to discuss with CEO	
Cyber KPI reporting to be implemented	SIRO to consider SIRO KPIs provided to previous SIRO.	
Trust Risk Appetite for information sharing and risk to be established, to inform Trust expectations for Cyber Security and Information Risk measures.	SIRO to discuss with Board.	
SIRO formally appointed by CEO	Previous SIRO appointed. Letter required for new SIRO	done
IAOs identified	Yes	done
IAOs appointed formally	Yes	done
IAOs trained	IAOs have been registered. Reminder regarding training sent. Monthly report provided and further action required for compliance.	
Policy suite review	done	done
Policy suite update/renewal	In train: Policies are being updated by the IG Manager.	
Cross-department cyber/information assurance forum	DIGS established and meets regularly.	done
Board support for Cyber communications plan	Will be delivered by other actions	done
Business Continuity Planning to include cyber attack scenarios	CIO + SIRO to discuss and action	
Business Continuity Cyber exercise undertaken	CIO + SIRO to discuss and action	

2. Communications and Culture Change

Recommendation	Progress	
CEO and Board Cyber messaging issued as part of Cyber Security communication plan	Discussed with PW and CH and included in media plan	
Cyber Security communication strategy and plan created	Updated and resent to PW with	done
Cyber Security governance structure communicated Trust-wide	Discussed with PW and CH and included in updated media plan	done
Comms plan for cyber incident prepared	NA	done
Comms and IT forum for collaborative working on Cyber Security	DIGS now attended by SIAOs	done
Comms Department to manage Trust intranet content to create coherent and accessible Trust-wide approach	Not reviewed ongoing	
Trust leadership training programme to include Cyber Security awareness content	IAO training set up and being delivered	
Social media tools to be used to assist delivery of Trust messages on Cyber Security	All channels discussed and included in updated Media plan	done
Alternatives to 'all mail' messages to improve Trust messaging on Cyber Security	See media plan.	done

3. Clinical

Recommendation	Progress	
Improve connectivity and integration between clinical IT systems and applications	WebV has moved much closer to being a single port of call for clinical staff. A ward round can now be done purely in WebV instead of requiring four systems as was previously the case. WebV has information fed into it from: iCS (PAS demographics, all patient activity and emergency department discharge letters) LabCentre (Pathology results) PACS (Radiology reports and images) Dragon Medical Workflow Manager (Clinic Letters) ICE (Inpatient discharge letters and endoscopy reports) Synatec (Emergency department letters) Patientrack (Inpatient observations and assessments) eRS (GP referrals) WebV also has contextual links into:	done

	ICE (For requesting pathology tests, viewing pathology reports from Leeds and York, writing inpatient discharge letters) ePMA (For prescribing and administering medication for inpatients)	
Web V3: create clear user guidelines	User guidelines have been created by WebV System Team, including documents, videos and walkthrough guides.	done
Clinical records to be accessible to clinicians in a form that allows all relevant information to be viewed.	Although paper Casenotes are still used the amount of information in them that is not also available in electronic form is reducing. There are currently 67 documents live in WebV to enable direct recording of records. This can also be done in conjunction with Dragon Medical One speech recognition to speed up data entry and improve quality and content. For outpatient clinics there is a rollout plan by specialty to perform paperless clinics. Urology have already achieved this using WebV to view all clinical information and Dragon Medical Workflow Manager. For inpatient care WebV provides a single point of access for mast information required for a ward round or consultation. Some MDTs are now documented using WebV documents. The nursing admission document is currently being tested by clinical staff in WebV.	
Single login access controls to be implemented to permit quick access to clinical files	Single sign in (tap and go) has been piloted in the Emergency Department and the Trust are actively working with Accenture and NHS Digital on a project reduce the burden of authentication on NHS staff. The ability to now do much more in WebV reduces the burden.	
Mitigate risk of clinical staff failing to log out of on-ward terminals	Single sign on has the ability to automatically log clinical staff out of terminals, but the nature of tap and go also makes it clinically easier to self-manage logging in and out.	done
Forum for ICT and Clinicians to work together on Cyber Security issues	Clinical and IT forum in place	done
Cyber Security and GDPR mandatory e-training rolled out	Information Governance and Data Security eLearning is mandatory	
Clinicians to work with Procurement Team to ensure that all medical procurements are conducted in accordance with Trust's procurement processes	Clinical device procurement is conducted via Trust Procurement	done

4. Procurement and Supply Chain

Recommendation	Progress	
Produce Procurement strategy that requires consideration of Cyber Security and information risk		
Trust intranet to contain freely accessible guidance on procurement		
SIRO to give IAOs responsibility to ensure Cyber Security is considered in procurement processes relating to their information assets		
Procurement team to be given training on Cyber Security in procurement and supply chain management		
Procurement team to map supply chain to identify key areas of Cyber Security risk and what measures should be in place via procurement to mitigate this risk		
Gap Analysis to be carried out on Trust procurement process to identify areas where Cyber Security risk can be mitigated		
Procurement team to develop templates and processes to manage Cyber Security risk in procurement		
Develop Trust Contract Register that identifies Cyber Security critical contracts and suppliers	Contract Register has been developed and is updated as required. All contracts where data protection forms part of the contract, clauses are passed through Data Protection Officer for ratification prior to sign off.	done
Set minimum Cyber Security requirements for suppliers delivering Cyber Security critical contracts	Minimum requirement required to liaise with providers for contract variations	
Establish clear contractual consequences for failure on the part of a supplier to comply with Cyber Security requirements		
Trust Risk Appetite for information sharing and risk to be established, to inform Trust expectations for Cyber Security and Information risk measures.	(also in Leadership, Policy and Governance)	
Retrospective check on contracts in place to assess Cyber Security risk.	Task to be undertaken	
Trust protocol for storage of contract documentation to be agreed and implemented	Contract documentation scanned and saved onto I Drive. Original filed.	done
Ensure Trust requirements for contract exit strategies are clear and implemented	Exit strategy forms part of contract where appropriate.	done

All contracts being renewed or extended to be updated to take account of Cyber Security risk	Task to be undertaken	
Right to audit Cyber Security compliance to be required in all relevant contracts	Task to be undertaken	
Establish Cyber Security assurance requirements (e.g. CE+, penetration testing etc.) for supply chain		
Establish KPIs for procurement to report against for Cyber Security		
Include Cyber Security in key supplier management meetings		
Procurement to take active role in the Trust's Cyber Security forum chaired by SIRO	DIGS	
Procurement team to work with Clinicians to ensure that all medical procurements are conducted in accordance with Trust's procurement processes	(also in Clinical)	

5. Enterprise Architecture & ICT Operations

Recommendation	**Progress**	
R2 CE+ Mitigation measure for risk of generic and auto login accounts used by clinicians	Initially we were looking at rolling out a VDI solution across the clinical areas to resolve this issue. This was put on hold due to the Covid 19 based activities and will be picked up again for initial review in October 2020.	
R13 CE+ Identify all unsupported systems and put support in place	All unsupported systems have been identified and will be either upgraded or segmented by March 2021. There is a cost to this and the budget will require approving.	
R6: PBAC and NAC port control and lockdown implementation complete	This is the same solution as R13 starting with unsupported devices, other areas will be addressed later.	
R5 CE+ Internal core network VLAN segmentation/segregation	This is the same solution as R13	
R14: Establish plan to provide protective monitoring across network	No progress due to Covid 19 – this will be reviewed in line with the new NHD Digital and N365 cyber security functionality after March 2020	
R15: Establish measures to prevent non-Trust/compromised devices from connecting to Trust network	No progress due to Covid 19 – this will be reviewed in line with the new NHD Digital and N365 cyber security functionality after March 2020	

R12: Plan and adopt use of available NGIPS to enhance boundary controls and network defence	No progress due to Covid 19 – this will be reviewed in line with the new NHD Digital and N365 cyber security functionality after March 2020	
R8: Replace instance PSKs and enforce authentication of clients by use of certificates based on central Trust infrastructure	No progress due to Covid 19 – this will be reviewed in line with the new NHD Digital and N365 cyber security functionality after March 2020	
R7: Secure configuration management of all end user devices and servers	A new change control process has been implemented using the upgraded Service Desk software linked to the Configuration Management Database.	done
R9: Protection in place for data in transit between PAS and users	No progress due to Covid 19 – this will be reviewed after March 2020 with the PAS supplier	
R10: Implement access control to DC environments	CCTV has been implemented into both Datacenters and a new Trust door access system is being implemented in 2021.	done
R11: Web V development assured and tested by suitably skilled developers	Joe Ingle will be responsible for this one.	done
R3: Joiners, Leavers and Movers policy to include linkages to IT so that user privilege etc. can be updated.	A project is under way to implement the NHSD JML software which will integrate the ESR and AD automatically updating user's privileges from the HR system. Estimated go live at the end of October 2020.	
R16: Implement good practice documentation to Trust IT Architecture.	Progress has been made working with MTI consultants and a new suite of policies should be completed for March 2020.	

Harrogate and District NHS Foundation Trust

Board Committee Report to the Board of Directors

Committee Name:	People and Culture Committee
Committee Chair:	Jeremy Cross, Non-executive Director
Date of meeting:	16 November 2020
Date of Board meeting this report is to be presented	24 November 2020

Summary of key issues

- It was encouraging to have the Co-chair of the BME network, together with the FTSUG present at the meeting. Both raised useful views and perspectives. As the other networks are developed (LGBTQ+ and Disability) we will invite their chairs to attend too. In addition for the first time we had Governor representation too.
- We received an update on the work on the people plan. Work is progressing on a number of fronts including the Disciplinary Process, Welfare Conversations, and Leadership Support Circles
- On Leadership Support Circles, in particular we had an excellent discussion with Sara Moore (Pharmacy department) as to how she had used the Circles to develop her own leadership style, and also to provide her with support during the difficult months of 2020. It was encouraging to hear that she had been able to create space in her diary to make this happen, and to share thoughts, feelings and experiences in a "safe space" with other leaders from other areas of the Trust. The Committee were all impressed with the programme and the potential benefits for those who were prepared to invest in it
- We received an update on the "At our best" Cultural improvement plan. Good progress is being made on all fronts and a number of the committee members had either attended or were about to attend the Workshops.
- The Co-Chair of the BME network gave an update on their work and in particular the Black Awareness Month activities. While it was felt that this could be better communicated around the Trust it was encouraging to hear that there had been a 25% increase in membership of the BME network as a result. The network are reviewing their workplan and will report back on their priorities
- At the prior meeting we had received a presentation on the structure and ambitions of the First Line Leadership programme. At this meeting we heard from a recent "Graduate" and it was encouraging to hear how she had found the programme of benefit, and was using the

practical advice in real life. There was a good discussion around who was attending this programme (i.e. the people least likely to put themselves forward are potentially the people who would most benefit from attending) and also on how we assess leadership capabilities for individuals who join the Trust into a leadership role, but from another organisation. This will be built on in future Recruitment work

- As part of the Leadership discussion we heard of events where people had been brave enough to "call out" inappropriate behaviour. This will become increasingly important as we complete our Culture work

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

- The CEO presented some recruitment statistics to the Committee that generated a lot of thought and discussion. The statistics show a significant bias in favour of white candidates during recruitment – both in being shortlisted, and then ultimately being appointed. The Committee were very concerned as to what these statistics mean, and what the wider implications are for the Trust. While there is a piece of work already started on recruitment processes, the read across from the numbers presented might imply a more significant issue for the Trust to deal with.
- It was agreed that next meeting we would devote our "Deep Dive" to all the data we had in various places (e.g. Staff Survey etc) on the experience of our BME colleagues in the Trust. We can then compare this with the planned work on making the Trust an Anti-Racist organisation, and ensure that we believe it is adequately resourced and focussed.

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

- Board Colleagues will want to stay close to the Anti Racist work outlined above
- Board Colleague experiences from attending the Cultural workshops would be interesting to hear

Harrogate and District NHS Foundation Trust

Board of Directors Meeting (held in Public)
25 November 2020
Workforce & Organisational Development

Agenda Item Number:	**10.1**
Presented for:	Discussion and Information
Report of:	Director of Workforce and Organisational Development
Author (s):	Workforce and OD senior team – various contributors
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 discuss and note the items included in the report.

Board of Directors Meeting (held in Public)

25 November 2020

Director of Workforce and Organisational Development

1.0 Executive Summary

1.1 The Workforce & Organisational Development paper for November contains several up-dates for information and also papers for review, feedback and action.

1.2 Updates include:

- Covid Workforce - Update
- Disciplinary training - update
- Leadership Circles – update
- UKVI and Brexit - update
- Clinical Excellence Awards – for information

2.0 Covid Workforce Update

2.1 The Government announced new guidance on the 4th November 2020 in preparation for the second lockdown. In light of this guidance the Workforce team have reviewed our Trust guidance to ensure that we are compliant.

2.2 One of the effected staff groups are Clinically Extremely Vulnerable (CEV) colleagues (formally known as Shielders). There is new national guidance in respect of CEV, and people should receive a letter from the healthcare provider offering them individual advice with regards to their specific condition.

2.3 In light of the updated letter, line managers need to revisit the risk assessment that is currently in place to ensure the colleague is safe and any temporary working arrangements are put in place for them.

2.4 There are FAQ's and Line Manager toolkits available on the Intranet page which are regularly updated to support colleagues across the business with the latest position.

2.5 It is important to retain focus on having the wellbeing discussion with colleagues and the completion of Risk Assessments for all staff. At present there a 60 outstanding Risk Assessments – See **Appendix 1**.

2.6 Directorate managers have been asked to bring leadership and focus to completing these discussions immediately where necessary.

3.0 Disciplinary Training Update

3.1 The Trust's disciplinary policy has recently been revised and updated to ensure that it remains up to date, represents best practice and is modernised.

3.2 Effective disciplinary procedures are a valuable management tool in avoiding allegations of disparity in the treatment of employees and minimising the risk of an action for unlawful discrimination, constructive dismissal or procedurally unfair dismissal. We know at HDFT that improving standardisation and consistency is important to improving the experiences of colleagues who are going through these procedures.

3.3 HR have remapped the whole process depicted in a user friendly flow chart and have revised and standardised accompanying documentation to support everyone.

3.4 In partnership with Hempson's, throughout November we are running a number of workshops that will support our managers undertaking key roles within our new process. The training includes:

- Investigating Officer
- Case Manager
- Panel and appeal panel training
- Maintaining High Professional Standards (MHPS)
- HR Team training

3.5 Everyone in a managerial position has responsibilities for undertaking one of these roles. It is therefore mandatory that all managers attend this training. HR Business partners are facilitating this through Directorate Boards.

4.0 Leadership Support Circles

Leadership Support Circles are a series of short, themed outline sessions based on 10 principles for leading compassionately during COVID19. They provide a space for people managers at all levels to come together, share their experiences and be heard. The Circles are multi-disciplinary, interactive and provide evidence-based guidance and tools. See **Appendix 2** for details of the 10 principles for leading compassionately.

The programme is highly recommend as a means of providing support to yourself as a leader, through both the learning and the peer support which comes with the programme, and enable you to provide support your team members.

In direct response to some of the current challenges additional dates have been created for the Leadership Support Circles, which those attending are finding extremely helpful. The Director team have asked all leaders use these sessions for support. They are 1 hour each bitesize so can be fitted in to working days.

5.0 UKVI and Brexit

5.1 We currently employ approximately 126 EU citizens across the Trust and HIF.

5.2 Due to Brexit some of these staff will need to apply to the EU Settlement Scheme by 30 June 2021 to continue living and working within the UK, staff must have arrived in the UK before January 2021 to apply.

5.3 Staff do not need to apply if they have: indefinite leave to enter the UK, indefinite leave to remain in the UK, British or Irish citizenship (including 'dual citizenship')

5.4 Staff who are an EU, EEA (*includes the EU countries and also Iceland, Liechtenstein and Norway),* or Swiss citizen along with their families can apply to the EU Settlement Scheme to continue living and working within the UK after 30 June 2021. Staff can also apply if they are a family member of an eligible person of Northern Ireland.

5.5 Staff will receive either settled or pre-settled status if their application is successful. Settled Status is awarded if the staff member has been in the UK for over 5 years and pre-settled is for those who have been in the UK for less than 5 years.

5.6 The deadline for applying is 30 June 2021 and it is free to apply to the scheme.

5.7 Staff need to apply even if they:

- were born in the UK but are not a British citizen –
- have a UK permanent residence document
- are a family member of an EU, EEA or Swiss citizen who does not need to apply - including if they're from Ireland
- are an EU, EEA or Swiss citizen with a British citizen family member
- If they have children they will need to apply for them separately..
- If you're an EU, EEA or Swiss citizen and you have a family member who is an eligible person of Northern Ireland,

5.8 Staff may be able to apply if they are not an EU, EEA or Swiss citizen but:

- they used to have an EU, EEA or Swiss family member living in the UK (but they have separated, they've died or the family relationship has broken down)
- they are the family member of a British citizen and they lived outside the UK in an EEA country together
- they are a family member of a British citizen who also has EU, EEA or Swiss citizenship and who lived in the UK as an EU, EEA or Swiss citizen before getting British citizenship
- they have a family member who is an eligible person of Northern Ireland
- they are the primary carer of a British, EU, EEA or Swiss citizen
- they are the child of an EU, EEA or Swiss citizen who used to live and work in the UK, or the child's primary carer.

5.9 The Citizens Advice have a presentation which gives a step by step guide of how to apply and the documents required - https://docs.google.com/presentation/d/e/2PACX-1vTQECCRZg8DJI7NzJwjIRM0DUEiNrBkfk_aOFLgVtk7gx-37YwOaHWTHDPUscZ8LImmBnXfyy7jLRcV/pub?start=true&loop=true&delayms=30000&slide=id.g907c0ec1ee_0_106

5.10 HR will be sending reminders to staff to apply over the next 2 months as applications are taking longer due to COVID.

6.0 Clinical Excellence Awards

6.1 The Clinical Excellence Local Awards Committee (LAC) met on 2nd and 4th November 2020 to discuss the allocation of awards to consultants for 2019/2020. This is an update on the outcome for this year.

6.2 No applications were received from Associate Specialists' for Discretionary Points or from Senior Staff Practitioners for Optional Points**.**

6.3 The awards allocation process changed for 2018 - 2021 which resulted in there no longer being levels within the new system. The value of an award is £3,092 and the LAC was able to award multiple awards to an applicant where the committee felt the application was outstanding and stood out from other applications. The awards for CEA 2018 - 2021 are no longer consolidated or pensionable and will be awarded for 3 consecutive years and then cease. The amount of each award for 2019 will be paid as a lump sum in November this year and April of each year following and will then cease on the 31st March 2023.

6.4 If consultants have previous awards, these will still be paid to them in the manner they have always received those.

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

- 125 consultants were eligible to apply which is then multiplied by 0.30 equalling the number of awards available (37.5).
- Number of awards (37.5) is then multiplied by the value of an award (£3,092) equating to £115,950 which is the minimum annual level of investment the Trust is required to award.

6.6 Ensuring fairness and equality of likelihood of success for all was important to the panel so the applications and scoring were looked at and triangulated across protected characteristics as well as balance of full time and less than full time applicants to ensure no bias emerged during the scoring. The results of this analysis were positive in that there was no evidence of bias towards one characteristic over another.

13 applicants were successful this year with 3 colleagues achieving multiple awards due to the evidence presented.

6.7 The LAC agreed that the quality of applications received was unfortunately lower than previous years and therefore did not award the full level of investment. The LAC agreed to consider how the Trust could support applicants who did not receive an award in order to improve the quality of future applications.

6.8 The LAC awarded £49,472, and have £66,478 which will be carried over to the next 2021/22 round.

6.9 In light of the issues raised in 6.7, the process will be relooked at over the next 12 months to ensure improvements are made and support given to colleagues who wish to apply.

7.00 **Conflict of Interest Policy**

7.1 The Board are aware that development and improvement of the above policy is one of the important measures we need to take in response to the findings in the Deloittes report.

7.2 Specifically, incorporation of a new provision in relation to relationships at work should improve the transparency required where there may be a perceived or actual benefit or conflict.

7.3 The Board have seen the new policy however a summary of some key improvements include;

- Additional requirements for the management of relationships at work/loyalty interest for all staff
- One standard form which will be available electronically for staff to complete
- Strengthened monitoring requirements to incorporate the recommendations from the internal audit carried out in 2019 which require line manager and Executive Director/Chief Executive approval in relation to gift and hospitality prior to staff acceptance.

7.4 The current management system is paper based and the Trust's Company Secretary is currently exploring a digital system to manage the process. This system is called Declare and is provided by Civica Declare system.

7.5 The Declare system is a cloud governance software system, enabling NHS staff declarations of interest to be captured and published on any device. The system is used by a number of NHS and Commissioner Organisations and is fully compliant with conflicts of interest's statutory regulations.

7.6 The policy has been approved by SMT in September and will proceed through the Trust's formally ratification process in November, to include Policy Review Group and Partnership Forum.

7.7 Once ratified the policy will be launched to staff via a number of manager and employee briefings and to new starters as part of the Trust's induction process.

7.8 The Trust's Company Secretary and Workforce team are currently exploring the management processes to support the implementation of the policy and declare system.

8.0 Recommendation

8.1 The Board of Directors is asked to discuss and note the items included in the report.

Supporting Information

The following papers make up this report:

- Appendix 1 - Risk Assessments
- Appendix 2 - Leadership Support Circles – module detail
- Appendix 3 - Conflict of Interest Policy Implementation Plan

Appendix 1

TOTAL RISK ASSESSMENTS (OF THOSE REQUIRED)

	#RA completed	#RA required	RA % Done	#RA Outstanding	of which New Starters within Last 2 Months
Childrens and County Wide Community Care	108	120	90.0%	12	1
Corporate Services	66	70	94.3%	4	1
Long Term and Unscheduled Care	281	303	92.7%	22	8
Planned and Surgical Care	217	234	92.7%	17	8
Harrogate Healthcare Facilities Management	103	108	95.4%	5	0
TOTAL (including HIF)	**775**	**835**	**92.8%**	**60**	**18**

TOTAL RISK ASSESSMENTS (OF ALL STAFF)

	#RA completed	Headcount of Staff	RA % Done	#RA Outstanding	of which New Starters within Last 2 Months
Childrens and County Wide Community Care	164	1,307	12.5%	1,143	16
Corporate Services	77	337	22.8%	260	14
Long Term and Unscheduled Care	322	1,154	27.9%	832	37
Planned and Surgical Care	246	790	31.1%	544	34
Harrogate Healthcare Facilities Management	109	229	47.6%	120	1
TOTAL (including HIF)	**918**	**3,817**	**24.1%**	**2,899**	**102**

BAME Risk Assessments

	#RA completed	#RA required	RA % Done	#RA Outstanding	of which New Starters within Last 2 Months
Childrens and County Wide Community Care	36	43	83.7%	7	1
Corporate Services	28	32	87.5%	4	1
Long Term and Unscheduled Care	196	216	90.7%	20	8
Planned and Surgical Care	141	152	92.8%	11	8
Harrogate Healthcare Facilities Management	19	20	95.0%	1	0
TOTAL (including HIF)	**420**	**463**	**90.7%**	**43**	**18**

SHIELDING Risk Assessments

	#RA completed	#RA required	RA % Done	#RA Outstanding	of which New Starters within Last 2 Months
Childrens and County Wide Community Care	6	6	100%	0	0
Corporate Services	2	2	100%	0	0
Long Term and Unscheduled Care	0	0	#DIV/0!	0	0
Planned and Surgical Care	1	1	100%	0	0
Harrogate Healthcare Facilities Management	2	2	100%	0	0
TOTAL (including HIF)	**11**	**11**	**100%**	**0**	**0**

Appendix 1

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

	#RA completed	#RA required	RA % Done	#RA Outstanding	of which New Starters within Last 2 Months
Childrens and County Wide Community Care	18	23	78.3%	5	0
Corporate Services	30	30	100%	0	0
Long Term and Unscheduled Care	65	67	97.0%	2	0
Planned and Surgical Care	56	62	90.3%	6	0
Harrogate Healthcare Facilities Management	79	83	95.2%	4	0
TOTAL (including HIF)	**248**	**265**	**93.6%**	**17**	**0**

PREGNANCY Risk Assessments

	#RA completed	#RA required	RA % Done	#RA Outstanding	of which New Starters within Last 2 Months
Childrens and County Wide Community Care	8	8	100%	0	0
Corporate Services	0	0	#DIV/0!	0	0
Long Term and Unscheduled Care	6	6	100%	0	0
Planned and Surgical Care	9	9	100%	0	0
Harrogate Healthcare Facilities Management	1	1	100%	0	0
TOTAL (including HIF)	**24**	**24**	**100%**	**0**	**0**

VULNERABLE Risk Assessments (e.g. Diabetic, other conditions)

	#RA completed	#RA required	RA % Done	#RA Outstanding	of which New Starters within Last 2 Months
Childrens and County Wide Community Care	47	47	100%	0	0
Corporate Services	8	8	100%	0	0
Long Term and Unscheduled Care	23	23	100%	0	0
Planned and Surgical Care	21	21	100%	0	0
Harrogate Healthcare Facilities Management	4	4	100%	0	0
TOTAL (including HIF)	**103**	**103**	**100%**	**0**	**0**

Leading Compassionately throughCOVID-19: 10 evidence-based behaviours

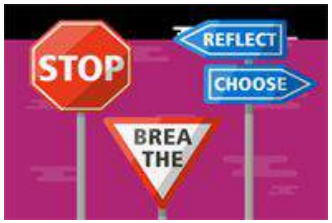
1. Look after yourself
You are not super-human! Who's got your back? Where is your space to recharge and make sense of the chaos? Paying attention to your own wellbeing will maximise your ability to help patients and colleagues through the crisis.

2. Speak candidly and compassionately
To be prepared for what is to come, people need a clear sense of direction and your full and clear assessment of the situation. Balancing your frankness with empathy is essential when your team is under pressure.

3. Set the emotional tone
Don't under-estimate the impact on your team of your actions and the way you come across. Your calm confidence will have a powerful influence.

4. Be inclusive in the way you lead
This crisis is highlighting how healthcare inequalities and biases persist, and even become magnified, in pressurised conditions. Consciously and actively inclusive leadership matters now more than ever.

5. Maintain routines
Teams who are newly formed and are under pressure need stability. Robust routines for starting and finishing shifts, for instance, can do a lot to ground, induct and connect team members who don't know each other and may be feeling a range of emotions.



6. Give yourself space to make the right call
To make hard decisions in the heat of the moment, you will need to be both rational and intuitive: STOP-BREATHE-REFLECT-CHOOSE. Just a brief moment's pause will allow you to reconnect with your purpose and values.

7. Create safe spaces
Share your own vulnerability. Let your team know that it's OK to 'wobble', to experience doubt, grief or fear. They will need times and physical spaces to de-stress. They will also need to feel safe to offer constructive challenge to ways of working regardless of hierarchy.

8. Encourage everyone to talk
…and to keep talking.
Crisis situations get worse and last longer without continuous, open and inclusive communication. And the hardest part can be attentive listening when the pressure is on.

9. Look out for your team
Look out, in particular, for those driving themselves beyond reasonable limits, those team members who withdraw and seem to reject offers of help, and for those who might feel excluded from the team.

10. Acknowledge the hurt
Being a compassionate leader means empathising with the pain your people may experience, recognising that it may endure and take action. We have a diverse workforce and inclusive leaders recognise the equally diverse spectrum of issues that colleagues face due to their different backgrounds, workload and current restrictions and offer support accordingly

Evidence base: Specialist task force and The Royal Military Academy Sandhurst, Centre for Army Leadership)

Appendix 3

Updated Conflicts of Interest (including Relationships at Work) Policy Implementation Plan

Action/Key Task	Responsible Lead	Completion Date
Virtual Policy Approval by Policy Review Group	Sarah Wilson	13.11.21
Policy Ratification by Partnership Forum	Sarah Wilson	18.11.21
Declare System or Alternative System Approval Required	Lynn Hughes Angela Wilkinson	By end of November
Establish process to support policy delivery with Directorates Establish process and SOP for process	HR team	By end of November
System administration; identify required support for set up and maintenance (number of hours per week)	Lynn Hughes Samia Hussain	By end of November
Incorporate Policy into Induction Process	Sarah Wilson/L&D	January 2021
Manager's and Employees Policy Briefings – communication material (including Risk Assessment Process for recruitment, internal promotions, new starters)	Lynn Hughes Samia Hussain Sarah Wilson	Commence December
Audit Committee request to provide update on policy & systems implementation plan	Lynn Hughes	2.12.21

Lyn Hughes, Company Secretary (LH)

Samia Hussain, Head of Operation HR (SH)

Sarah Wilson, HR Business Partner (SW)