Board of Directors public - 26 April 2017 - all documents

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Harrogate and District NHS Foundation Trust

The meeting of the Board of Directors held in public will take place on Wednesday 26 April 2017 Boardroom, Harrogate District Hospital, HG2 7SX

Start: 9.30am Finish: 1.00pm

	AGENDA		
Item No.	**Item**	**Lead**	**Paper No.**
09.30am – 10.45am			
1.0	**Welcome and Apologies for Absence** *To receive any apologies for absence*	Mrs S Dodson, Chairman	-
2.0	**Declarations of Interest and Register of Interests** *To declare any interests relevant to the agenda and to receive any changes to the register of interests*	Mrs S Dodson, Chairman	2.0
3.0	**Minutes of the Board of Directors meetings held on 29 March 2017** *To review and approve the minutes*	Mrs S Dodson, Chairman	3.0
4.0	**Review Action Log and Matters Arising** *To provide updates on progress of actions*	Mrs S Dodson, Chairman	4.0
5.0	**Board of Directors Terms of Reference** *To review and approve the Terms of Reference*	Mrs Sandra Dodson, Chairman	5.0
6.0	**Bi-annual review of Strategic KPIs**	Dr R Tolcher, Chief Executive	6.0
7.0	**Report by the Chief Executive Including the Integrated Board Report** *To receive the report for comment*	Dr R Tolcher, Chief Executive	7.0
10.45am – 10.55am – Break			
10.55am – 1.00pm			
8.0	**Report by the Finance Director** *To receive the report for comment*	Mr J Coulter, Deputy Chief Executive/ Finance Director	8.0
9.0	**Report from the Chief Operating Officer** *To receive the report for comment*	Mr R Harrison, Chief Operating Officer	9.0
10.0	**Report by the Director of Workforce and Organisational Development** *To receive the report for comment*	Mr P Marshall, Director of Workforce & Organisational Development	10.0

11.0	**Report from the Chief Nurse** *To receive the report for comment*	Mrs J Foster, Chief Nurse	11.0
12.0	**Report from the Medical Director** *To receive the report for comment*	Dr D Scullion, Medical Director	12.0
12.1	**Guardian of Safe Working Hours Quarterly Report** *To receive the report for comment*	Dr D Scullion, Medical Director	12.1
13.0	**Oral Reports from Directorates** 13.1 Planned and Surgical Care 13.2 Children's and County Wide Community Care 13.3 Long Term and Unscheduled Care	 Dr K Johnson Clinical Director Dr N Lyth, Clinical Director Mr A Alldred, Clinical Director	 - - -
14.0	**Committee Chair Reports** *14.1 To receive the report from the Quality Committee meeting held 5 April 2017*	Mrs L Webster, Non-Executive Director / Quality Committee Chair	14.1
15.0	**Infection Control Update**	Dr Jenny Child	15.0
16.0	**Other matters relating to compliance with the Trust's Licence or other exceptional items to report, including issues reported to the Regulators** *To receive an update on any matters of compliance:*	Mrs S Dodson, Chairman	-
17.0	**Any other relevant business not included on the agenda** *By permission of the Chairman*	Mrs S Dodson, Chairman	-
18.0	**Board Evaluation**	Mrs S Dodson, Chairman	-
Confidential Motion – the Chairman to move: *Members of the public and representatives of the press to be excluded from the remainder of the meeting due to the confidential nature of business to be transacted, publicly on which would be prejudicial to the public interest.*			

Harrogate and District NHS Foundation Trust

BOARD OF DIRECTORS – REGISTERED DECLARED INTERESTS

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

The register is maintained by the Foundation Trust Office.

Name	Position	Interests Declared
Mrs Sandra Dodson	Chairman	1. Partner in Oakgate Consultants 2. Trustee of Masiphumelele Trust Ltd (a charity raising funds for a South African Township) 3. Trustee of Yorkshire Cancer Research 4. Chair of Red Kite Learning Trust – multi-academy Trust
Dr Ros Tolcher	Chief Executive	1. Specialist Adviser to the Care Quality Commission 2. Member of NHS Employers Policy Board
Mr Jonathan Coulter	Deputy Chief Executive/ Finance Director	None
Mrs Jill Foster	Chief Nurse	None
Mr Robert Harrison	Chief Operating Officer	1. Appointed Voluntary Member of the Strategy and Resources Committee of the Methodist Church 2. Charity Trustee of Acomb Methodist Church, York
Mr Phillip Marshall	Director of Workforce and Organisational Development	1. Member of the Local Education and Training Board (LETB) for the North
Mr Neil McLean	Non-Executive Director	Director of: - Northern Consortium UK Limited (Chairman) - Ahead Partnership (Holdings) Limited - Ahead Partnership Limited - Swinsty Fold Management Company Limited - Acumen for Enterprise Limited
Dr David Scullion	Medical Director	1. Member of the Yorkshire Radiology Group
Mrs Maureen Taylor	Non-Executive Director	None

Mr Christopher Thompson	Non-Executive Director	1. Director – Neville Holt Opera 2. Member – Council of the University of York
Mr Ian Ward	Non-Executive Director	1. Vice Chairman and Senior Independent Director of Charter Court Financial Services Limited, Charter Court Financial Services Group Limited, Exact Mortgage Experts Limited, Broadlands Financial Limited and Charter Mortgages Limited 2. Chairman of the Board Risk Committee and a member of the Remuneration and Nominations Committee, the Audit Committee and the Funding Contingent Committee for the organisations shown at 1 above 3. Director of Newcastle Building Society, and of its wholly owned subsidiary IT company – Newcastle Systems Management Limited 4. Member, Leeds Kirkgate Market Management Board
Mrs Lesley Webster	Non-Executive Director	None
Mr Andrew Alldred	Clinical Director UCCC	None
Dr Kat Johnson	Clinical Director EC	None
Dr Natalie Lyth	Clinical Director IC	None
Dr David Earl	Deputy Medical Director	1. Private anaesthetic work at BMI Duchy hospital
Dr Claire Hall	Deputy Medical Director	1. Trustee, St Michael's Hospice Harrogate
Mrs Joanne Harrison	Deputy Director W & OD	None
Mr Jordan McKie	Deputy Director	1. Familial relationship with NMU Ltd, a company providing services to the NHS
Mrs Alison Mayfield	Deputy Chief Nurse	None
Mr Paul Nicholas	Deputy Director Performance and Infomatics	None

April 2017

Harrogate and District NHS
NHS Foundation Trust

Report Status: Open

BOARD OF DIRECTORS MEETING

Minutes of the Board of Directors meeting held in public at 9.00 on Wednesday 29 March 2017 in the Board Room, Trust Headquarters, Harrogate District Hospital.

Present:
Mrs Sandra Dodson, Chairman
Dr Ros Tolcher, Chief Executive
Mr Jonathan Coulter, Deputy Chief Executive/Finance Director
Mrs Jill Foster, Chief Nurse
Mr Robert Harrison, Chief Operating Officer
Mr Phillip Marshall, Director of Workforce and Organisational Development
Dr David Scullion, Medical Director
Professor Sue Proctor, Non-Executive Director
Mr Neil McLean, Non-Executive Director
Mr Chris Thompson, Non-Executive Director
Mr Ian Ward, Non-Executive Director
Mrs Lesley Webster, Non-Executive Director
Mrs Maureen Taylor, Non-Executive Director

In attendance:
Mr Brian Courtney, Interim Company Secretary
Mr Andrew Alldred, Clinical Director for Long Term and Unscheduled Care
Dr Natalie Lyth, Clinical Director for Children's and County Wide Community Services
Dr David Earl, Deputy Medical Director
Mr Jonathon Hammond, Interim Operational Director, Planned and Surgical Care (representing Dr Johnson)

1. Welcome and Apologies for Absence

Apologies for absence were received from Dr Kat Johnston, Clinical Director for Planned and Surgical Care. Mrs Dodson welcomed to the meeting four elected Governors and Mr Paul Widdowfield, Marketing and Communications Manager.

2. Declarations of Interest and Board Register of Interests

There were no declarations of interest relevant to items on the agenda.

3. Minutes of the meetings of the Board of Directors on 22 February 2017

The draft minutes of the meetings held on 22 February 2017 were considered.

APPROVED:
- **The Board of Directors approved the minutes of the meetings held on 22 February 2017 as accurate records of proceedings.**

4. Review of Action Log and Matters Arising

Completed actions were noted.

Item 4 - Deferred to June 2017

Item 8 – Deferred to April 2017.

Item 19 – Mrs Webster would take the lead for adults and Mr McLean would lead on children.

Item 26 – Deferred till May.

Items 27 and 28 – both covered in Director's written reports.

Item 29 – Deferred to April 2017.

ACTION:

- **Actions 27 and 28 were closed.**

Overview by the Chairman

Mrs Dodson identified three themes for the Board meeting: accuracy of forecasting of activity and costs in 2017/18; maximising our greatest resource – staff, with particular reference to the positive outcome from the staff survey; delivering a high quality service, ensuring that we strive to achieve upper quartile performance in all areas.

5. Report by the Chief Executive including the Integrated Board Report (IBR)

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

5.1 Dr Tolcher highlighted the very positive result in the 2016 Staff Survey. She also drew attention to the good performance in the A&E Department, where recent performance had been better than the 95.7% performance set for March; the previous day's performance had been 98.6%. The Trust was consistently in the top five performing trusts in England and was the second best performer nationally the previous week. Dr Tolcher praised the work of colleagues in the Department and receiving wards.

5.2 In relation to the West Yorkshire STP, the focus was on collaborative commissioning. Dr Tolcher also highlighted that an independent Chair was being recruited.

5.3 Dr Tolcher highlighted an increase in funding to Local Authorities, specifically targeted at reducing hospital delayed transfers of care (DTOCs) announced in the March budget. For NYCC this amounted to an additional £9.3M. Decisions on investment were to be agreed via local A&E Delivery Boards, guidance on where funding should be focused was awaited.

5.4 The NHS England New Care Models (NCM) team have confirmed £1.55m funding to the Harrogate Vanguard project for the third and final year of the programme. The NCM team required a revised delivery plan by 31 March and all parties were working to achieve this. It was therefore imperative that the system moved rapidly to an affordable model funded on a recurrent basis, which was not the case with the current model of care. Despite great efforts made to date it was now clear that commissioner savings from Emergency Department activity and non-elective admissions would not be sufficient to fund the new model in its current

format. Integration between NHS and Local Authority provision at a patient level had not been achieved and new solutions were now needed to be explored.

5.5 In terms of the financial position Dr Tolcher highlighted that whilst the Trust remained in a surplus position overall, the underlying operational position was a deficit of £949k. Reasons for the deteriorating financial position were that income was below plan and spend on medical agency expenditure, ward nursing expenditure and some non-pay costs were above plan. As a result of this the Trust had reported a Use of Resource Rating of 2 for the year to February, which was an adverse variance to the planned rating of 1.

5.6 On a more positive note, Dr Tolcher noted progress on achieving the 2016/17 Cost Improvement Plan (CIP) remained good, with 94% achieved year to date and a high degree of confidence that the planned saving target of £9.4m would be achieved in full. She also highlighted positive progress with the 2017/18 CIP programme. A full year savings target of £9.4m had been agreed with outline plans for 106% in place. The risk adjusted plan stood at 80% of the total.

5.7 Dr Tolcher drew attention to the NHS Mandate that the government had published on 21 March, which highlighted five key areas: Seven day working, with four clinical standards to be achieved; improved A&E performance; delivery of the 62 Day cancer treatment standard; eliminating NHS delayed transfers of care; and delivery of the five year forward view for mental health services.

5.8 Dr Tolcher drew attention to the recently published report from the Care Quality Commission "The State of Care in NHS acute hospitals: 2014 to 2016". This reported the findings from the first round of acute and specialist hospital trust inspections undertaken of all 136 NHS acute non-specialist trusts and 17 specialist trusts between September 2013 and June 2016. While the report showed variation in the quality of hospital services across the country, it highlighted Harrogate and District NHS Foundation Trust's practical changes to the way the Trust had delivered care and the outstanding services and improvements to patient care which had resulted.

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5.9 Finally Dr Tolcher highlighted the on-going financial challenges facing the NHS as a whole and the Trust with cost pressures of 5.2% going forward, not being matched by increases in funding. This placed significant additional financial pressures on the Trust.

5.10 Mr McLean asked whether the improved position in the A&E department was as a result of improved patient flows or due to lower demand. Mr Harrison responded that the performance was influenced by three factors: firstly demand in January and February had been below plan, although there was some evidence that patients at A&E were "sicker", March demand, whilst up, still had been below plan; secondly, as a result of the 'Every Hour Matters' initiative, discharges at weekends had improved significantly and planned discharges had similarly improved, easing pressure on beds; and thirdly the improved physical space in the A&E department, as a result of the building works being completed, had enabled the Trust to cope better with surges of patients.

5.11 Mr Ward asked about the impact on elective activity. Mr Harrison responded that there was no direct link between elective and non-elective activity. However waiting lists in many specialties were growing and hat a £1.5m contingency funding had been built into the budget for 2017/18 to undertake the additional work to address these growing waiting lists. The potential impact of IR35 was raised and Mr Marshall explained that IR35 would impact on all off-payroll contractors and that some may choose to no longer work in the public sector as a result, which could make staffing some key roles more difficult. Dr Scullion highlighted the

positive impact the new facilities were having on staff in A&E, particularly the new staff room and additional space.

5.12 Professor Proctor raised the question of how the Trust could influence the spending of the additional funding directed at social care. Dr Tolcher advised that detailed guidance was expected, but that the focus should be on reducing the numbers of delayed transfers of care. She highlighted some of the potential issues going forward; for example, North Yorkshire covered three Sustainability and Transformation Plan (STP) footprints which presented a challenge for the local authority. It was expected that local A&E Delivery Boards would lead on directing where the additional monies would be spent, however there was concern about the lack of senior leadership and decision makers from local authorities. There was also concern about capacity in both the care home and home care markets, with local authorities reluctant to seek to expand capacity, given the short-term nature of the additional funding.

5.13 Mrs Taylor raised the issue of variance from plan in 2016/17 and its impact on plans going forward. Mr Coulter said that the 2017/18 plan was based on outturn not plan, so this should not be a problem. He felt that the plan for 2017/18 was coherent; however the NHS nationally was facing a huge financial challenge. He highlighted that providers as a whole were £2.4 billion in deficit, which put Harrogate's surplus position in stark contrast. Mr Coulter felt that the areas of focus going forward would be on reducing the £4.5m agency spend, improving theatre utilisation, (one extra case undertaken everyday would generate around £250k of additional revenue) and procurement.

5.14 Mrs Webster queried whether some of the newly obtained contracts delivered a financial benefit to the Trust. Mr McLean said it was important that reporting to the Board linked all the various actions together, productivity was clearly the key. Mrs Dodson agreed and asked that the Finance Committee review the overall financial position and the distance from target and asked that Mrs Taylor and Mr Coulter agree how to take this forward.

Action:

- **Finance Committee to review the overall financial position and the distance from target and asked that Mrs Taylor and Mr Coulter agree how to take this forward.**

5.15 Mr Thompson asked whether the Trust's involvement with WYAAT prevented the Trust undertaking work with other Trusts. Dr Tolcher confirmed this would not restrict the Trust from working with other Trusts and collaborative work with York continued.

5.16 Mr McLean raised CRR22 on the Corporate Risk Register and queried why actions to date had not achieved the required improvement. Mrs Foster responded that a lot of focus was being given to addressing the issue of DNA CPR. Mrs Webster asked whether the Trust was adopting the Recommended Summary Plan for Emergency Care and Treatment (REsPECT), which was a more robust methodology which incorporates DNA CPR. Dr Scullion said there was a challenge in rolling out the methodology. Mr Alldred stated that he would provide updates to the Quality Committee on the implementation of REsPECT.

5.17 The position with regard to sepsis screening was raised. Dr Earl outlined issues with a new computer based system which had been introduced, which had proved not user-friendly and as a result there was currently double running with a paper based system. Mrs Foster also highlighted that there was an issue on who should undertake the recording, a Health Support Worker or a Registered Nurse, which needed to be resolved.

5.18 In relation to the IBR Mr Thompson queried the increase in the number of complaints. Dr Tolcher stated these related to a number of different services across the Trust and were partly reflective of the operational pressures that the Trust was under during the month.

5.19 Mr Thompson also queried the position on e-rostering and why progress had apparently stalled. Mr Alldred explained that a Task and Finish Group had been set up to address the issue. Mr Hammond added that a process was in place to recover the lost shifts.

5.20 Professor Proctor raised 62 day cancer standard performance. Mr Alldred highlighted that in some cases the issue was linked to partner trusts. For February there had been eleven breaches of which eight were attributed to the Trust. Dr Tolcher asked where any harm might arise for individual patients as a result of breaches? Mr Alldred stated that breach analysis was in hand. Delays relate to medical staffing challenges and discussions were on-going with York regarding acute oncology.

5.21 Mrs Webster queried incident reporting, particularly "no harm/near miss" incidents. Mrs Foster highlighted issues with the Datix system which led to staff not reporting incidents. It was highlighted that a potential IT solution was available at a cost of £10k. Mr Coulter said it was not just a technical issue and that if £10k would resolve the issue then the money would be found, however he did not believe this was the case. Dr Scullion said this was more of a cultural issue rather than a technical one and more work was needed with staff to improve the position.

6. Report by the Director of Finance

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

6.1 The Trust's financial position had been covered in part under the Chief Executive's report (item 5). Mr Coulter reiterated that the risk rating against the Use of Resources metric had deteriorated to a rating of 2, which was of concern. He highlighted that whilst activity had increased in March, and the Trust would deliver a surplus at year-end, achieving the agreed Control Total was dependent on the outcome of factors now outside the Trust's immediate control.

6.2 Mr Coulter outlined that NHS Improvement had indicated that they would write to Trusts to clarify how much STF funding they would receive, and how much they would have received if they had delivered their plan. As a result of not delivering the Q4 target the Trust would not receive £1.15m. Mr Harrison asked whether the Trust should appeal against the non-award given the pressures it had been subjected to. Dr Tolcher advised that all providers had been subject to similar pressures and therefore there were no grounds for an appeal.

6.3 Mrs Dodson asked if the Board were prepared to approve the recommendation from the Audit Committee in relation to Going Concern. The Board of Directors agreed to approve the recommendation.

APPROVAL:
The Board of Directors approved the recommendation from Audit Committee in relation to Going Concern.

6.4 Mr Coulter outlined that the cash position of the Trust stood at £2.2m in February, significantly behind plan.

7. Operational Plan 2017/18 – 2018/19

7.1 In relation to the Operational Plan budgets had been submitted to Directorates. The Board of Directors were asked to approve the Summary Financial Plan to allow the issuing of budgets to budget holders prior to 1 April 2017.

APPROVAL:
The Board of Directors approved the Summary Financial Plan.

7.2 In relation to the Capital Plan and the proposed Endoscopy works Mr Coulter stated that no decision was expected from the ITFF before Easter. Mr Thompson asked if the delay would cause any issues with regard to builder availability. Mr Coulter said he did not envisage any problems. The Board of Directors were asked to approve the Summary Capital Plan for 2017/18.

APPROVAL:
The Board of Directors approved the Summary Capital Plan for 2017/18.

8. Report from the Chief Operating Officer

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

8.1 Mr Harrison highlighted the Stroke Improvement Plan and his intention to take the full action plan to the next meeting of the Quality Committee. He outlined that the Task and Finish Group will continue to work on the action plan with the aim to meet the national average and the aspiration to achieve a score of 'B' in all areas. Mr McLean said performance in 3.3 "thrombolysed within one hour of clock start" was extremely worrying and that the level of performance was not acceptable. Mr Thompson asked the number of patients involved; Mr Harrison responded that approximately 320 people per annum were admitted with stroke but that only around 10% of these would require thrombolysis. Mrs Dodson said given concerns about the performance in this area, Mr Harrison should report back to the Board in May on progress on implementation of the action plan.

ACTION:
A report on progress against the implementation of the Stroke Improvement Plan to be received by the Board in May.

8.2 In relation to re-admissions within 30 days, Mr Harrison highlighted that the work to review the position in Paediatrics would be reported next month. With regard to adults, an audit had been completed and no patient had been identified who should not have been discharged, the audit had highlighted some gaps in commissioning of services. It had also indicated more work was needed on the heart failure pathway.

8.3 In relation to the Information Governance Toolkit year-end submission Mr Harrison asked the Board to note performance against the Information Governance Toolkit and approve it for submission.

APPROVAL:
The Board of Directors approved submission Information Governance Toolkit year end submission

8.4 Mrs Webster asked about the level of elective activity being undertaken in March by the Trust and would it create any issues with the CCG. Mr Harrison confirmed that this was not at odds with CCG's financial recovery plans. The number of patients on the waiting list was a third higher than twelve months ago and the Trust was working to ensure compliance with access targets as well as delivering work for other commissioners.

9. Report from the Chief Nurse

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

9.1 Mrs Foster highlighted a number of re-inspections following an unannounced Director Inspection that had resulted in the red-ratings remaining in place. In relation to the Pannal ward the re-inspection had taken place that morning. The rating had remained red due to issues related to cannula recording for one baby. Mr McLean commented that he was very impressed on a recent visit to Nidderdale ward and queried who was responsible for addressing identified issues. Professor Proctor commented that Pannal ward had been rated red for the past nine months. Mr Ward commented that such a constant red rating must have a detrimental impact on staff morale and that someone should be held to account. Mrs Foster commented the issues with a couple of wards related to the lack of IV cannulas which were being addressed.

9.2 In relation to Patient Safety Visits Mrs Foster highlighted a number of issues raised following a recent visit to the Trinity ward and Minor Injuries Unit at Ripon Community Hospital, which would be addressed. Mr Alldred commented that a deep dive had been undertaken at both the Trinity Ward and the Minor Injuries Unit and an action plan been produced, which would be overseen by the Quality Committee. Some changes had taken place and a change of leadership had been put in place. Dr Tolcher commented that there were some long standing embedded practices involving doing work at the unit which should be undertaken by GP practices. Mr Alldred commented that patient feedback was universally positive. Mrs Webster commented that whilst this was probably true, when she had visited the unit, only one patient was present.

9.3 In relation to complaints Mrs Foster noted that the number of complaints received in February was the highest of the year to date with fifteen of the 26 complaints relating to the Emergency Department and the Wards. While this was disappointing it was not surprising in view of the increase and intensity of activity and pressure on services in December, January and February. The Directorates are currently in the process of responding to the complaints.

9.4 Mrs Foster highlighted the position with regard to recruitment where a total of 40 conditional offers of employment had been made to student nurses qualifying in September. An 'on-boarding' event, where prospective employees are kept in touch with, would be taking place on the evening of Wednesday 29 March 2017 with 25 students confirmed as attending.

9.4 In relation to midwifery supervision the position was in-hand with the Quality Committee maintaining oversight throughout the year. The Quality Committee would receive a verbal report in April of how the Trust intended to bridge the gap between the old and new model of midwifery supervision.

10. Report from the Medical Director

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

10.1 Dr Scullion referred to the CQC mortality alert for stroke. Following an internal case note review involving 38 cases, a response was sent to the CQC on 16 March 2017. The detail of this response, the original alert letter from the CQC and a copy of the case note review proforma, would be made available in the BoardPad Reading Room. The case note review had not identified any major lapses in care, although areas for improvement and examples of good practice were identified.

10.2 Dr Scullion also drew the Board's attention to a meeting he had attended in London to hear of the national initiative for learning from deaths in the NHS. The meeting had been attended by almost 500 delegates from multiple agencies. The main point of the day had been the release and discussion of "National Guidance on Learning from Deaths. This document set out the timescales for implementation and importantly the roles and responsibilities of Board members in executing and overseeing the process, which needed careful consideration.

10.3 Dr Scullion highlighted that from 6 March 2017, a resident surgical Middle Grade rota was now in place. At all times an expert Middle Grade opinion was available to support both General Surgery and Trauma and Orthopaedics. Whilst not a perfect solution, the rota improved the position of the Trust. Feedback going forward from junior doctors on the working of the rota would be key to its success.

10.4 Dr Scullion also highlighted some positive news in relation to the NHSLA with a reduction of £50k to the Trust's maternity contribution for 2017/18 due to changes made in the maternity service, which were a credit to the hard work of the maternity team.

11. Report by the Director of Workforce and Organisational Development

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

11.1 Mr Marshall highlighted a positive new story in that following a review the Trust had been granted a Bronze award by Investors in People. He then moved to outline the results from the National Staff Survey, which had been carried out amongst a sample of Trust staff between September and November 2016. 1,250 surveys had been distributed to members of staff and 655 had been completed. At 54% HDFT had the third highest response rate in the country for our benchmark category. The average return rate in the Combined Acute and Community Trusts category was 42%. HDFT's overall Staff Engagement score of 3.92 was ranked above average (which was the highest rank in the category of combined acute and community trusts). HDFT was rated the highest for overall staff engagement in all Trusts in the Yorkshire and Humber area. He outlined that the results of the survey were presented in 32 key areas known as 'Key Findings' along with the measure of overall Staff Engagement. HDFT scores above average in 22 out of the 32 Key Findings.

11.2 The top five scores for HDFT were:

- Quality of non-mandatory training, learning or development
- Staff agreeing that their role makes a difference to patients / service users
- Staff believing that the organisation provides equal opportunities for career progression or promotion
- Staff satisfied with the opportunities for flexible working patterns
- Staff confidence and security in reporting unsafe clinical practice

11.3 Mr Marshall then turned to the Global Health Exchange and explained that ten nurses had taken an English language test aiming to score level 7 or above. He explained that one

nurse successfully attained the required score, with a further four narrowly missing the grade. These four nurses will be able to re-sit the specific elements they did not pass. Mr Ward said he thought the one in ten take-up was very disappointing. Dr Tolcher responded that this is an early stage in the proof of concept and that experience so far would be used to help refine candidate selection in any future cohort. The scheme was just one of a number of recruitment strategies being deployed.

11.4 Mr Marshall outlined that the PMO office was now fully staffed and in terms of job planning across the Trust, plans were in place to address staff vacancies. He also noted the work underway across WYAAT to avoid the need to engage agency workers as far as possible.

11.5 Mr Marshall highlighted that sickness across the Trust had increased for the third month in a row. He outlined that whilst most of the increase in sickness absence in January could be attributed to short term sickness such as cough, cold, flu and gastrointestinal issues, Dr Tolcher had raised long term absence as a cause for concern and action. There has been an improvement in the number of staff classified as being on long term absence (over 28 days) in the first three months of this year from 88 long- term cases in January to 71 currently. He outlined that work continues to bring ongoing long term absences to a satisfactory conclusion.

11.6 Mr Marshall expressed disappointment with the slow progress on consultant job planning. In accordance with agreements at the Trust LNC, Schedule 15 will now be enacted and automatic pay progression will be withheld for consultants with no current job plan.

11.7 Finally, Mr Marshall stated that a pay award for NHS staff of 1% from April 2017 had just been announced.

12. Oral Reports from Directorates

12.1 Planned and Surgical Care Directorate

12.1.1 Mr Hammond highlighted that the Directorate was focused on activity, and the desire to get back on plan. He said that the recent report on theatre staffing had been well received, particularly the structure and OPD progression elements. There remain issues around morale in theatres relating to workforce gaps, and the directorate is working to resolve these.

12.2 Children's and County Wide Community Services Directorate

12.2.1 Dr Lyth reported that the Clinical Leads Development programme had started and had been positively received. Similarly, funding for the Quality Development Programme had been agreed and ten staff were signed-up.

12.2.2 Dr Lyth highlighted some recent community connectivity issues in Durham, where two recent incidents had been reported leading to problems. The Trust's IT team were working on resolving the issues.

12.2.3 The Operation Encompass was highlighted, which related to the safety of children who had been subject to domestic abuse. Information on the scheme and their role in it was being rolled out across 0-19 children services.

12.2.4 Finally, Dr Lyth commented on issues with capacity and demand in some block contracts, with significant increases in activity in services such as Speech and Language therapy and Chronic Pain.

12.3 Long Term and Unscheduled Care Directorate

12.3.1 Mr Alldred stated that the Directorate were focusing on New Models of Care. He also highlighted that the revised OOHs service at Friarage Hospital had commenced. The proof of concept proposed was to remove the doctor overnight.

13. Committee Chair Reports

13.1 Report from the Quality Committee meeting held 2 March 2017

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

13.1.1 Mrs Webster highlighted that the Board's request for the Quality Committee to seek assurance on the Quality of Care Teams was being followed up with a 'state of the nation' report requested for April which would inform the Committee as to what assurance needed to be made for these teams' outputs. Similarly the Quality Committee was seeking assurance on falls with the Falls Prevention Co-ordinator invited to present an annual report at the Committee's May meeting.

13.2 Report from the Audit Committee meeting held 9 March 2017

The minutes had been circulated in advance of the meeting and were taken as read.

13.2.1 Mr Thompson highlighted two issues discussed at the Committee. Firstly, whilst there has been some good progress in respect of the implementation of Internal Audit recommendations in respect of some recent Limited Assurance audits, this was not the case for all such audits. The Committee would review progress on recommendations in advance of the May Audit Committee. If it was considered that insufficient progress has been made, then the executive responsible for the area(s) in question would be asked to attend the meeting and explain the particular difficulties that were being encountered. Secondly, in relation to Post Project Evaluations (PPEs) the Trust required these to be prepared for all capital and revenue projects that satisfied certain criteria. These would be reviewed in detail by the PPE Group, with the minutes of the Group and all large PPEs being in turn reviewed by the Audit Committee. The PPE Group and the Committee are increasingly concerned by the failures of PPEs to be submitted in accordance with the agreed timetable. It has been agreed that management would be encouraged to submit all outstanding PPEs and that if this had not been achieved in advance of the next PPE Group meeting on 24th April, then the manager concerned would be invited to attend the May Audit Committee meeting, to provide the necessary background.

14. Freedom of Information Act Requests Annual Report 2016

14.1 The Board received and noted the report

15. Procurement Transformation Plan

15.1 The Board received and noted the report.

16. Other matters relating to compliance with the Trust's Licence or other exceptional items to report.

16.1 None

17. Any other relevant business not included on the agenda

17.1 Mrs Dodson formally acknowledged the significant contribution made by Professor Proctor who was attending her final meeting as a Non-Executive Director before taking up her new role as Chair at Leeds and York Partnership NHS Foundation Trust.

Mrs Dodson declared the meeting closed.

18 Board Evaluation

Mr McLean said that he felt that the Board had focused on the right issues during the meeting. Dr Tolcher said that she felt that the Board had made good progress on addressing the key issues the Trust faced, and that this had improved over time.

Confidential Motion

The Chairman moved 'that members of the public and representatives of the press be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest'.

The Board agreed the motion unanimously.

The meeting closed at 12.35pm.

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NHS
Harrogate and District
NHS Foundation Trust

HDFT Board of Directors Actions Schedule as at April 2017
Completed Actions

This document logs actions completed since the previous Board of Director meeting. Completed items will remain on the schedule for three months and then be removed.

Item Description	Director/ Manager Responsible	Date of completion/ progress update	Confirm action Complete
To circulate dates of Schwartz round to Board members	Mrs J Foster – Chief Nurse	February 2017	Complete – dates circulated outside Board meeting
Executive Team to review the resource and investment profile for the Informatics Team and reflect the risks in the Board Assurance Framework	Dr R Tolcher, Chief Executive	February 2017	Complete – dealt with under matters arising
Inclusion of KPIs on Children's Services and Community Services to be included in the IBR following a review of the new dashboard for the Directorate (4.1)	Dr N Lyth, Clinical Director	February 2017	Complete – dealt with under matters arising
Junior Doctor Vacancy Rates to be added to the Corporate Risk Register Dr Gray to be invited to attend the Board annually and on an ad hoc basis to address issues relating to Guardian of safe Working.	Dr D Scullion, Medical Director	February 2017	Complete – dealt with under matters arising
Equality Diversity Scheme 2' summary report to be completed and circulated to the board of directors before publication on 31 January 2017	Mrs J Foster, Chief Nurse	February 2017	Complete - Report circulated to the Board
The Board of Directors to receive confirmation of dates and details of planned Patients Safety Visits for 2017	Mrs J Foster, Chief Nurse	February 2017	Complete – dates confirmed
A Non-Executive Director to be appointed to provide oversight of arrangements for learning from deaths in people with learning disabilities	Mrs S Dodson, Chairman	March 2017	Complete – dealt with under matters arising
Paper to come to the Board on the possible impact and implications of IR35	Mr P Marshall, Director of Workforce & OD	March 2017	Complete – in Report from Director of Workforce & OD
Stroke action plan to be brought back to the Board	Mr R Harrison, Chief Operating Officer	March 2017	Complete – in report from Chief Operating Officer

HDFT Board of Directors Actions Schedule – Outstanding Actions as at March 2017

This document logs items for action from Board of Directors meetings which remain outstanding. Board members will be asked to confirm completion of actions or give a progress update at the following Board meeting when they do not appear on a future agenda.

Ref	Meeting Date	Item Description	Director/Manager Responsible	Completion date	Detail of progress
4	November 2016	A recommendation paper to be submitted to Board on the Trust's substantive nursing workforce requirements.	Mrs J Foster – Chief Nurse	March 2017	**Deferred to June 2017**
6	November 2016	To include a bi-annual report on progress against the Clinical Workforce Strategy action plan to the Board on the Board Forward Plan	Dr R Tolcher, Chief Executive	February 2017	**Deferred to May 2017**
8	November 2016	Update on the standardised readmissions	Mr R Harrison, Chief Operating Officer	February 2017	**Deferred to April 2017**
11	June 2016 July 2016	Additional information to be included in the IBR relating to readmissions of older people. Update on reducing readmissions in older people to be submitted to the September Board meeting (8.9)	Mr A Alldred, Clinical Director	31 May 2017	**As part of IBR review** **To update at next Board to Board with CoG 31/05/17**
12	May 2016	Further update on progress of the Care of Frail Older People Strategy (11.2.3)	Mr A Alldred, Clinical Director	31 May 2017	**To update at next Board to Board with CoG 31/05/17**
13	June 2016	Update on the programme of work to reduce hospital admissions (9.3)	Mr A Alldred, Clinical Director	31 May 2017	**To update at next Board to Board with CoG 31/05/17**
14	January 2016	Update Board on progress with EDS2 action plan (11.10)	Mrs J Foster – Chief Nurse	January 2017	N/A
15	September 2016	Provide an update on progress with regard to actions associated with Corporate Risk Register CR8: risk of ophthalmology patients being lost to follow up (6.13)	Dr K Johnson, Clinical Director	April 2017	**Local benchmarking to be undertaken**
16	October 2016	Update on progress of internal and system wide work to improve discharge planning to *Board Strategy Day* (7.4)	Mr R Harrison, Chief Operating Officer	31 May 2017	**To update at next Board to Board with CoG 31/05/17**
17	March 2016	Submission of a Research and Development Strategy for Board comment	Dr A Layton - Associate Director for Research	January 2017	**To be brought to April Board**
18	March 2016	Additional information on learning from cases of C. Diff and associated action planning during 2015/16 to be included in the	Mrs J Foster, Chief Nurse	February 2017	N/A

		annual report (6.3)			
21	January 2017	The Board of Directors to receive a more detailed overview of recruitment and retention issues April 2017	Mr P Marshall, Director of Workforce & OD	April 2017	N/A
24	February 2017	A report of the effectiveness of Quality of Care Teams to be brought to the Quality Committee in three months	Mrs J Foster, Chief Nurse	June 2017	
25	February 2017	• Re-admission rates to be the subject of a deep dive at the Board Strategy Day on 15 March 2017. • Benchmarking data on re-admissions to be shared with the Board prior to 15 March.	Mr R Harrison, Chief Operating Officer	31 May 2017	**To update at next Board to Board with CoG 31/05/17**
26	February 2017	IBR to be reviewed by a small group post April 2017. Membership to be confirmed in March	Mrs S Dodson, Chairman	March 2017	**Deferred till May 2017**
29	February 2017	An update to be provided on the lymphoedema services and how it might be provided in the future.	Kat Johnston, Clinical Director	March 2017	**Deferred till April 2017**
30	February 2017	A report on absconding patients to be brought back to the Board after review by SMT.	Mrs J Foster, Chief Nurse	April 2017	
31	March 2017	Finance Committee to review the overall financial position and the distance from target.	Mrs M Taylor and Mr Coulter, Director of Finance	April 2017	
32	March 2017	A report on progress against the implementation of the Stroke Improvement Plan to be received by the Board	Mr R Harrison, Chief Operating Officer	May 2017	

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Harrogate and District NHS
NHS Foundation Trust

Report to the Trust Board of Directors: 26 April 2017	**Paper No: 5.0**
Title	**Terms of Reference for the Board of Directors**
Sponsoring Director	Mrs Sandra Dodson, Chairman
Author(s)	Mrs Sandra Dodson, Chairman
Report Purpose	To provide an updated Terms of Reference for the Board of Directors

Key Issues for Board Focus:

- Revised Terms of Reference to reflect, in particular, the legal status of the Board of Directors when it meets as Corporate Trustee, when undertaking its role in overseeing the effective management of the Harrogate Hospital & Community Charity

The Board of Directors are asked to note:

- Changes to the Terms of Reference in paragraphs 1.2, 9.4.4 and 9.4.5

Related Trust Objectives:

1. To deliver high quality care	Yes – the Terms of Reference reflects an organisational focus on providing high quality care and ensuring robust controls and assurances on care quality.
2. To work with partners to deliver integrated care	Yes – the Terms of Reference reflects the commitment to partnership working in Harrogate and West Yorkshire areas.
3. To ensure clinical and financial sustainability	Yes – the Terms of Reference are a particular focus on financial performance.

Risk and Assurance	None
Legal implications/ Regulatory Requirement	There are no legal/regulatory implications highlighted within the report.

Action Required by the Board of Directors

The Board is requested to review and approve the Terms of Reference

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Harrogate and District NHS
NHS Foundation Trust

Harrogate and District NHS Foundation Trust Board of Directors

Terms of Reference

1. Introduction

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

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

2. Membership

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

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

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

2.3 The Deputy Chief Executive shall be selected from the Executive Director cohort (currently the Director of Finance).

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

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

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

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3.0 Voting

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

4. Quorum

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

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

5. Frequency

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

6.0 Notice of Meetings

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

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

6.3 The agenda of the Board of Director meetings held in public shall be forwarded to the Council of Governors prior to the meeting, and ensure that agenda, minutes and supporting papers are available publicly on the Trust's website.

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

7.0 Meetings Administration

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

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

7.3 The Chairman shall ascertain, at the beginning of each meeting, the existence of any conflicts of interest and the Secretary shall minute them accordingly.

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8.0 Main Responsibilities

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

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

8.2.1 The strategic direction of the Trust;

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

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

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

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

8.2.6 Ensuring compliance with the Trust's Provider Licence and associated legislation, regulation and best practice.

9.0 Duties

9.1 Leadership and Culture. The Board:

9.1.1 Ensures there is a clear vision for the Trust that people understand and that is being implemented within a framework of prudent and effective controls.

9.1.2 Sets values, ensuring they are widely communicated and that the behaviour of the Board is entirely consistent with those values.

9.1.3 Promotes and patient-centred culture of openness, transparency and candour, has an intolerance of poor standards and fosters a culture which puts patients first.

9.1.4 Ensures the Trust is an excellent employer through the development of a workforce strategy and its appropriate implementation and operation.

9.1.5 Ensures that Directors, Governors, staff and volunteers adhere to any codes of conduct adopted or introduced.

9.1.6 Implements an effective Board and Committee structure and clear lines of accountability and reporting throughout the organisation.

9.1.7 Ensures there are appropriately constituted appointment arrangements for senior appointments such as Executive Directors and consultant medical staff.

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9.2 Strategy. The Board:

9.2.1 Sets and maintains the Trust's strategic vision, aims and objectives ensuring that the necessary financial, physical and human resources are in place for it to meet its objectives.

9.2.2 Develops and maintains an annual business plan, with due regard to the views of the Council of Governors, and ensures its delivery, as a means of taking forward the strategy of the Trust to meet the expectations and requirements of stakeholders.

9.2.3 Ensures that national policies and strategies are effectively addressed and implemented within the Trust.

9.3 Quality and Performance. The Board:

9.3.1 Ensures that the Trust's quality of service responsibilities for clinical effectiveness, patient safety and patient experience are achieved.

9.3.2 Monitors and reviews management performance to ensure the Trust's objectives are met and identifies opportunities for improving the delivery of high quality services.

9.3.3 Monitors feedback relating to the experiences of people who use the services and the processes for proactive engagement.

9.3.4 Ensures it engages with all stakeholders, including patients and staff on quality issues and that issues are escalated appropriately and dealt with when required.

9.3.5 Ensures the proper management of resources and that responsibility for financial and quality of service are achieved.

9.3.6 Oversees both the delivery of planned services and the achievement of objectives, monitoring performance to ensure corrective action is taken when required.

9.3.7 Ensures that there are sound processes and mechanisms in place to ensure effective patient and carer involvement with regard to development of care plans, the review of quality of services provided and the development of new services.

9.1.8 Ensures that there are sound processes in place to ensure compliance with, and awareness of equality and diversity standards.

9.4 Finance. The Board:

9.4.1 Ensures the Trust operates effectively, efficiently and economically to ensure the continuing financial viability of the organisation.

9.4.2 Ensures the proper management of resources and that financial and quality of service responsibilities are fulfilled, and ensures the achievement of targets and requirements of stakeholders within available resources.

9.4.3 Ensure effective financial stewardship through effective value for money, financial control and financial planning and strategy.

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9.4.4 Acts as Corporate Trustee for the Trust's fundraising charity, charity number 1050008 (*known as the Harrogate Hospital & Community Charity*) and in respect of all existing charitable funds.

9.4.5 Oversee the effective management of the Harrogate Hospital & Community Charity and ensure good governance and legal compliance in the areas of public fund-raising and donor data protection.

9.5 Governance. The Board:

9.5.1 Ensures compliance with relevant principles, systems and standards of good corporate governance and has regard to contemporary guidance, and appropriate codes of conduct, accountability, openness and transparency.

9.5.2 Ensures that the Trust complies with the requirements of its Licence, governance and assurance obligations in the delivery of safe clinically effective services.

9.5.3 Ensures that the Trust has comprehensive governance arrangements in place guarantee the resources vested in the Trust are appropriately managed and deployed.

9.5.4 Ensures that all required returns and disclosures are made to the Regulators.

9.5.5 Formulates, implements and reviews Standing Orders and Standing Financial Instructions as a means of regulating the conduct and transactions of the Trust's business.

9.5.6 Agrees the schedules of matters reserved for decision by the Board of Directors.

9.5.7 Ensures proper management of, and compliance, with, statutory requirements of the Trust and, ensures the statutory duties of the Trust are effectively discharged.

9.5.8 Establishes appeals panels as required by employment policies particularly to address appeals against dismissal and final stage grievance hearings.

9.6 Risk Management and Internal Control. The Board:

9.6.1 Determines the nature and extent of the risk it is willing to take in achieving its strategic objectives.

9.6.2 Ensures that key risks are identified and effectively managed and that the Trust fulfils its accountability requirements in line with the requirements of the Provider Licence.

9.6.3 Ensures an effective system of integrated governance, risk management and internal control across the whole of the Trust's clinical and corporate activities.

9.7 Communication and Engagement. The Board:

9.7.1 Ensures relationships are maintained with the Trust's stakeholders, regulators, public, governors, staff and patients, such that the Trust can discharge its wider duties.

9.7.2 Meets its engagement obligations in respect of the Council of Governors and members and ensures that the Governors are equipped with the skills and knowledge they require to undertake their role.

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9.7.3 Works in partnership with service users, carers, local health organisations, local government authorities and others to provide safe, effective, accessible and well governed services.

9.7.4 Ensures the effective dissemination of information on organisational strategies and plans, providing a mechanism for feedback.

9.7.5 Holds an annual meeting of its members which is open to the public.

9.7.6 Approves and publishes the Trust's Annual Report and Accounts, Quality Accounts and other statutory submissions.

10.0 Committees

10.1 The Board is responsible for establishing and maintaining committees with delegated responsibilities and powers as prescribed by the Trust's Standing Orders and/or by the Board of Directors.

11. Review and revision

11.1 These Terms of Reference will be reviewed annually and the Board will conduct an annual review of its effectiveness and shall act on its findings.

SD March 2017

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Harrogate and District NHS
NHS Foundation Trust

Report to the Trust Board of Directors: 26 April 2017	**Paper No: 6.0**

Title	Bi-annual review of Strategic KPIs
Sponsoring Director	Dr R Tolcher, Chief Executive
Author(s)	Ms Rachel McDonald, Head of Performance & Analysis Mrs Samantha McLachlan, Assistant Planning Manager
Report Purpose	To update the Board in relation to Strategic KPIs.

Key Issues for Board Focus:

The presentation of the indicators contained within this report have been updated and amended in line with recent feedback received from the Board of Directors and the Executive Team. Additional metrics are currently being developed and will be included in the report in future on the following topics:

- Yorkshire Cancer Alliance
- Children's Services metric

Key issues to note:

- Continued positive external validation of the Trust's performance;
- Benchmarking our corporate costs against Carter targets for future years is positive;
- Further work is needed to understand our current incident reporting ratio of high/low risks incidents as latest published data places us in the bottom 25% of Trusts nationally;
- More action to undertake over the next year in terms of catchment population and out of Harrogate activity, as part of local and West Yorkshire STP discussions;
- Indications of positive trends in terms of avoidable admissions. However total non-elective bed days increased in 2016/17.

Related Trust Objectives	
To deliver high quality care	Yes – the report tracks progress against the agreed strategic KPIs for monitoring delivery of high quality care.
To work with partners to deliver integrated care	Yes – the report tracks progress against the agreed strategic KPIs for monitoring working with partners to deliver integrated care.
To ensure clinical and financial sustainability	Yes – the report provides the Board with assurance on progress of work across the region to ensure clinical and financial sustainability.
Risk and Assurance	Risks associated with the content of the report are reflected in the Board Assurance Framework via: BAF# 1: risk of a lack of medical, nursing and clinical staff; BAF# 2: risk of a high level of frailty in local population; BAF# 9: risk of failure to deliver the operational plan; and BAF# 12: external funding constraints.
Legal/regulatory implications	The report does not highlight any legal/regulatory implications for the period.

Action Required by the Board of Directors

The Board of Directors are asked to receive and note the content of the report.

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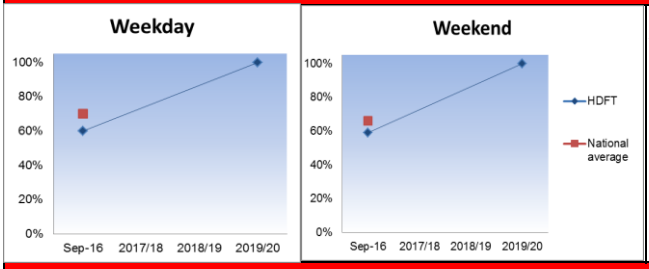
Quarterly Board of Directors Strategic KPIs report - March 2017

Delivering high quality care

Patient safety

Emergency admissions receiving senior reviews within 14 hours of admission to hospital

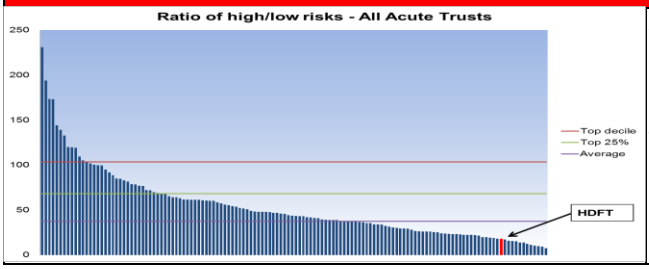


All emergency admissions should receive a clinical assessment by a senior clinician as soon as possible, but at the latest within 14 hours of admission to hospital. Trusts should be achieveing this for 100% of patients by 2019.

The results opposite came from the last case note review, undertaken in September 2016. The overall proportion of patients seen and assessed by a suitable senior clinician within 14 hours of emergency admission was 60%, which fell short of both the National and North England averages. There was little variability between weekday and weekend admissions.

The next review is being compiled in March and will be due for reporting in May 2017.

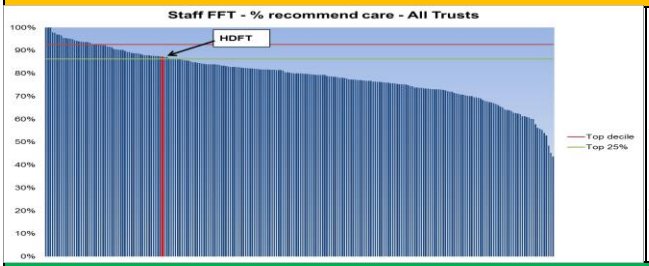
Reporting culture - Ratio of high/low risks.



A large number of reported incidents but with a low proportion classified as causing significant harm is indicative of a good incident reporting culture.
The latest published national data (for the period April to September 2016) shows that Acute Trusts reported an average ratio of 37 no harm/low harm incidents for each incident classified as moderate harm, severe harm or death (a high ratio is better). HDFT's local reporting ratio for the same period was 18 which places the Trust in the bottom 25% nationally. There was an increase in moderate harm incidents reported by HDFT during this period - reasons for this are known and include the fact that duty of candour was introduced in this period and there was a change in the way staff assessed severity.
HDFT aspires to be in line with the national average by March 2018, within the top 25% of Acute Trusts by March 2019 and within the top 10% of Acute Trusts by March 2020.

Patient experience

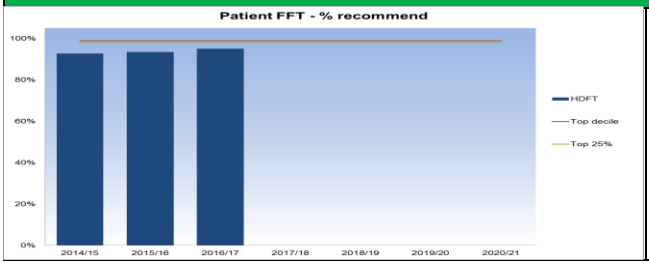
Friends & Family Test (FFT) - Staff - % recommend as a place to receive care



The Staff Friends and Family Test (FFT) was introduced in 2014/15 and gives staff the opportunity to give feedback on the organisation they work in. The chart shows the percentage of staff that would recommend the Trust as a place to receive care for each Trust that submitted data during Q2 2016/17. A high percentage is good.

HDFT's score of 87% places us in the top 25% of Trusts. HDFT's aim is to feature in the top 10% of Trusts within 5 years. Based on current nationally performance, this would mean that 93% of staff would recommend the Trust as a place to work.

Friends & Family Test (FFT) - Patients

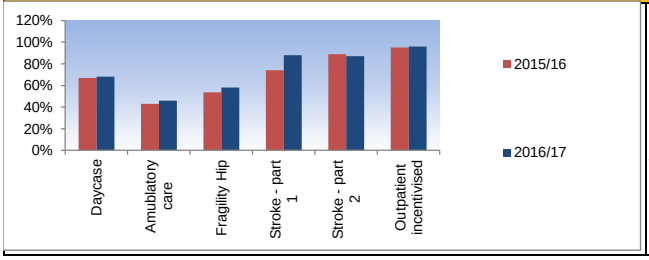


The Patient Friends and Family Test (FFT) gives patients and service users the opportunity to give feedback. They are asked whether they would recommend the service to friends and family if they required similar care or treatment. This indicator covers a number of hospital and community services including inpatients, day cases, outpatients, maternity services, the emergency department, some therapy services, district nursing, community podiatry and GP OOH. A high percentage is good.

During 2016/17, 95.1% of patients surveyed by HDFT would recommend our services. This is an increase on 2015/16. The top decile performance nationally equates to a performance of 98.9%.

Patient outcomes

Proportion of Best Practice Tariff achieved

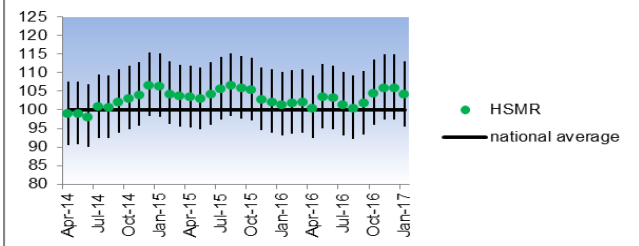


The chart compares each key area of Best Practice Tariffs achieved/monitored from 2015/16 to 2016/17.

The achievement of Best Practice Tariff has increased in 2016/17 in all areas except stroke part 2 which saw a 2% decrease compared to last year's baseline.

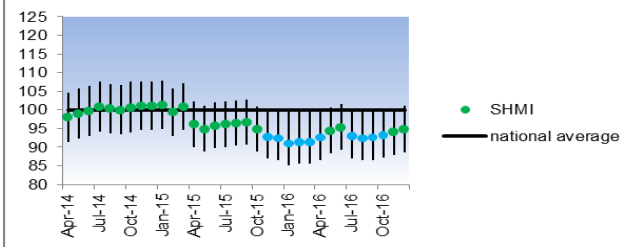
Delivering high quality care

HSMR and SHMI indicator



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.

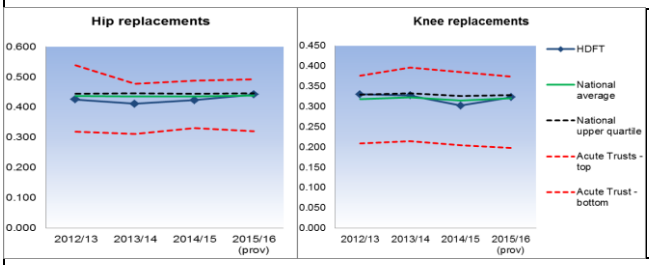
HDFT's HSMR decreased to 104.11 for the rolling 12 months ending January 2017 and remains within expected levels. At specialty level, two specialties (Geriatric Medicine and Stroke Medicine) have a standardised mortality rate above expected levels.



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.

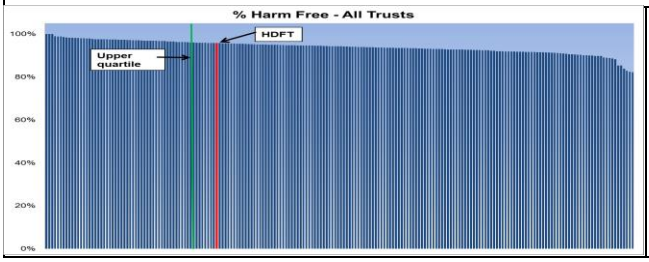
HDFT's SHMI increased to 94.72, compared to 94.03 last month, remaining within expected levels. At specialty level, two specialties (Geriatric Medicine and Gastroenterology) have a standardised mortality rate above expected levels.

PROMs (Patient Reported Outcome Measures) - adjusted average health gains



PROMs measures health gain in patients undergoing elective surgery including hip and knee replacements, based on responses to questionnaires before and after surgery. The surveys are coordinated nationally and updated data is published quarterly by NHS Digital. The charts show HDFT's performance for hip and knee replacements adjusted health gains compared to national average and to the top and bottom scores of all Acute Trusts. A high score is good. As can be seen, HDFT's provisional scores for 2015/16 are in line with the national average and both hip and knee replacement scores have seen an improvement on the previous year.

Safety Thermometer

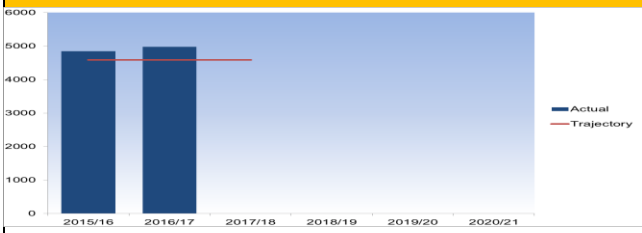


Measures the percentage of patients receiving harm free care (defined as the absence of pressure ulcers, harm from a fall, urine infection in patients with a catheter and new VTE) in the Safety Thermometer audits conducted once a month. The data includes hospital and community teams. A high score is good. Whilst there is no nationally defined target for this measure, a score of 95% or above is considered best practice.

The harm free percentage reported for HDFT for February 2017 was 95.7%, placing the Trust 60th out of 204 NHS organisations who submitted data. A score of 96.0% or above would place HDFT in the top 25% of Trusts. A score above this level was achieved by HDFT in 7 out of 12 months during 2016/17 with an average reported during the year of 96.0%.

Quarterly Board of Directors Strategic KPIs report - March 2017
Working with Partners

Non-elective bed days



The charts shows the number of non-elective (emergency) bed days at HDFT for patients aged 18+, per month per 100,000 population. The chart only includes the local HARD CCG area. A lower figure is preferable. The trajectory is based on allowing for demographic growth and reducing by the non-elective reductions identified in the Value Proposition.
Average non-elective bed days seen in 2016/17 were above this trajectory. The Trust is currently carrying out analysis to model the likely bed capacity needed over the next 5 years. This will take into account the likely impact of current transformation workstreams as well as demographic growth and will help inform both short term operational planning and the setting of a trajectory for this metric for 2018/19 onwards, which will be done in conjnction with partners in the local health community.

Avoidable admissions

The chart shows 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 admission. Conditions include pneumonia and urinary tract infections in adults and respiratory conditions in children.

In 2016/17 year to date (to end February), there were on average 258 avoidable admissions per month, equating to a 5.4% reduction on the 2015/16 average. A trajectory for future years will be agreed in conjnction with partners in the local health community.

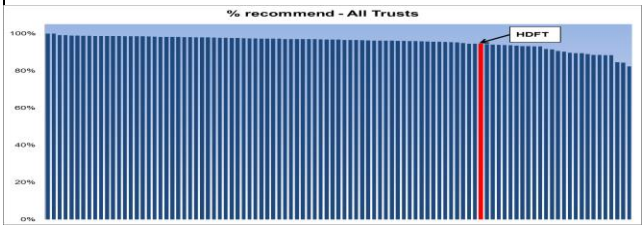
Delivery of IT strategy in line with agreed milestones

Milestone	Action
Aug 16–Jul 17	Delivery of Year One of the WebV EPR Proof of Concept including a Clinical Portal, Noting and Documentation Project, and a Self-Check In Project (On track)
Aug 17–Jul 18	Delivery of Year Two of the WebV EPR Proof of Concept including continuation of the Year One Clinical Portal, Noting and Documentation Project and a number of other WebV Projects prioritised by the EPR Board from the EPR Roadmap (To be Planned)
2016/18	Ongoing delivery of Patientrack assessments and roll out of eObservations (due for closure Q1 2017/18)
2016/17	Delivery of Endosoft (on-going on track)
2017/18	Delivery of Complex Infusions in ePMA (on track)
2017/18	PACS Replacement – Awaiting contract sign off before planning commences

The IM&T highlight report and EPR roadmap with further detail is available on request

The Strategy aims to provide a robust scalable IT infrastructure that delivers information where staff need it; robust governance arrangements; high quality information management; training and development of IT skills in staff; efficient project management and procurement; and collaborative working with other NHS organisations.
The key deliverable at the centre of the IT strategy is the implementation of an integrated Electronic Patient Record (EPR) in support of a paperless environment by 2020. Introducing a clinical solution that delivers real-time information is a fundamental part of the strategy. Beyond the scope of this strategy is the continued development of the Trust's Informatics capability which supports the utilisation of data to improve quality and operational efficiency.
In August 2016, the Trust signed a memorandum of agreement for a two year proof of concept with North Lincolnshire and Goole Foundation Trust (NLG) to deploy the WebV EPR system. This supports the delivery of the Trusts strategy of an integrated electronic patient record system which will enable the organisation to be paperless, provide clinicians with clinical decision tools and enable the sharing of information not just to HDFT staff but to the wider community.

Patient satisfaction of new models of care - Adult Community Services Friends and Family Test

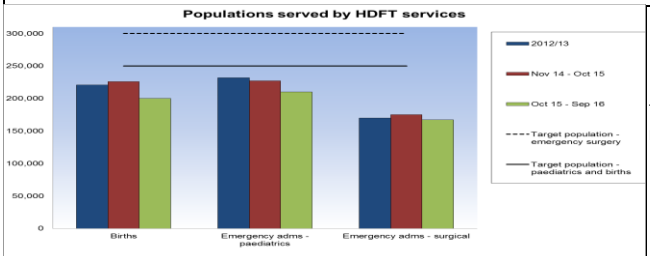


The Patient Friends and Family Test (FFT) gives patients and service users the opportunity to give feedback. They are asked whether they would recommend the service to friends and family if they required similar care or treatment. The data presented is for community services, including district nursing, community podiatry and GP OOH. A high percentage is good.

In February, HDFT reported that 94.4% of patients surveyed would recommend our community services. This places us below the national average but within the middle 50% of the 99 NHS organisaitons who subimtted data. A score of around 98% would be required to place the Trust within the top 25% nationally.

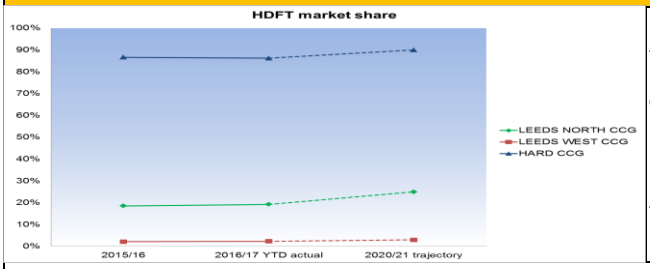
Quarterly Board of Directors Strategic KPIs report - March 2017
Clinical and financial

Sufficient catcment population for key specialities of maternity, paediatrics and emergency surgery



The chart shows estimated catchment populations served by HDFT services in recent years for maternity, paediatrics and emergency surgery, along with target population sizes.

Increased share of HaRD CCG, Leeds North CCG and Leeds West CCG referrals

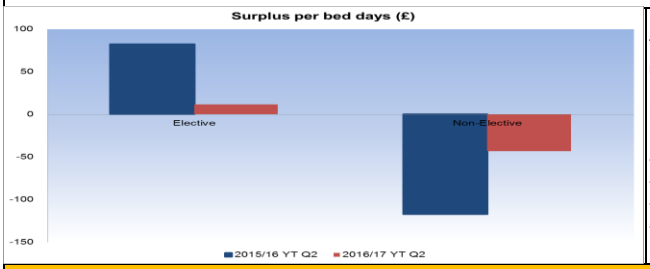


The chart shows the proportion of first outpatient attendances from each locality that are seen at HDFT. The data is sourced from the HED (Healthcare Evaluation Data) benchmarking system and only includes specialties for which HDFT run services.

HDFT's market share in 2016/17 to date was 86% in HARD CCG, 19% in Leeds North CCG and 2% in Leeds West CCG, no significant change on the previous year.

The chart also shows the aspirational market shares for 2020/21.

Surplus per occupied bed days

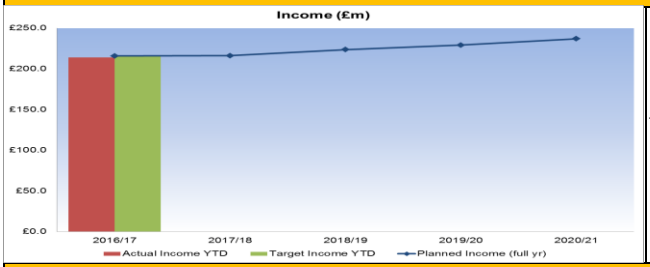


The chart outlines the current surplus per occupied bed day for elective and non-elective activity, utilising information from the service line reporting system.

Movements between years are influenced by a number of items which include:

- Movements in tariff prices;
- Performance against elective activity plan and prior year position;
- Move to daycase from elective work (daycase income and activity excluded);
- Higher levels of non elective bed occupancy.

Income



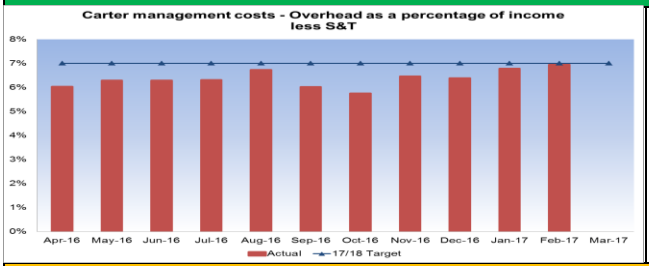
The chart opposite shows the income acheivement to date, excluding S&T funding.
Income plans are in line with Business Development Strategy.

I&E surplus

This chart shows the I&E Surplus acheivement to date, excluding S&T funding.

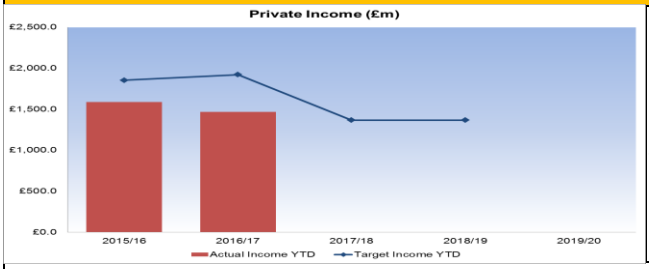
Clinical and financial

Carter management costs



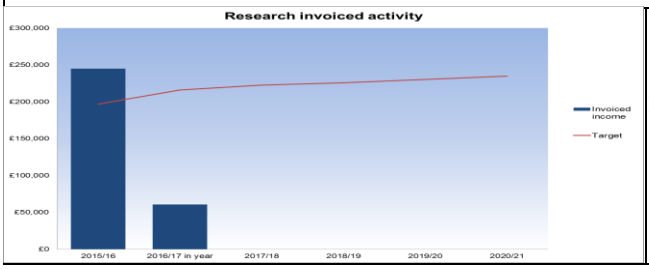
This indicator highlights the Hospital Management Overheads using 2016/17 data.
This chart shows that the Trust has operated its management costs below next year's target of 7%.

Private income



Private patient income has been behind plan for the past two financial years. The resultant pressure is being addressed through the 2017/18 planning process. The strategy for Private Patient Services will then build on this reset position.

Research income



As set out in the Research & Development strategy, the Trust intends to maintain its current income from commercial research activity and NIHR income to support research staff to 2019. In 2015/16, the Trust invoiced for a total of £223k. The figure shown for 2016/17 is provisional and likely to increase.

Quarterly Board of Directors Strategic KPIs report - March 2017

External monitoring

NHS Improvement Financial Risk Rating

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

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.

The Trust reported a rating of 1 for 2016/17, in line with plan.

NHS Improvement Single Oversight Framework

Standard	Oct-16	Nov-16	Dec-16
RTT incomplete pathways	94.4%	94.1%	94.0%
A&E 4-hour standard	95.1%	93.8%	92.5%
Cancer - 62 days	91.3%	94.6%	91.4%
Diagnostic waits	99.9%	99.8%	99.9%

Standard	Jan-17	Feb-17	Mar-17
RTT incomplete pathways	94.2%	94.0%	94.0%
A&E 4-hour standard	93.9%	94.8%	97.2%
Cancer - 62 days	92.0%	84.3%	92.1%
Diagnostic waits	99.9%	99.8%	99.8%

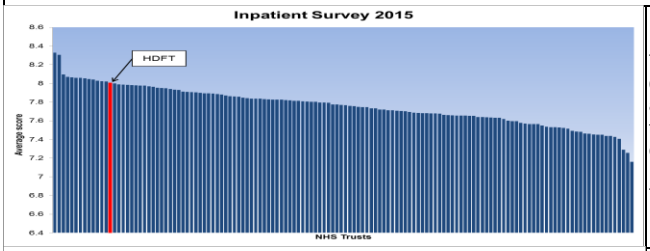
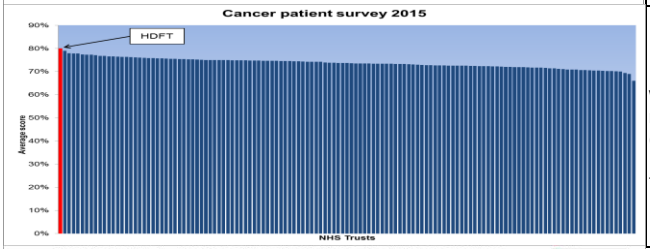
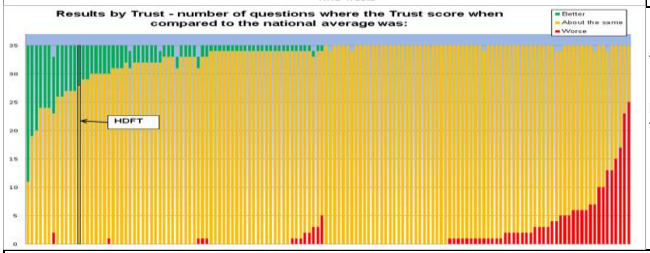
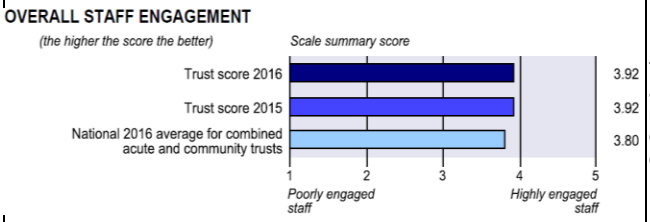
From October 2016, NHS Improvement will use a variety of information to assess a Trust's governance risk rating, including CQC information, access and outcomes metrics, third party reports and quality governance metrics. The table to the left shows how the Trust is performing against the national performance standards in the “operational performance metrics” section.
In March, HDFT was above the required level for all 4 key operational performance metrics.

CQC Inspection Rating

Ratings	
Overall rating for this trust	Good
Are services at this trust safe?	Requires improvement
Are services at this trust effective?	Good
Are services at this trust caring?	Outstanding
Are services at this trust responsive?	Good
Are services at this trust well-led?	Good

CQC monitor, inspect and regulate health and social care services to make sure they meet fundamental standards of quality and safety and publish their findings. HDFT was last inspected by CQC in February 2016.
Overall, HDFT was given a "good" rating in the inspection report published by CQC in July 2016. A further breakdown of the rating is provided in the table to the left. Following publication of the report, the Trust agreed an action plan with CQC and HARD CCG to address the small number of issues identified during the inspection. Actions are now being progressed with a view to an early re-inspection.

External monitoring

Patient survey	
	The national **adult inpatient survey** for 2015 was published in May 2016. In 18 out of the 65 questions, HDFT scored significantly better than average, about the same as average for 46 questions and significantly below average for 1 question. In terms of HDFT's overall ranking compared to other trusts, HDFT was ranked 14th out of 136 Trusts that answered all the questions in the survey. This compares to 10th out of 140 Trusts in the 2014 survey. The 2016 inpatient survey results are due to be published in May 2017.
	In the national **cancer patient survey** 2015 were published, HDFT came 3rd out of the 146 Trusts who took part in the survey achieving an average score of 80%. However, of the trusts which responded to all the questions, HDFT came top out of 131. Asked to rate their care on a scale of zero (very poor) to 10 (very good), HDFT respondents gave an average rating of 8.9. The 2016 cancer patient survey results are due to be published in late July 2017.
	The latest national **A&E patient survey** 2014 was published by CQC in December 2014. Overall HDFT performed well, scoring "significantly better than average" for 7 out of 35 questions. HDFT had no questions rated "significantly worse than average". This placed HDFT 13th our of 142 participating Trusts, as illustrated in the chart to the left. Results from the 2016 A&E patient survey are due to be published in early Summer 2017.
Staff survey (Top 10%)	
	The anonymous national survey was carried out among a sample of Trust staff between September and November 2016. Results are presented in 32 key areas known as 'Key Findings' as well as a measure of overall Staff Engagement. HDFT scores above average in 22 out of 32 areas. HDFT's overall Staff Engagement score is ranked above average, which is the highest rank possible in the category of Combined Acute and Community Trusts, and is shown in the chart opposite.

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Report to the Trust Board of Directors 26 April 2017	**Paper No: 5.0**
Title	**Report from Chief Executive**
Sponsoring Director	Dr Ros Tolcher, Chief Executive
Author(s)	Dr Ros Tolcher, Chief Executive
Report Purpose	To update the Board of Directors on significant strategic, operational and performance matters

Key Issues for Board Focus:

The Board of Directors are asked to note:

- An overview of performance during 2016/17 is presented. The Trust has delivered sound results across quality, finances and performance.
- The West Yorkshire Association of Acute Trusts Committee in Common met for the first time this month. Terms of Reference were signed and adopted; three initial case for change reports were endorsed.
- The Trust reported a surplus of £3,688k for the year to the end of March. The underlying operational position is a surplus of £238k.
- The Department of Health has published the Next Steps on the Five Year Forward View document

Related Trust Objectives:

1. To deliver high quality care	Yes – the report reflects a sustained organisational focus on providing high quality care and ensuring robust controls and assurances on care quality.
2. To work with partners to deliver integrated care	Yes – the report provides updates on the work of the Harrogate Health Transformation Board and West Yorkshire reflect partnership working in Harrogate and West Yorkshire areas.
3. To ensure clinical and financial sustainability	Yes – the report notes from the SMT meeting demonstrate a particular focus on financial performance

Risk and Assurance	Strategic and operational risks are noted in section 6. Risks associated with this report are reflected in the Board Assurance Framework: BAF 14: risk to deliver of integrated models of care; BAF 15: misalignment of partner strategic plans; and BAF 9; failure to deliver the operational plan.
Legal implications/ Regulatory Requirements	There are no legal/regulatory implications highlighted within the report.

Action Required by the Board of Directors

- The Board is requested to **note** the strategic and operational updates
- The Board is asked to **note** progress on risks recorded in the BAF and Corporate Risk Register and confirm that progress reflects the current risk appetite.

1.0 MATTERS RELATING TO QUALITY, PATIENT EXPERIENCE AND PERFORMANCE

1.1 Overview of performance 2016/17

I would like to record my thanks to colleagues across the Trust who have contributed to sustaining strong performance throughout the last twelve months. The national context in which we operate requires no further rehearsal and it is very pleasing to report that once again the Trust has performed well across care quality, operational performance and finance. This is evidenced through external reports as well as our Integrated Board Report. I have summarised the headlines below:

- A 'good' Care Quality Commission rating overall, with four core services rated outstanding and an outstanding rating for the 'caring' domain.
- Bronze level Investors in People Award achieved.
- In the NHS Staff Survey we maintained an overall engagement score of 3.92 with notable improvements in scores relating to safety culture.
- In the National In-patient Survey 2016 HDFT demonstrated year on year improvements and was ranked 12th out of 83 Trusts.
- In the National Emergency Department survey 2016 HDFT was significantly better than average in 33 questions and average in only 2 questions (35 questions in total).
- The Emergency Department 4 hour target was met in three quarters of the year. Over the full year, 95.06% of people attending the ED were seen and treated, admitted or discharged within four hours despite a 1.59% increase in attendances.
- RTT and cancer targets were met in all four quarters.
- Work to improve fundamental standards of care as achieved some positive outcomes for patients: the number of falls reported has fallen by 14%; the number of hospital acquired grade 3 pressure ulcers has fallen by 20% and the number of cases of C. Difficlie (CDI) recorded has fallen by 17%. Overall there were seven cases of CDI for whom lapses in care were reported compared to 12 in the prior year.
- Only two Serious Incidents were identified, compared to 11 in 2015/16.
- Successful business development actions contributing to overall growth in revenue of 15.2%.
- Roll out of new services in County Durham, Darlington and Middlesbrough with high levels of commissioner and staff satisfaction.
- An outturn surplus of £3.688m which although short of our planned position includes our largest operating surplus since 2012/13. 100% of cost improvement savings have been achieved.
- Many other small successes for individuals and teams which we can celebrate.

Inevitably there remain some areas where we have not reached internal targets and these remain the focus of work in the year ahead. Failing to achieve the financial control total is due to both income shortfall and overspending particularly on additional staffing. High bed occupancy rates are driven by escalating numbers of delayed transfers and patients with extended length of stay ('stranded patients'). Workforce gaps continue to impact on clinical resilience and pay costs. The number of complaints received during the year has increased by approx. 8.9% although the proportion of complaints rated red/amber has reduced.

We aspire to upper quartile/upper decile performance in all areas. While we have improving trends in fundamental standards it remains difficult to know how our care compares with that of other high performing Trusts on incidents such as falls, pressure

ulcers and CDI. We will continue to strive for excellence and eliminate avoidable patient harm.

1.2 **National Emergency Department Survey 2016 - Picker Results**

The latest survey results were published on 11 April 2017. The Emergency Department survey is currently repeated every other year. Picker was commissioned by 75 trusts to undertake the Emergency Department Survey 2016. A total of 1250 patients from Harrogate and District NHS Foundation Trust were sent a questionnaire. 1182 patients were eligible for the survey, of which 420 returned a completed questionnaire, giving a response rate of 36%. The average response rate for the 75 'Picker trusts' was 26%.

The survey shows that in comparing Harrogate with the other 75 Trusts surveyed, the Trust's results were significantly better than average on 33 questions and average on the other two questions. Compared to the 2014 survey, Harrogate was significantly better on seven questions. There were no questions where results had deteriorated.

2.0 STRATEGIC UPDATE

2.1 **West Yorkshire and Harrogate Sustainability and Transformation Partnership (WYH STP) and West Yorkshire Association of Acute Trusts (WYAAT) update**

The success of the West Yorkshire Emergency Department Acceleration Zone was noted at the WYH STP meeting. West Yorkshire and Harrogate achieved an aggregate performance of 93.66% against the target of 91.4% for March. This was an extremely positive outcome from a starting point of 83% aggregate performance in December. Ongoing funding for Quarter 1 has been secured and decisions will now be made on how to embed new practices and how to share learning from the project regionally and nationally.

The WYAAT strategic approach to Elective Care is being developed. The initial focus will be on the potential benefits of clinical standardisation and designated elective care centres. I am the lead CEO for this work stream and Rob Harrison will be the lead executive. A clinical lead is also being recruited. An initial case for change paper will be prepared for the August Committee in Common (CIC).

WYAAT also endorsed three 'case for change' papers prior to the April CIC (Estates & Facilities Management; Information Management & Technology and Procurement).

The Committee in Common met on 6 April. The terms of reference were duly signed and adopted and the three cases for change papers supported.

The WYH STP Leadership Group considered the messages in the Five Year Forward View Next Steps document (see 6.1 below). The plan sets a direction of travel for Sustainability and Transformation Partnerships which is broadly consistent with the work done so far by West Yorkshire and Harrogate, but also gives the potential to go further faster, with greater local autonomy and determination.

On behalf of the WYH STP Leadership Group I have also been leading the development of an NHS / Care Home Charter designed to improve arrangements for people living in Care Home or supported living arrangements. The Charter has been developed with wide stakeholder involvement and sets out a series of undertakings between the NHS and Care Homes, underpinned by 'asks' and 'offers', for example, providing support with skills development to care homes, adopting trusted assessor and discharge to assess

methodologies. The draft Charter was warmly supported by the STP Executive Board and will now be progressed within each of the six local STP areas.

3.0 WORKING IN PARTNERSHIP

1.1 New Models of Care (Vanguard Programme) and Harrogate Health Transformation Board (HHTB)

An extraordinary meeting of HHTB CEOs / Accountable Officers was held on 3 April to review the current position in respect of resources and models of care. All partners remain committed to achieving a sustainable position which achieves the best outcomes for local people. Harrogate and Rural District Clinical Commissioning Group (CCG) and North Yorkshire County Council (NYCC)are working on an Integrated Commissioning Strategy which should be defined within the next 12 months.

It is recognised that work to date has not achieved savings equivalent to the level of non-recurrent funding invested in services at present and therefore steps need to be taken to bring costs back down to contractual levels. It was agreed that the partners would develop an ambitious 'proof of concept' to be trialled on one locality for three months predicated on true integration between HDFT, Tees Esk and Wear Valley (TEWV) and NYCC core teams. Adopting the Purposeful and Productive Community Services methodology pioneered by TEWV will be tested as a means of unlocking resource.

A listening event for community staff was held on 18 April - staff expressed concerns about workload and uncertainty regarding staffing levels.

Following publication of the Five Year Forward View Next Steps document the HHTB will be renamed the 'Harrogate Sustainability and Transformation Partnership Board'. Its scope will be extended to encompass all health and care work across the Harrogate and District area.

1.2 Harrogate Public Services Leadership Board (PSLB)

The PSLB Action plan was reviewed at a meeting of the PSLB held on 3 April. This is a three year plan encompassing employment and skills, financial and social inclusion; health and wellbeing and sustainable public service provision across Harrogate. It also encompasses Joint Strategic Needs Assessment priorities. The health and wellbeing section has been dominated by work on dementia so far. Over the next year there will be more focus on prevention at a strategic level. The issue of affordable housing for the health sector was discussed as part of an economic overview of the Harrogate system. Consideration is to be given to using local assets to support recruitment.

4.0 FINANCIAL POSITION

The Trust reported a surplus of £3,688k for the year to the end of March. The underlying operational position is a surplus of £238k. Key variances across the organisation were consistent through the year, namely income performance, pressures in relation to medical agency expenditure, and ward nursing expenditure.

Due to the financial position as at month 12, no Sustainability and Transformation funding has been assumed for the final quarter.

As noted above, this position although adverse of plan is a significant achievement in a challenging operating environment. The provider sector as a whole recorded an overall deficit of c£2.5bn.

Further detail is contained within the report of the Finance Director.

5.0 SENIOR MANAGEMENT TEAM (SMT) MEETING

The SMT met on 19 April. The following key areas are for noting:

- The number of CDI cases reported has fallen by 17% compared to 2015/16. The number of individuals affected by CDI due to a lapse in care was seven, compared to 12 last year.
- The Director for Infection Prevention and Control presented an analysis of trends and apportionment of cases. A step change in case ascertainment in September may be due to changes in antibiotic stewardship.
- The adverse trend in Delayed Transfers of Care and standardised readmissions was discussed. A task and finish group is exploring underlying issues and will report back next month.
- Feedback from the West Yorks Local Workforce Advisory Board (LWAB) was shared, including potential funding for backfill to support new ACP posts.
- A report on the first 12 months of the Quality Charter was received. Feedback has been very positive and funding has been made available to continue this programme.
- A limited assurance internal audit report on rostering was discussed and actions agreed.

6.0 COMMUNICATIONS RECEIVED AND ACTED UPON

6.1 Next Steps on the Five Year Forward View

This update on the Five Year Forward View was published on 31 March. It sets out progress to date and next steps. The plan identifies four clinical priority areas for transformation (Urgent and Emergency Care; Cancer: Mental Health; Primary Care) and a 10 point efficiency plan.

It draws out the importance of integrating health and care in line with New Care Models, the opportunities accessible through technology and innovation and the importance of patient safety. Actions to strengthen workforce and address enduring gaps in workforce supply are described.

Importantly it also describes the governance expectation for STPs now and in the future:

- All require a governance and implementation support ‘chassis’:
    - Establish STP boards with NED representation and joint committees or Committees in Common as necessary (NHS England and NHS Improvement can take action where organisations are not working together effectively);
    - Re/appoint leader chair and costs covered;
    - Align NHS staff to support STP programme office function;
    - Allow STPs to propose adjustments to footprint;
    - Develop an STP policy framework; and publish STP level metrics from July;
    - Emphasis on public participation and involvement as plans become further developed; and
    - 5th test for reconfigurations based on having plans for ensuring sufficient capacity.
- Progress towards Accountable Care Systems is based on a list of ‘gives’ and ‘gets’:

The give:

- Agree an accountable performance contract, for faster delivery against key deliverables in plan;
- Manage a system control total for the footprint;
- Create effective decision making and governance structure;
- Demonstrate provider collaboration across the footprint, and vertical integration with local GPs working in hubs;
- Deploy population health management capabilities that enhanced prevention and early intervention and reduce avoidable demand; and
- Preserve patient choice for elective care.

The get:

- Delegated decision rights for primary and specialist care;
- Devolved transformation funding from 2018;
- A single regulatory relationship with NHS England (NHSE) and NHS Improvement (NHSI); and
- Alignment of staff and related funding from NHSE and NHSI. A number of STPs (or parts of STPs) are going ahead as ACO/ACS from 2017/18 – light touch process in Q1 to encourage other STPs to take part.

The report will now be considered in more detail by the Trust, the Harrogate STP Board and the WYH STP Leadership Group.

The full report and a summary document produced by the STP Programme Management Office are available in the Reading Room.

6.2 The Naylor Review of NHS Property and Estates

This report, titled "NHS Property and Estates: Why the estate matters for patients" was published on 31 March 2017. The review assesses the current national estate strategy, local delivery of estate management and the capital requirements for the NHS estate in the future. The review makes 17 recommendations. These include:

- The establishment of a new Property Board (NHSPB) to provide leadership, strategic direction and resources to the NHS. The board would also support delivery of STPs;
- It recommends that each STP should develop an affordable estate and infrastructure plan aligned to a capital strategy. The new board, using benchmarking set out in the review, will assess STP plans. Access to capital funding will be denied to any STP failing to provide a robust estate and infrastructure plan;
- £10billion of additional capital investment to deliver the transformation set out in STPs, which should come from a combination of private investment, support from the treasury, and between £2.7 - £5.7billion from rationalising the current estate;
- A robust capital investment plan for the NHS by summer 2017;
- The Department of Health should provide assurance to STPs that sale receipts of locally owned assets will not be recovered centrally;
- Treasury should provide additional funding for a short term only, to incentivise land disposals through a "2 for 1 offer" to incentivise STPs to dispose of land;
- Urgent action to be taken to accelerate the delivery of land for housing (the report identifies the potential to build up to 40,000 homes on surplus NHS land), which should be prioritised for the development of residential homes for NHS staff where there is a need; and
- A continued focus on back office efficiencies, with a cost reduction target of 30%.

7.0 BOARD ASSURANCE AND CORPORATE RISK

No new risks have been added to the BAF this month.

Following the 'Deep Dive' into BAF#14 (risk to the delivery of integrated models of care) at the Board Strategy Day on 15 March this strategic risk has been re-specified. The residual risk is now recorded as 12.

Five risks are currently assessed as having achieved their target risk score. The strategic risks are as summarized as follows:

Ref	Description	Risk score	Progress score	Target risk score reached
BAF 1	Risk of a lack of medical, nursing and clinical staff	*Red 12 ↔*	*Unchanged at 2*	
BAF 2	Risk of a high level of frailty in the local population	*Amber 8 ↔*	*Unchanged at 1*	✓
BAF 3	Risk of a failure to learn from feedback ar Incidents	*Amber 9 ↔*	*Unchanged at 3*	
BAF 4	Risk of a lack of integrated IT structure	*Red 12 ↔*	*Unchanged at 1*	
BAF 5	Risk of maintaining service sustainability	*Yellow 6 ↔*	*Unchanged at 1*	✓
BAF 9	Risk of a failure to deliver the Operational Plan	*Amber 9 ↔*	*Unchanged at 1*	
BAF 10	Risk of breaching the terms of the Trust's Licenc to operate	*Yellow 5 ↔*	*Unchanged at 1*	✓
BAF 12	Risk of external funding constraints	*Red 12 ↓*	*Unchanged at 1*	✓
BAF 13	Risk of a reduced focus on quality	*Yellow 4 ↔*	*Unchanged at 1*	✓
BAF 14	Risk of delivery of integrated models of care	*Red 12 ↓*	*Unchanged at 2*	
BAF 15	Risk of misalignment of strategic plans	*Amber 9 ↔*	*Unchanged at 1*	
BAF 16	Risk that the Trust's critical infrastructure is not for purpose	*Red 12↔*	*Unchanged at 1*	
BAF 17 (formerly BAF#6)	Risk to senior leadership capacity	*Amber 9 ↔*	*Unchanged at 1*	

Key to progress score on actions:
1. *Fully on plan across all actions*
2. *Actions defined – some progressing, where delays are occurring, interventions are being taken*
3. *Actions defined – work commenced but behind plan*
4. *New risk and/or actions defined – work not yet commenced*

7.2 Corporate Risk Register (CRR)

The CRR was reviewed at the monthly meeting of the Corporate Risk Review Group on 7 April 2017. The Corporate Risk Register contains ten risks. Changes to the CRR since the February meeting of the Board of Directors are:

Risks removed

CR7: Risk of significant impact of failure to meet the 4-hour A&E waiting time national standard and poor patient experience.

CR11: Financial risk due to activity behind plan (incorporated into CR14).

The corporate risks are as follows:

Ref	Description	Risk score	Progress score
CR2	Risk to the quality of service delivery in Medicine due to gaps in rotas following the Deanery allocation process	*Red 12 ↔*	*2*
CR5	Risk to service delivery due to the lack of experienced registered nurses due to national labour market shortage	*Red 16 ↔*	*2*
CR12	Risk to financial sustainability from failure to deliver the Clinical Transformation Programme at pace and scale	*Red 12 ↔*	*2*
CR13	Risk to urgent care system due to a lack of capacity in the out of hospital services	*Red 12 ↔*	*2*
CR14	Risk of financial deficit and impact on service delivery due to failure to deliver the Trust annual plan by having excess expenditure or a shortfall in income.	*Red 12 ↔*	*2*
CR17	Risk of patient harm as a result of being lost to follow-up	*Red 12 ↔*	*2*
CR18	Risk to provision of service and not achieving national standards in cardiology due to potential for lab equipment breaking down	*Red 12 ↔*	*2*
CR19	Risk to patient safety due to lack of provision of Acute Oncology, CUP, Breast and Urology Oncology services.	*Red 12 ↔*	*1*
CR21	Risk of temporary reduced or loss of activity as a result of disruption to services du to the major refurbishment to the Sterile Services department	*Red 12 ↔*	*2*
CR22	Risk to reputation due to non-compliance with DNACPR policy caused by failure of some clinicians to implement policy.	*Red 12 ↔*	*5*

8.0 DOCUMENTS SIGNED AND SEALED

29 March 2017: Deed of Guarantee between Essci Ltd and Harrogate and District NHS Foundation Trust
Common Seal Number 058

Dr Ros Tolcher
Chief Executive
20 April 2017

Integrated board report - March 2017

Key points this month

1. In March, HDFT achieved all 4 key operational performance metrics in the NHS Improvement Single Oversight Framework and reported a rating of 1 (where 1 is best) for the Use of Resource Metric.

2. A significant improvement in the Trust's performance against the A&E 4-hour standard was seen in March, with Trust level performance at 97.2%. HDFT has therefore delivered the 4-hour standard for the 2016/17 year overall with annual performance of 95.1%.

3. The cash balance position continues to be a concern for the Trust with a number of actions in place to improve the outstanding debtors position.

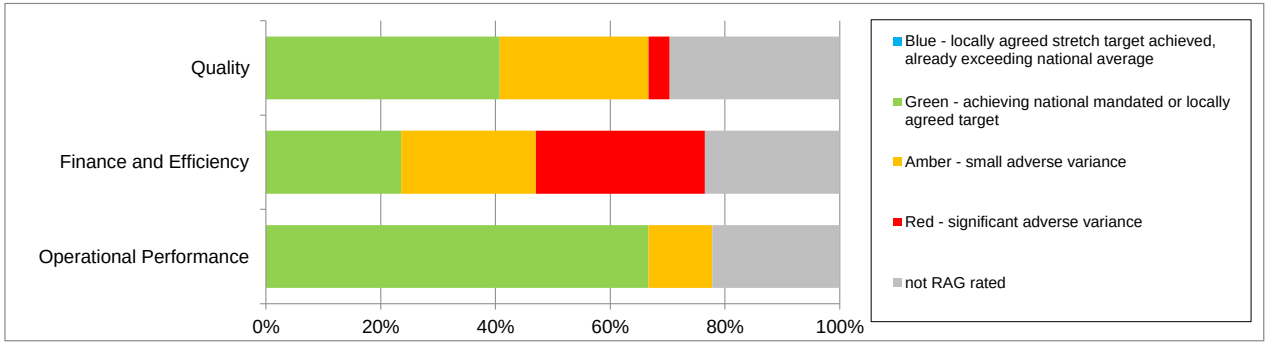
4. Agency spend increased in March to 3.7% of pay spend. Although the value is below the agency ceiling for the Trust, this ceiling reduces in 2017/18 and the current run rate would potentially result in exceeding the new value.

5. Further work is needed to understand the Trust's current incident reporting ratio of high/low risks incidents as latest published data places us in the bottom 25% of Trusts nationally. Despite this, the number of inpatients falls fell by 14% in 2016/17 and the number of reported SIRIs was also much lower than last year.

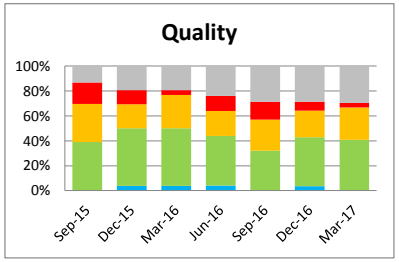
6. The number of complaints received by the Trust remained above average in March with 25 received during the month. These relate to a number of different services across the Trust and are partly reflective of the significant operational pressures that the Trust was under during the month.

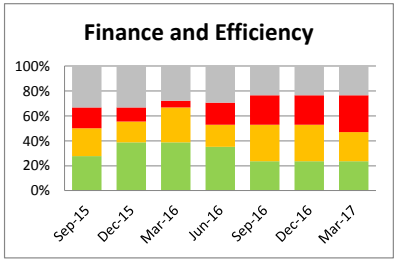
7. Delayed transfers of care remain high and increased to 6.6% when the snapshot was taken in March, remaining above the maximum threshold of 3.5% set out in the contract.

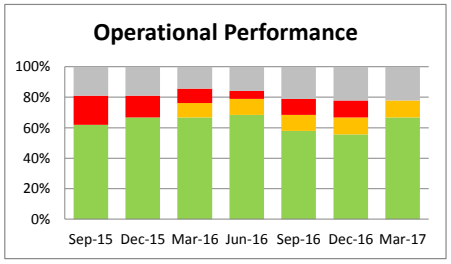
Summary of indicators - current month



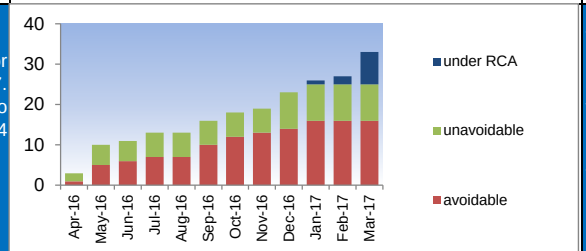
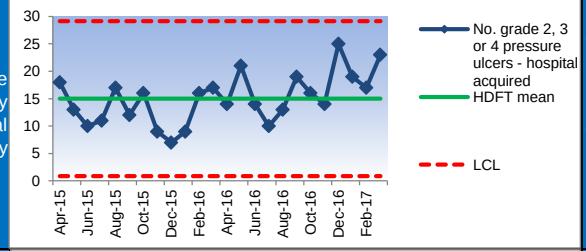
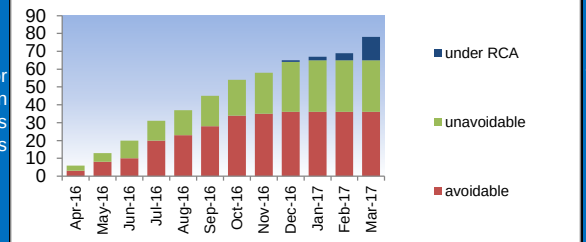
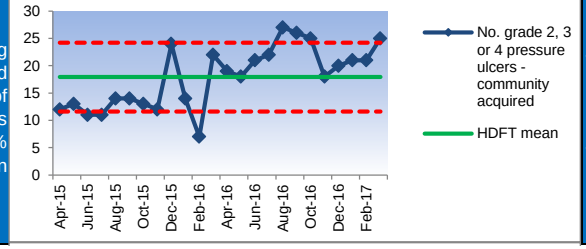
Summary of indicators - recent trends



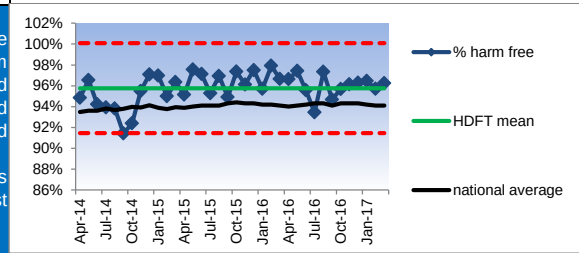
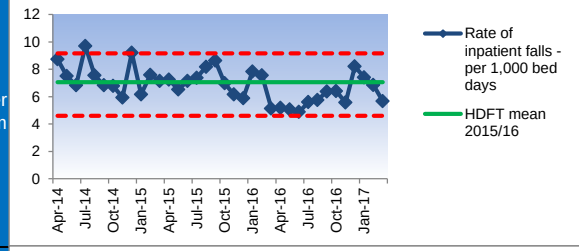
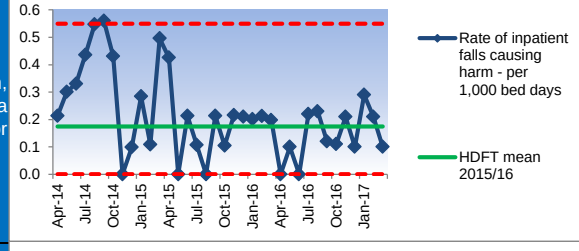
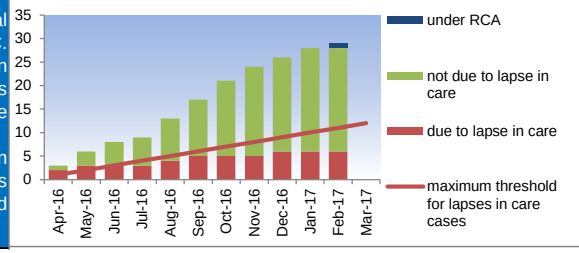




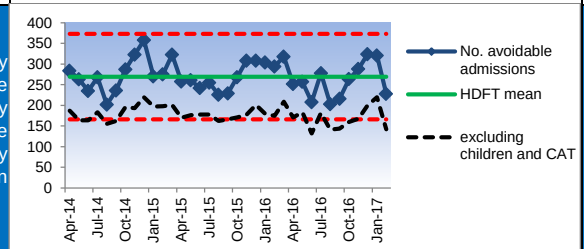
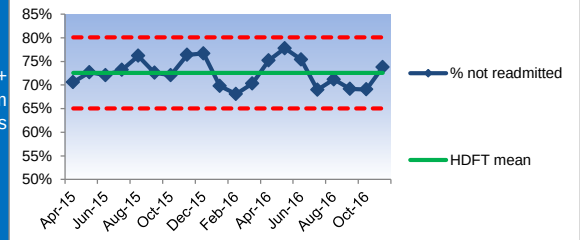
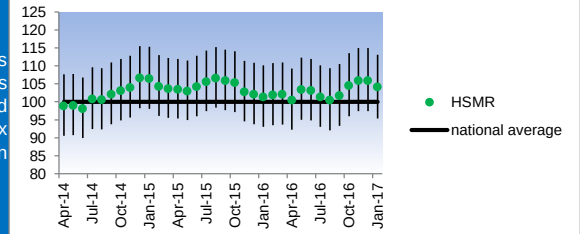
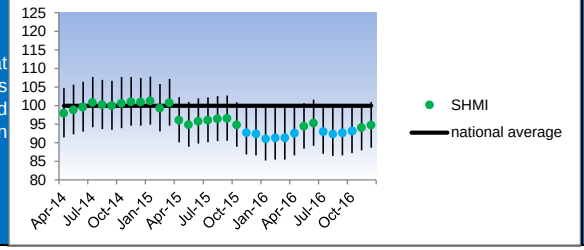
Quality - March 2017

Indicator name / data quality assessment	Description	Trend chart	Interpretation
✓ **Pressure ulcers - hospital acquired**	The chart shows the cumulative number of category 3 or category 4 hospital acquired pressure ulcers in 2016/17. The Trust has set a local trajectory for 2016/17 of zero avoidable hospital acquired category 3 or category 4 pressure ulcers. The data includes hospital teams only.		There were 5 hospital acquired category 3 pressure ulcers and 1 unstageable pressure ulcer reported in March. In 2016/17, 33 hospital acquired category 3 or unstageable pressure ulcers have been reported. Of these, 16 were deemed to be avoidable, 9 unavoidable and 8 cases are still under root cause analysis (RCA). There have been no hospital acquired category 4 pressure ulcers reported in 2016/17.
✓	The chart includes category 2, 3 and 4 and unstageable hospital acquired pressure ulcers. A maximum trajectory for 2016/17 of 155 cases of category 2-4 hospital acquired pressure ulcers has been agreed via the Quality Committee. The data includes hospital teams only.		The number of hospital acquired category 2-4 (or unstageable) pressure ulcers increased in March with 23 cases reported, compared to 17 in February. There have now been 205 cases reported in 2016/17. This compares to 155 in 2015/16.
✓ **Pressure ulcers - community acquired**	The chart shows the cumulative number of category 3 or category 4 community acquired pressure ulcers in 2016/17. This metric includes all pressure ulcers identified by community teams including pressure ulcers already present at the first point of contact.		There were 6 community acquired category 3 (or unstageable) pressure ulcers reported in March. In the year to date, 78 community acquired category 3 or 4 or unstageable pressure ulcers have been reported (including 3 category 4 cases). Of these, 36 were deemed to be avoidable, 29 unavoidable and 13 cases are still under root cause analysis (RCA).
▲	This additional chart has been added this month showing the trend in category 2, 3 and 4 community acquired pressure ulcers. A maximum trajectory for the number of category 2-4 community acquired pressure ulcers was agreed at the Quality Committee and is based on a 20% reduction against the number of cases reported in 2015/16. The data includes community teams only.		The number of community acquired category 2-4 (or unstageable) pressure ulcers reported in March was 25 cases, compared to 21 last month. In 2016/17, 263 cases have been reported, compared to 167 in 2015/16. The observed increase in reported cases may be partly due to improvements in incident reporting during the period.

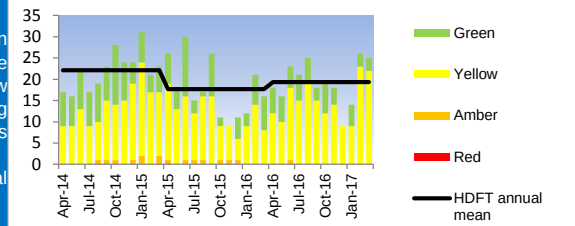
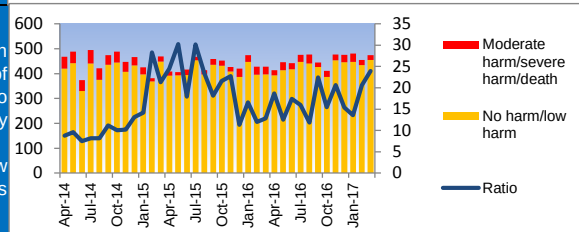
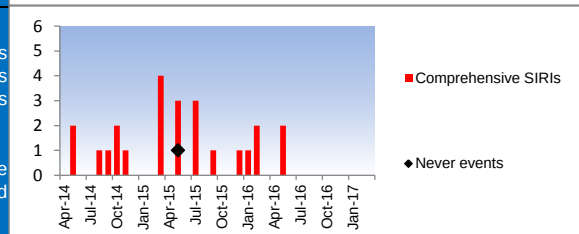
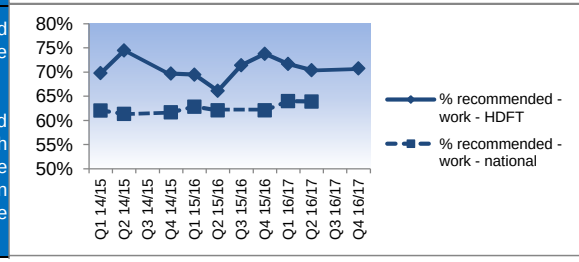
Quality - March 2017

Indicator name / data quality assessment	Description	Trend chart	Interpretation
Safety Thermometer - harm free care ✓	Measures the percentage of patients receiving harm free care (defined as the absence of pressure ulcers, harm from a fall, urine infection in patients with a catheter and new VTE) in the Safety Thermometer audits conducted once a month. The data includes hospital and community teams. A high score is good. Whilst there is no nationally defined target for this measure, a score of 95% or above is considered best practice.		The harm free percentage for March was 96.3%, an increase on last month and remaining above the latest national average.
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.		The rate of inpatient falls was 5.8 per 1,000 bed days in March, a decrease on last month. In 2016/17, 697 inpatient falls have been reported (including those not causing harm). This is a 14% reduction on the number of inpatient falls reported on 2015/16.
Falls causing harm ✓	The number of inpatient falls causing significant harm, expressed as a rate per 1,000 bed days. The data includes falls causing moderate harm, severe harm or death. A low rate is good.		There was 1 inpatient fall causing moderate harm in March, compared to 2 last month. The rate per 1,000 bed days is now below the HDFT average for 2015/16. There have been 16 inpatient falls causing moderate or severe harm in 2016/17, 15 of which resulted in a fracture. This compares to 20 in 2015/16.
Infection control ✓	The chart shows the cumulative number of hospital apportioned C. difficile cases during 2016/17. HDFT's C. difficile trajectory for 2016/17 is 12 cases, no change on last year's trajectory. Cases where a lapse in care has been deemed to have occurred would count towards the Monitor risk assessment framework. Hospital apportioned MRSA cases will be reported on an exception basis. HDFT has a trajectory of 0 MRSA cases for 2016/17. The last reported case of hospital acquired MRSA at HDFT was in Oct-12.		There was no cases of hospital apportioned C. difficile reported in March, making the year to date total 29 cases. 28 cases have now have root cause analysis (RCA) completed and discussed and agreed with HARD CCG. Of these, 6 have been determined to be due to a lapse in care and 22 were determined to not be due to a lapse in care. No cases of hospital apportioned MRSA were reported in 2016/17.

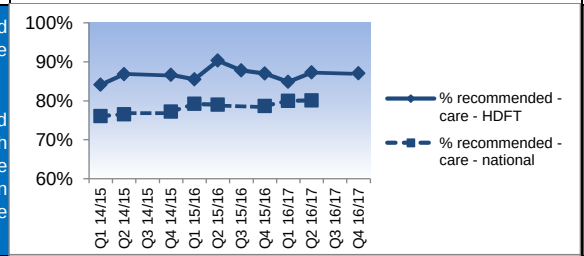
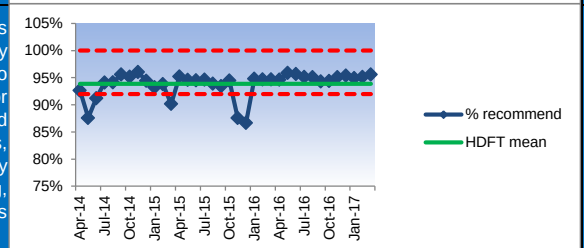
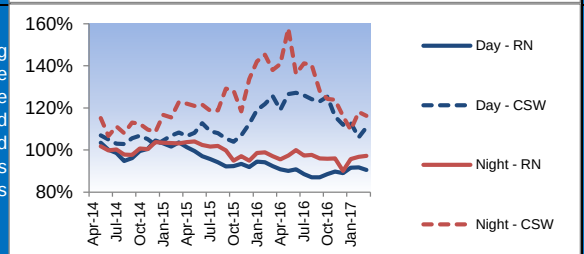
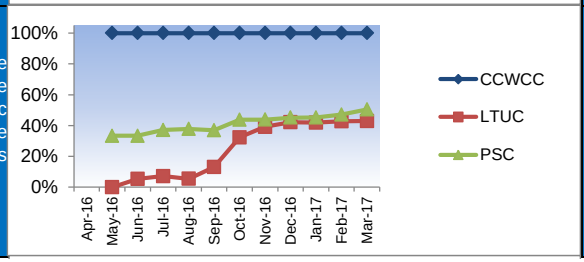
Quality - March 2017

Indicator name / data quality assessment	Description	Trend chart	Interpretation
Avoidable admissions 	The chart shows 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 admission. Conditions include pneumonia and urinary tract infections in adults and respiratory conditions in children.		There were 228 avoidable admissions in February, a significant decrease on recent months. Adult admissions (excluding CAT attendances) also fell this month.
Reducing hospital admissions in older people 	The chart shows the proportion of older people aged 65+ who were still at home 91 days after discharge from rehabilitation or reablement services. A high figure is good. *This indicator is in development.*		*This indicator has not been updated this month.* For patients discharged from rehabilitation or reablement services in November, 74% were still in their own home at the end of February, an improvement on the previous month. From next month onwards, this metric will report on patients discharged from any service within the new Integrated Care Teams. This will provide a more robust metric involving a larger group of patients but it will not be possible to present historical trend data.
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.		HDFT's HSMR decreased to 104.11 for the rolling 12 months ending January 2017 and remains within expected levels. At specialty level, two specialties (Geriatric Medicine and Stroke Medicine) have a standardised mortality rate above expected levels. The Trust is in the process of reviewing recently published national guidance about the requirement for Trusts to start publishing information on learning from deaths during 2017/18. This work will be led by the Medical Director, in conjunction with the existing mortality review process.
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.		HDFT's SHMI increased to 94.72, compared to 94.03 last month, remaining within expected levels. At specialty level, two specialties (Geriatric Medicine and Gastroenterology) have a standardised mortality rate above expected levels.

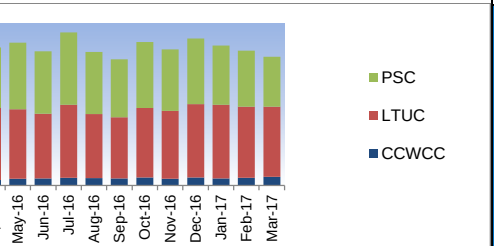
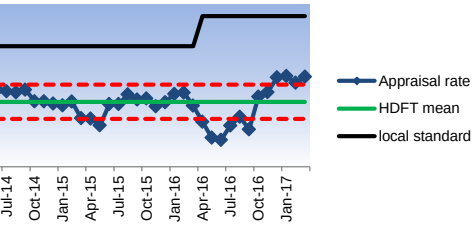
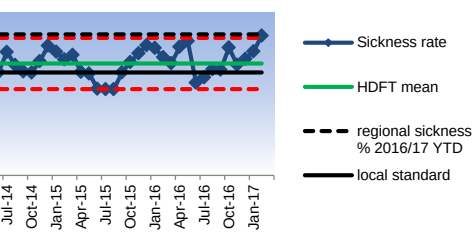
Quality - March 2017

Indicator name / data quality assessment	Description	Trend chart	Interpretation
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.		25 complaints were received in March, compared to 26 last month, remaining above the 2015/16 average. This remains above the 2015/16 average. As with last month, the complaints received in March relate to a number of different services across the Trust and are partly reflective of the significant operational pressures that the Trust was under during the month. There were no complaints classified as amber or red in March.
Incidents - all ✓	The chart shows 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		The latest published national data (for the period Apr - Sep 16) shows that Acute Trusts reported an average ratio of 37 no harm/low harm incidents for each incident classified as moderate harm, severe harm or death (a high ratio is better). HDFT's local reporting ratio for the same period was 18 which places the Trust in the bottom 25% nationally. The focus going forward is to improve our incident reporting rate particularly encouraging staff to report no harm/ near miss incidents. Options to improve the Datix system to simplify the incident reporting process are being explored.
Incidents - SIRIs and never events ✓	The chart shows the number of Serious Incidents Requiring Investigation (SIRIs) and Never Events reported within the Trust each month. The data includes hospital and community services. We have changed this indicator to only include comprehensive SIRIs, as concise SIRIs are reported within the presure ulcer and falls indicators above.		There were no comprehensive SIRIs and no never events reported in March.
Friends & Family Test (FFT) - Staff - % recommend as a place to work ✓	The Staff Friends and Family Test (FFT) was introduced in 2014/15 and gives staff the opportunity to give feedback on the organisation they work in. The chart shows the percentage of staff that would recommend the Trust as a place to work. A high percentage is good. The Trust's aim is to feature in the top 20% of Trusts nationally which would typically mean that 71% of staff would recommend the Trust as a place to work.		In Quarter 4, 70.8% of HDFT staff surveyed would recommend HDFT as a place to work, a slight increase on Quarter 2 (when the survey was last carried out) and remaining above the most recently published national average of 64%. The response rate at HDFT for Quarter 4 was 15%, compared to the most recently published national average of 12%.

Quality - March 2017

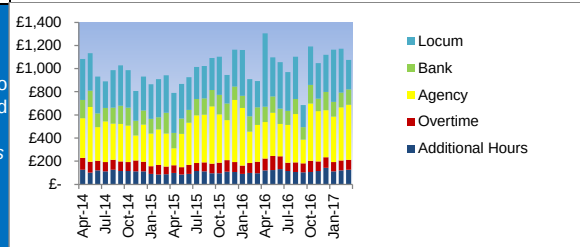
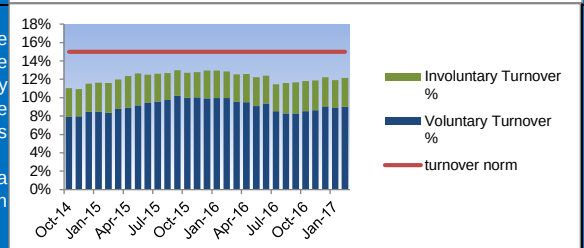
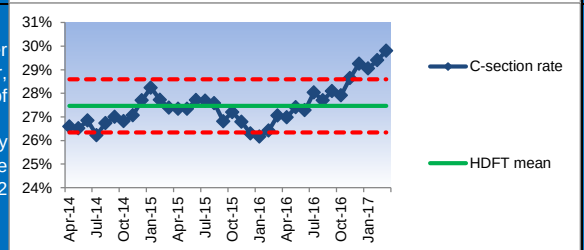
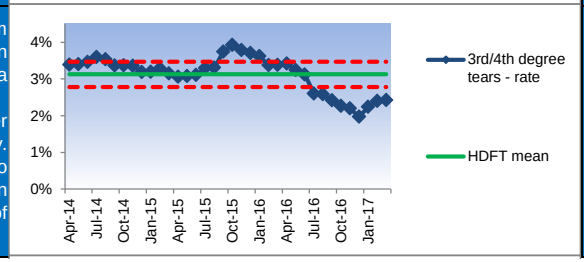
Indicator name / data quality assessment	Description	Trend chart	Interpretation
Friends & Family Test (FFT) - Staff - % recommend as a place to receive care ✓	The Staff Friends and Family Test (FFT) was introduced in 2014/15 and gives staff the opportunity to give feedback on the organisation they work in. The chart shows the percentage of staff that would recommend the Trust as a place to receive care. A high percentage is good. The Trust's aim is to feature in the top 20% of Trusts nationally which would typically mean that 88% of staff would recommend the Trust as a place to work. .		In Quarter 4, 87.0% of HDFT staff surveyed would recommend HDFT as a place to receive care. This is a slight decrease on Q2 (when the survey was last carried out) but remains above the most recently published national average of 80%. The response rate at HDFT for Quarter 4 was 15%, compared to the most recently published national average of 12%.
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.		95.6% of patients surveyed in March would recommend our services, remaining in line with recent months and above the latest published national average. Around 5,600 patients responded to the survey this month, which equates to an average of 179 responses per day, an increase on last month.
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 published on the Trust website.		Overall staffing compared to planned was at 99.5% in March. Registered nurse staffing levels remain similar to last month at 93% overall. Care Support Worker staffing remains high compared to plan - this is reflective of the increased need for 1-1 care and the number of newly qualified nurses working before they have received full registration.
Electronic rostering timeliness ▲	The chart shows the proportion of rosters that were published on time on Rosterpro (at least 4 weeks before the roster start date). It includes data for 20 specific clinical areas (mostly inpatient wards) involved in the pilot phase. Data presented is for a rolling 12 months period and is split by Clinical Directorate. A high percentage is good.		Overall, 52% of rosters were published on time during the period May 2016 to March 2017. All three Clinical Directorates are showing improvements in recent months. Publishing electronic rosters in a timely manner improves staff morale, increases bank fill rates and reduces bank/agency costs.

Quality - March 2017

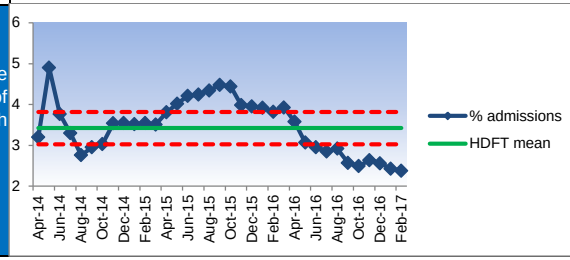
Indicator name / data quality assessment	Description	Trend chart	Interpretation
Electronic rostering hours owed	This metric shows the sum of unused hours for staff as a running balance from the Trust's predefined audit start date. To allow for some flexibility in assigning hours over rosters (ie. for Night workers), an alert will be triggered when staff owe 15 hours or more. Data is split by Clinical Directorate for 20 specific clinical areas (mostly inpatient wards) involved in the pilot phase. A low number is good.		The data has been rebased and now shows the cumulative position from March 2015 onwards (previously March 2016). As can be seen on the chart, the number of owed hours has consistently reduced over the last 3 months. this is a positive downward trend demonstrating that wards are getting these balances under control. Properly managed balances increase available clinical hours, improves staff morale and management decision making.
Staff appraisal rates	The chart shows the staff appraisal rate over the most recent rolling 12 months. The Trusts aims to have 90% of staff appraised. A high percentage is good. The figures from May 2016 onwards exclude employees currently on maternity leave, career break or suspension and staff who TUPE transferred into the organisation from Darlington, Durham and Middlesbrough from 1st April 2016.		The appraisal rate for the 12 months to end March is 79%. The new appraisal period commences from 1st April and runs until 30th September. The expectation is that all appraisals will be completed during this timeframe for 2017/18. There are a number of briefings scheduled for managers and staff during April with more to be scheduled in May. Guidance on conducting team appraisals has been up-loaded onto the Appraisal toolkit and incorporated into Pathway to Management training.
Mandatory training rates	The table shows the most recent training rates for all mandatory elements for substantive staff.		The data shown is for the end of March and includes the staff who were TUPE transferred into the organisation on the 1st April 2016. The overall training rate for mandatory elements for substantive staff is 90%. The new follow up procedure is now in place for Directorates to use and we hope to see a positive impact on compliance going forward.
Sickness rates	Staff sickness rate - includes short and long term sickness. The Trust has set a threshold of 3.9%. A low percentage is good.		The staff sickness rate rose to 4.58% in February. However the Trust remains below the regional average of 4.8% for the month and just below the year to date regional (and national) average of 4.6%. HDFT's sickness for the year to date is 4.1%. Our new attendance lead Vicki Godfrey joined the Trust in April. She is currently in the process of reviewing all long-term sickness cases and updating action plans appropriately. In line with developing some further workforce metrics, she will establish our baseline for the average length of long term sickness which will then be reviewed quarterly. The sickness rate and reasons for this were discussed at SMT this month. Directorates were requested to ensure there was an absolute focus on the completion of return to work interviews and to continually monitor sickness levels and progress matters through the policy when it is appropriate to do so.

Competence Name	% Completed
Equality, Diversity and Human Rights - Level 1	90
Fire Safety Awareness	79
Infection Prevention & Control (Including Hand Hygiene) 1	100
Infection Prevention & Control (Including Hand Hygiene) 2	85
Information Governance: Introduction	91
Information Governance: The Beginners Guide	96
Prevent Basic Awareness (December 2015)	99
Safeguarding Children & Young People Level 1 - Introduction	95

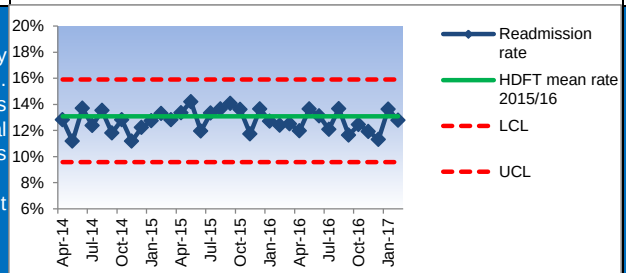
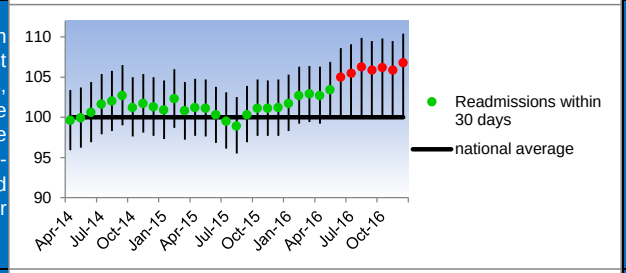
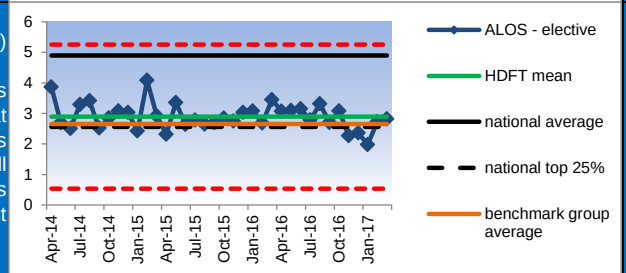
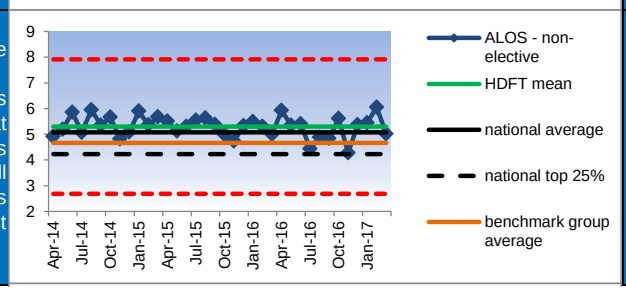
Quality - March 2017

Indicator name / data quality assessment	Description	Trend chart	Interpretation
Temporary staffing expenditure - medical/nursing /other	The chart shows staff expenditure per month, split into contracted staff, overtime and additional hours and temporary staff. Lower figures are preferable. *The traffic light criteria applied to this indicator is currently under review.*		The Trust has established an advisory group to address actions designed to reduce, and if possible eliminate, spend and reliance on engagement of temporary staff, especially through agencies. Meetings are held fortnightly and review all agency bookings, and especially those above wage and/or rate cap. The instruction not to engage temporary staff with substantive NHS contracts through agencies, issued by NHSI at the end of February, was rescinded the day before implementation, although agreement had been reached across WYAAT to enforce it. Separately the business case for the development of an internal bank for temporary medical staff will be considered at ODG on 25 April. Once established, this has the potential to reduce significantly expenditure on this group and is a first step towards a collaborative bank across WYAAT.
Staff turnover rate	The chart shows 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.		Turnover was at 12.2% in March. Analysis is taking place in relation to identifying key areas with high level of labour turnover. Once identified a process for completing exit/save interviews within those areas will be drafted and sent to ODG and Directors for approval. This will provide data, identifying themes on experience of working at the Trust and reasons for leaving which will in turn inform our retention strategy.
Maternity - Caesarean section rate	The caesarean section rate is determined by a number of factors including ability to provide 1-1 care in labour, previous birth experience and confidence and ability of the staff providing care in labour. The rate of caesarean section can fluctuate significantly from month to month - as a result we have amended the presentation of this indicator this month to show a 12 month rolling average position.		HDFT's C-section rate for the 12 months ending March was 29.8% of deliveries, an increase on last month and remaining higher than average. The major contributing factor to the recent upward trend appears to be a significant increase in elective caesarean sections during 2016/17, with the emergency caesarean section rate remaining static and within expected parameters.
Maternity - Rate of third and fourth degree tears	Third and fourth degree tears are a source of short term and long term morbidity. A previous third degree tear can increase the likelihood of a woman choosing a caesarean section in a subsequent pregnancy. Recent intelligence suggested that HDFT were an outlier for third degree tears with operative vaginal delivery. Quality improvement work is being undertaken to understand and improve this position and its inclusion on this dashboard will allow the Trust Board to have sight of the results of this.		The rate of third or fourth degree tears was 2.4% of deliveries in the 12 month period ending March, remaining well below previous months. This may reflect the significant amount of quality improvement work aimed at reducing the incidence of third degree tears.

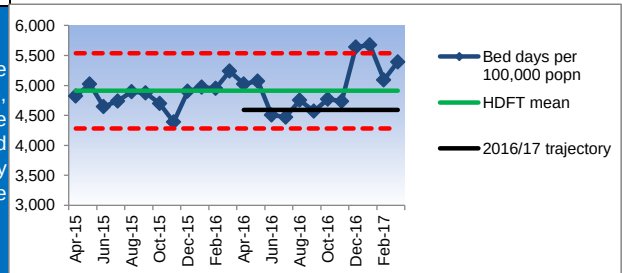
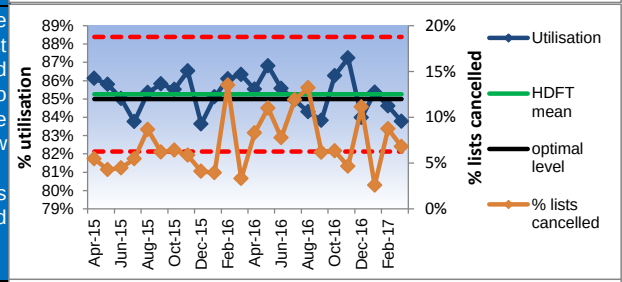
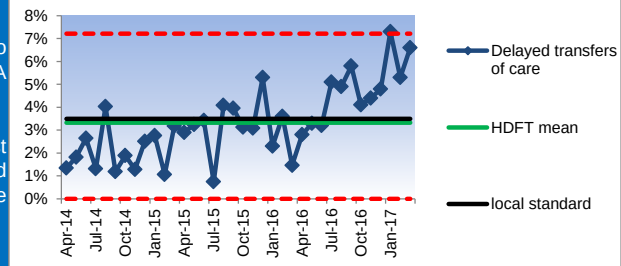
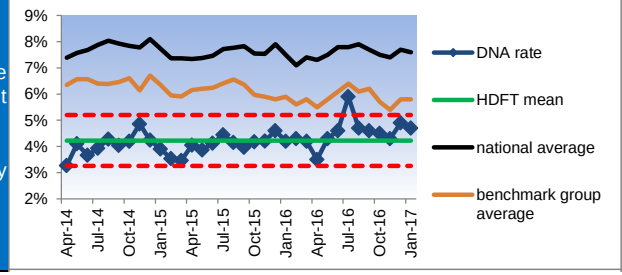
Quality - March 2017

Indicator name / data quality assessment	Description	Trend chart	Interpretation
Maternity - Unexpected term admissions to SCBU 	This indicator is a reflection of the intrapartum care provided. For example, an increase in the number of term admissions to special care might reflect issues with understanding of fetal heart rate monitoring in labour. The charts shows a 12 month rolling average position.		The chart shows the percentage of term babies (those born at greater than 37 weeks gestation) who were admitted to the Special Care Baby Unit (SCBU). The chart has been amended this month as it was identified that the data being displayed was the number of admissions to SCBU, not the percentage of births as was being described. This has been corrected this month to show the percentage. 2.1% of term babies were admitted to SCBU in the 12 months ending March, continuing the downward trend seen in recent months.

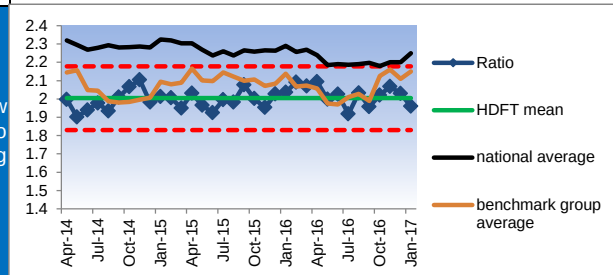
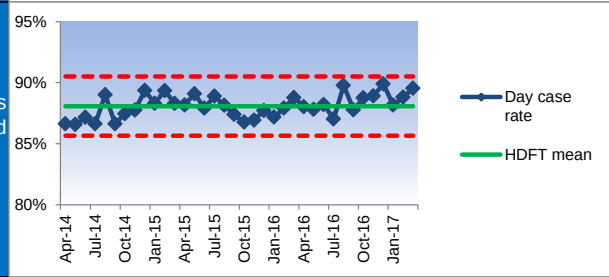
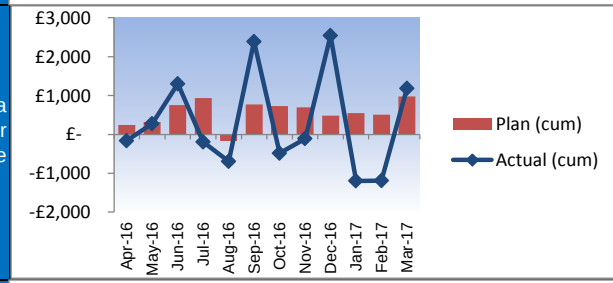
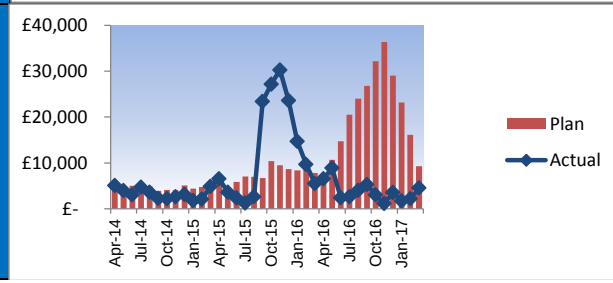
Finance and Efficiency - March 2017

Indicator name / data quality assessment	Description	Trend chart	Interpretation
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.		The number of readmissions decreased in February, when expressed as a percentage of all emergency admissions, and is now below the average rate for 2015/16. HDFT and HARD CCG are now concluding a joint clinical audit of readmissions to determine the proportion which were avoidable.
Readmissions - standardised ✓	This indicator looks at the standardised readmission rate within 30 days. The data is standardised against various criteria including age, sex, diagnosis, comorbidites etc. The standardisation enables a more like for like comparison with other organisations. The national average is set at 100. A low rate is good - rates below 100 indicate a lower than expected readmission rate and rates above 100 indicate higher than expected readmission rate.		HDFT's standardised readmission rate increased to 106.8 in the most recently available data on HED, remaining above the national average and above expected levels. At specialty level, the same 5 specialties have a standardised emergency readmission rates above expected levels (Cardiology, Clinical Haematology, Paediatrics, Medical Oncology and Well Babies). A clinical audit of a sample of paediatric and well babies readmissions is being carried out by CCCC Directorate.
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.		The average elective length of stay for March was 2.8 days, an increase on the previous month and just above benchmark group average.
Length of stay - non-elective ✓	Average length of stay in days for non-elective (emergency) patients. A shorter length of stay is preferable. When a patient is admitted to hospital, it is in the best interests of that patient to remain in hospital for as short a time as clinically appropriate – patients who recover quickly will need to stay in hospital for a shorter time. As well as being best practice clinically, it is also more cost effective if a patient has a shorter length of stay.		The average non-elective length of stay for March was 5.0 days, a significant decrease on last month and now below the national average. However, HDFT's length of stay remains above the benchmark group average.

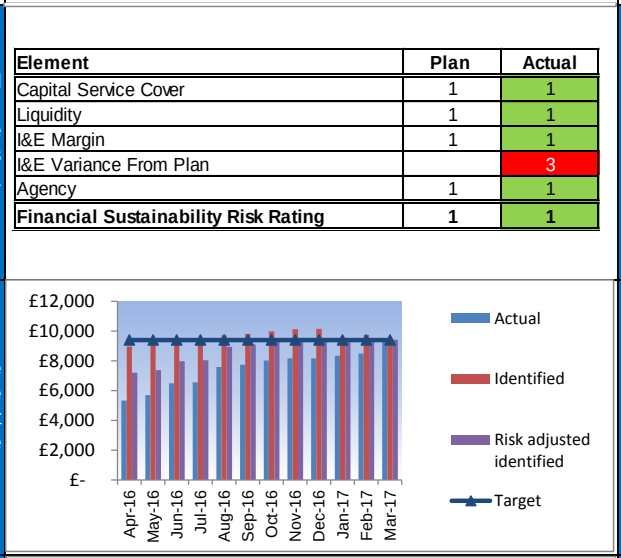
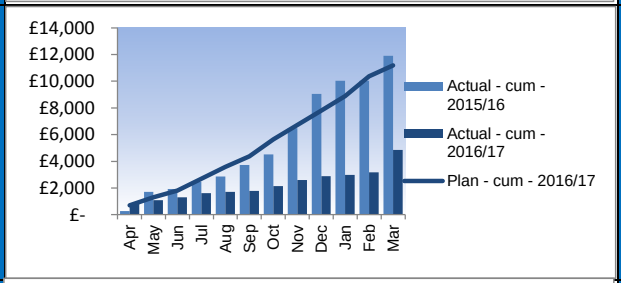
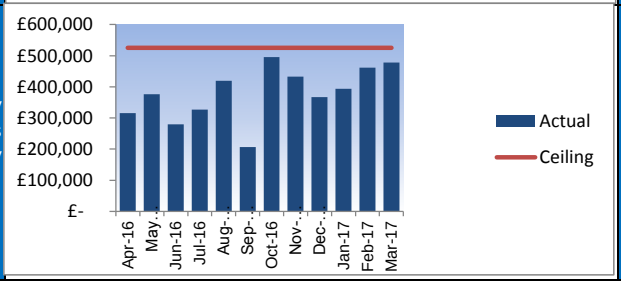
Finance and Efficiency - March 2017

Indicator name / data quality assessment	Description	Trend chart	Interpretation
Non-elective bed days ✓	The charts shows the number of non-elective (emergency) bed days at HDFT for patients aged 18+, per 100,000 population. The chart only includes the local HARD CCG area. The 2016/17 trajectory is based on allowing for demographic growth and reducing by the non-elective reductions identified in the Value Proposition. A lower figure is preferable.		Non-elective bed days for patients aged 18+ increased in March and is above the level reported in March last year. However when expressed per day, this is a reduction on last month.
Theatre utilisation △	The percentage of time utilised during elective theatre sessions (i.e. those planned in advance for waiting list patients). The utilisation calculation excludes cancelled sessions - operating lists that are planned not to go ahead due to annual leave, study leave or maintenance etc. An extra line has been added to the chart to allow monitoring of this. A higher utilisation rate is good as it demonstrates effective use of resources. A utilisation rate of around 85% is often viewed as optimal.		Theatre utilisation decreased to 83.8% in March. However the number of cancelled sessions also decreased to 6.8%.
Delayed transfers of care ✓	The proportion of patients in acute hospital beds who are medically fit for discharge but are still in hospital. A low rate is preferable. A snapshot position is taken at midnight on the last Thursday of each month. The maximum threshold shown on the chart (3.5%) has been agreed with the CCG.		Delayed transfers of care increased to 6.6% when the snapshot was taken in March, remaining above the maximum threshold of 3.5% set out in the contract. Data shared by NHS Improvement suggests that nationally delayed transfers of care have been at around 5% in 2017 to date. Further work to understand the reasons for this continued increase is being carried out by the Discharge Steering Group.
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.		HDFT's DNA rate decreased to 4.7% in January and remains below that of both the benchmarked group of trusts and the national average.

Finance and Efficiency - March 2017

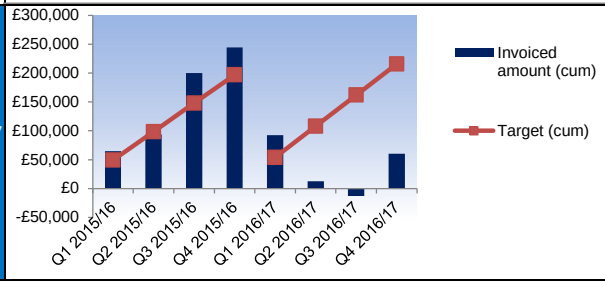
Indicator name / data quality assessment	Description	Trend chart	Interpretation
Outpatient new to follow up ratio ✓	The number of follow-up appointments per new appointment. A lower ratio is preferable. A high ratio could indicate that unnecessary follow ups are taking place.		Reducing the number of follow ups is a major part of HARD CCG's financial recovery plan. HDFT's new to follow up ratio decreased in January and remains below both the national average and the benchmark group average.
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.		The day case rate increased to 89.5% in March and remains above the HDFT average.
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.		The Trust reported a surplus of £3,688k for 2016/17. This position included £3,450k of sustainability and transformation funding, resulting in an underlying surplus of £238k. This position was £2m behind the control total set by NHS Improvement.
Cash balance ✓	Monthly cash balance (£'000s)		Cash continues to be a concern for the Trust. The cash balance at the end of March was reported at £4.55m, with a number of actions in place to improve the outstanding debtors position. The increase in March is a result of these actions, as well as prepayment of a contract.

Finance and Efficiency - March 2017

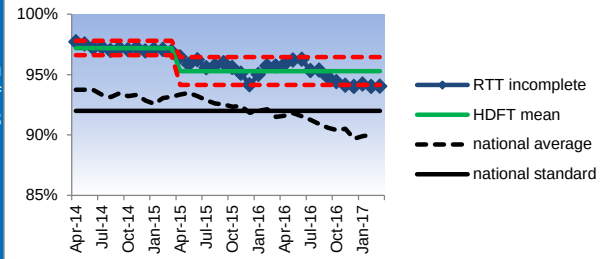
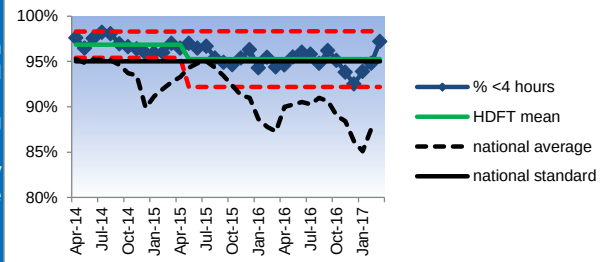
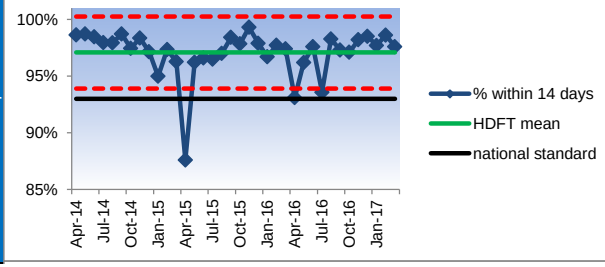
Indicator name / data quality assessment	Description	Trend chart	Interpretation
NHS Improvement Single Oversight Framework - Use of Resource Metric ✓	From 1st October 2016, NHS Improvement introduced the Single Oversight Framework. As part of this this, Use of Resource Metric was introduced to replace the previous Financial Sustainability Risk Rating. This is the product of five elements which are rated between 1 (best) to 4.		The Trust reported a rating of 1 in March, in line with plan.
CIP achievement ✓	Cost Improvement Programme (CIP) performance outlines full year achievement on a monthly basis. The target is set at the internal efficiency requirement (£'000s). This indicator monitors our year to date position against plan.		Despite the adverse position above, performance against the efficiency programme has remained positive with directorates actioning schemes for the full target set for 2016/17. This contains a number of non recurrent benefits, adding risk to the 2017/18 programme.
Capital spend ✓	Cumulative Capital Expenditure by month (£'000s)		Cumulative capital expenditure remains behind plan.
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.		At 3.7% of pay spend, agency expenditure was high in March. At £477k for the month (October was the only higher month) this is a concern for the Trust. Although the value is below the agency ceiling for the Trust, this ceiling reduces in 2017/18 and the current run rate would potentially result in exceeding the new value.

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

Finance and Efficiency - March 2017

Indicator name / data quality assessment	Description	Trend chart	Interpretation
Research - Invoiced research activity 	Aspects of research studies are paid for by the study sponsor or funder.		As set out in the Research & Development strategy, the Trust intends to maintain its current income from commercial research activity and NIHR income to support research staff to 2019. Each study is unique. Last year the Trust invoiced for a total of £223k.

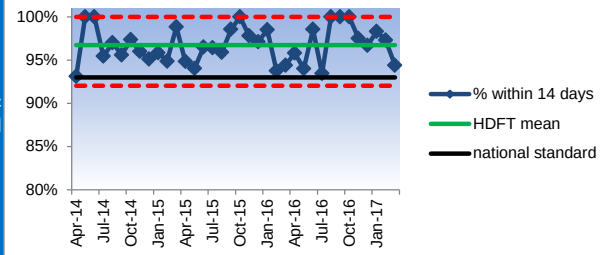
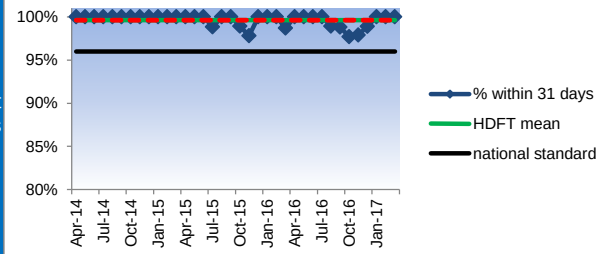
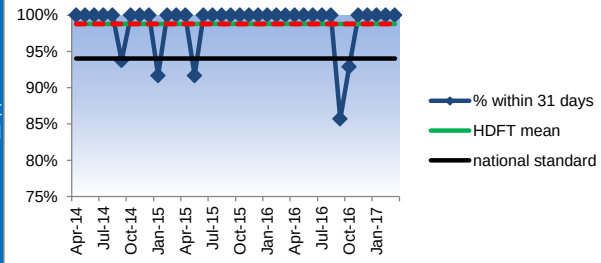
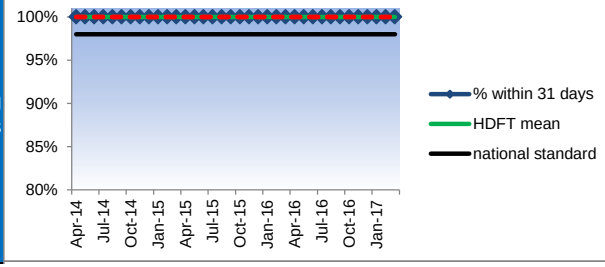
Operational Performance - March 2017

Indicator name / data quality assessment	Description	Trend chart	Interpretation
NHS Improvement Single Oversight Framework ✓	From October 2016, NHS Improvement will 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 left shows how the Trust is performing against the national performance standards in the "operational performance metrics" section.		In March, HDFT was above the required level for all 4 key operational performance metrics.
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.		94.0% of patients were waiting 18 weeks or less at the end of March, above the required national standard of 92% and no change on last month's performance. At specialty level, Trauma & Orthopaedics and General Surgery remain below the 92% standard.
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. Historical data for HDFT included both Ripon and Selby MIUs. In agreement with local CCGs, York NHSFT are reporting the activity for Selby MIU from 1st May 2015.		HDFT's Trust level performance for March was 97.2%, above the required 95% standard. This includes data for the Emergency Department at Harrogate and Ripon MIU. Performance for Harrogate ED in March was 96.6%. HDFT has therefore delivered the 4-hour standard for the 2016/17 year overall with annual performance of 95.1%.
Cancer - 14 days maximum wait from urgent GP referral for suspected cancer referrals ✓	Percentage of urgent GP referrals for suspected cancer seen within 14 days. The operational standard is 93%. A high percentage is good.		Delivery at expected levels.

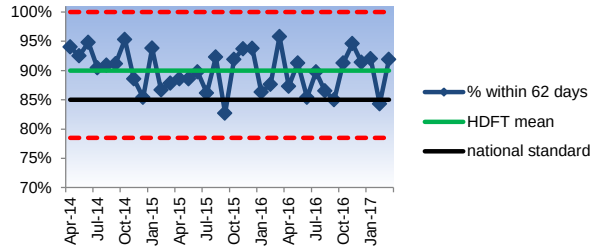
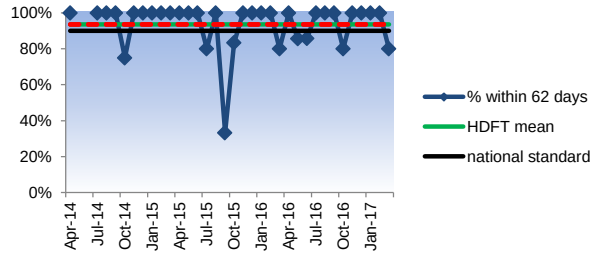
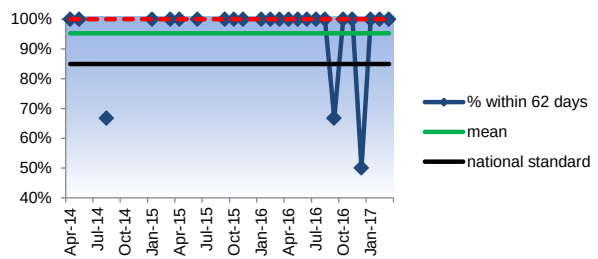
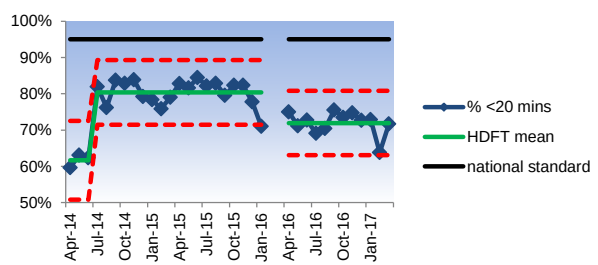
Standard	Oct-16	Nov-16	Dec-16
RTT incomplete pathways	94.4%	94.1%	94.0%
A&E 4-hour standard	95.1%	93.8%	92.5%
Cancer - 62 days	91.3%	94.6%	91.4%
Diagnostic waits	99.9%	99.8%	99.9%

Standard	Jan-17	Feb-17	Mar-17
RTT incomplete pathways	94.2%	94.0%	94.0%
A&E 4-hour standard	93.9%	94.8%	97.2%
Cancer - 62 days	92.0%	84.3%	92.1%
Diagnostic waits	99.9%	99.8%	99.8%

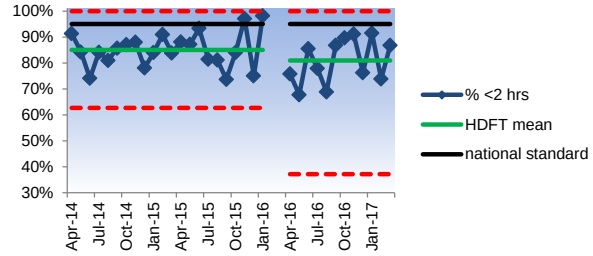
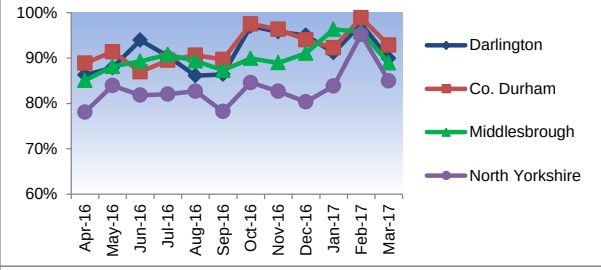
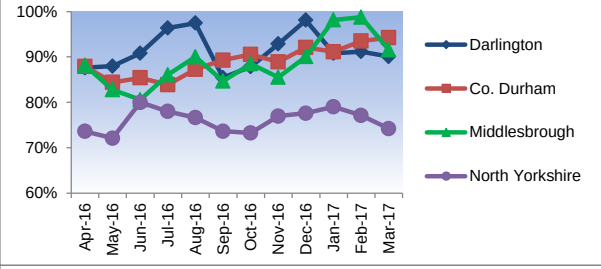
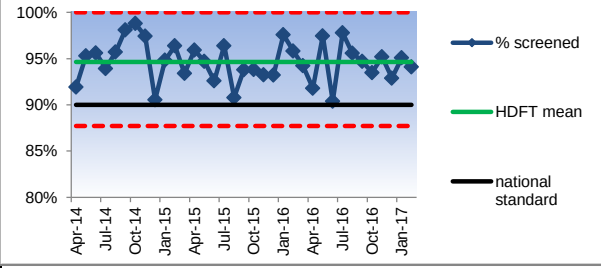
Operational Performance - March 2017

Indicator name / data quality assessment	Description	Trend chart	Interpretation
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.		Delivery at expected levels.
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.		Delivery at expected levels.
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.		Delivery at expected levels.
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.		Delivery at expected levels.

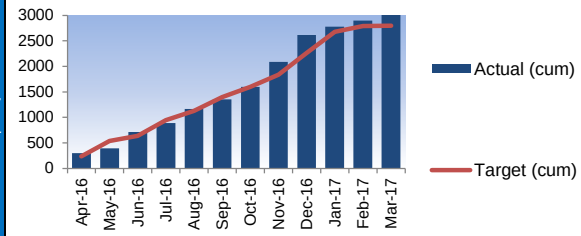
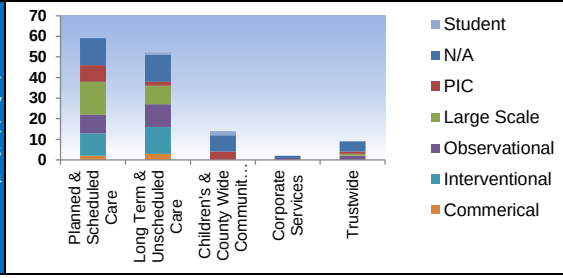
Operational Performance - March 2017

Indicator name / data quality assessment	Description	Trend chart	Interpretation
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.		Provisional performance for March is above the required 85% standard at 91.9% with 5 accountable breaches. Of the 11 tumour sites, 2 had performance below 85% in March - colorectal and upper gastrointestinal.
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.		Performance was below 90% in March. However with only 5 accountable pathways in the month, this is below the de mininis level for reporting performance. Performance for Quarter 4 overall is above the standard at 94.4%.
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.		Delivery at expected levels.
GP OOH - NQR 9 ▲	NQR 9 (National Quality Requirement 9) looks at the % of GP OOH telephone clinical assessments for urgent cases that are carried out within 20 minutes of call prioritisation. A high percentage is good.		Performance remains below the required 95% for this metric but improved to 72% in March. Work continues with the Information Team to implement new, meaningful performance metrics and assure the quality of the data and reports from the Adastra system. The service is also undertaking a GP performance review which will provide further assurance as to the quality of the service provision.

Operational Performance - March 2017

Indicator name / data quality assessment	Description	Trend chart	Interpretation
GP OOH - NQR 12	NQR 12 (National Quality Requirement 12) looks at the % of GP OOH face to face consultations (home visits) started for urgent cases within 2 hours. The data presented excludes Selby and York as these do not form part of the HFT OOH service from April 2015. A high percentage is good.		Performance remains below the required 95% for this metric but improved to 87% in March. Work continues with the Information Team to implement new, meaningful performance metrics and assure the quality of the data and reports from the Adastra system. The service is also undertaking a GP performance review which will provide further assurance as to the quality of the service provision.
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 the 0-5 Health Visiting Service in North Yorkshire and the Healthy Child Programme in Darlington, Co. Durham and Middlesbrough. A high percentage is good. The contract does not specify a required level.		In March, the provisional, unvalidated performance position is that 89% of babies were recorded on Systmone as having had a new birth visit within 14 days of birth. It is anticipated that once the data is fully validated that we will report an improved, more accurate performance position for March. This will be reflected in next month's report. As can be seen on the chart, the improved validation process recently implemented has had a significant impact on the February performance position which now better reflects the actual performance of the services.
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 the 0-5 Health Visiting Service in North Yorkshire and the Healthy Child Programme in Darlington, Co. Durham and Middlesbrough. A high percentage is good. The contract does not specify a required level.		In March, the provisional performance position is that 86% of children were recorded on Systmone as having had a 2.5 year review. It is anticipated that once the data is fully validated that we will report an improved, more accurate performance position. This will be reflected in next month's report.
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.		Delivery at expected levels.

Operational Performance - March 2017

Indicator name / data quality assessment	Description	Trend chart	Interpretation
Recruitment to NIHR adopted research studies ✓	The Trust has a recruitment target of 2,800 for 2016/17 for studies on the NIHR portfolio. This equates to 234 per month. Over recruitment is encouraged.		Provisional data indicates that recruitment to research studies during 2016/17 was 12% above plan.
Directorate research activity ✓	The number of studies within each of the directorates - included in the graph is Trustwide where the study spans directorates. The Trust has no specific target set for research activity within each directorate. It is envisaged that each clinical directorate would have a balanced portfolio.		The directorate research teams are subject to studies that are available to open. The 'type of study', Commercial, Interventional, Observational, Large scale, Patient Identification Centre (PIC) or N/A influence the activity based funding received by HDFT. Each category is weighted dependant on input of staff involvement. N/A studies are those studies which are not on the NIHR portfolio. They include commercial, interventional, observational, large scale, PIC, local and student projects. They do not influence the recruitment target.

Data Quality - Exception Report

Report section	Indicator	Data quality rating	Further information
Quality	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.
Operational Performance	GP Out of Hours - National Quality Requirement 9	**Amber** 	Following patient pathway changes in late 2015, reports from the Adastra system no longer calculate the correct start time for these patients and as a result, the performance reported for NQR9 was incorrect. Significant work from has been carried out by information staff at HDFT and we are now able to report performance again for this metric again, based on calculations from raw data extracts from the Adastra system. The new calculations have been shared with HARD CCG.
Operational Performance	GP Out of Hours - National Quality Requirement 12	**Amber** 	
Quality	Reducing readmissions in older people	**Amber** 	This indicator is under development. We have recently amended the calculation of this indicator so that it correctly handles patients who had multiple admissions and multiple contacts with community services.
Finance and efficiency	Theatre utilisation	**Amber** 	The utilisation calculation excludes cancelled sessions - operating lists that are planned not to go ahead due to annual leave, study leave or maintenance etc. An extra line has been added to the chart to allow monitoring of cancelled sessions.
Operational Performance	Children's Services - 10-14 day new birth visit	**Amber** 	Caution should be exercised as further work is required to understand the completeness and quality of this data.
Operational Performance	Children's Services - 2.5 year review	**Amber** 	Caution should be exercised as further work is required to understand the completeness and quality of this data.
Quality	Electronic rostering timeliness	**Amber** 	Caution should be exercised as further work is required to understand the completeness and quality of this data.
Quality	Electronic rostering hours owed	**Amber** 	Caution should be exercised as further work is required to understand the completeness and quality of this data.

Indicator traffic light criteria

Section	Indicator	Further detail	Traffic light criteria	Rationale/source of traffic light criteria
Quality	**Pressure ulcers - hospital acquired**	No. category 3 and category 4 avoidable hospital acquired pressure ulcers	tbc	tbc
Quality	**Pressure ulcers - community acquired**	No. category 3 and category 4 community acquired pressure ulcers	tbc	tbc
Quality	**Safety thermometer - harm free care**	% harm free	Blue if latest month >=97%, Green if >=95% but <97%, red if latest month <95%	National best practice guidance suggests that 95% is the standard that Trusts should achieve. In addition, HDFT have set a local stretch target of 97%.
Quality	**Falls**	IP falls per 1,000 bed days	Blue if YTD position is a reduction of >=50% of HDFT average for 2015/16, Green if YTD position is a reduction of between 20% and 50% of HDFT average for 2015/16, Amber if YTD position is a reduction of up to 20% of HDFT average for 2015/16, Red if YTD position is on or above HDFT average for 2015/16.	Locally agreed improvement trajectory based on comparison with HDFT performance last year.
Quality	**Falls causing harm**	IP falls causing moderate harm, sever harm or death, per 1,000 bed days		
Quality	**Infection control**	No. hospital acquired C.diff cases	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
Quality	**Avoidable admissions**	The number of avoidable emergency admissions to HDFT as per the national definition.	tbc	tbc
Quality	**Reducing hospital admissions in older people**	The proportion of older people 65+ who were still at home 91 days after discharge from rehabilitation or reablement services.	tbc	tbc
Quality	**Mortality - HSMR**	Hospital Standardised Mortality Ratio (HSMR)	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.
Quality	**Mortality - SHMI**	Summary Hospital Mortality Index (SHMI)		
Quality	**Complaints**	No. complaints, split by criteria	Blue if no. complaints in latest month is below LCL, Green if below HDFT average for 2015/16, Amber if on or above HDFT average for 2015/16, 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.
Quality	**Incidents - all**	Incidents split by grade (hosp and community)	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.
Quality	**Incidents - complrehensive SIRIs and never events**	The number of comprehensive SIRIs and the number of never events reported in the year to date. The indicator includes hospital and community data.	Green if none reported in current month; Red if 1 or more never event or comprehensive reported in the current month.	
Quality	**Friends & Family Test (FFT) - Staff**	% staff who would recommend HDFT as a place to work	Blue if latest month score places HDFT in the top 10% of acute trusts nationally and/or the % staff recommending the Trust is above 95%, Green if in top 25% of acute trusts nationally, Amber if within the middle 50%, Red if in bottom 25%.	Comparison with performance of other acute trusts.
Quality	**Friends & Family Test (FFT) - Staff**	% staff who would recommend HDFT as a place to receive care		
Quality	**Friends & Family Test (FFT) - Patients**	% recommend, % not recommend - combined score for all services currently doing patient FFT	Green if latest month >= latest published national average, Red if < latest published national average.	Comparison with national average performance.
Quality	**Safer staffing levels**	RN and CSW - day and night overall fill rates at trust level	Green if latest month overall staffing >=100%, amber if between 95% and 100%, red if below 95%.	The Trusts aims for 100% staffing overall.
Quality	**Staff appraisal rate**	Latest position on no. staff who had an appraisal within the last 12 months	Annual rolling total - 90% green. Amber between 70% and 90%, red<70%.	Locally agreed target level based on historic local and NHS performance
Quality	**Mandatory training rate**	Latest position on the % 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
Quality	**Staff sickness rate**	Staff sickness rate	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
Quality	**Temporary staffing expenditure - medical/nursing/other**	Expenditure per month on staff types.	tbc	tbc
Quality	**Staff turnover**	Staff turnover rate excluding trainee doctors, bank staff and staff on fixed term contracts.	Green if remaining static or decreasing, amber if increasing but below 15%, red if above 15%.	Based on evidence from Times Top 100 Employers
Quality	**Maternity - Caesarean section rate**	Caesarean section rate as a % of all deliveries	Green if <25% of deliveries, amber if between 25% and 30%, red if above 30%.	tbc
Quality	**Maternity - Rate of third and fourth degree tears**	No. third or fourth degree tears as a % of all deliveries	Green if <3% of deliveries, amber if between 3% and 6%, red if above 6%.	tbc
Quality	**Maternity - Unexpected term admissions to SCBU**	Admissions to SCBU for babies born at 37 weeks gestation or over.	tbc	tbc
Finance and efficiency	**Readmissions**	No. emergency readmissions (following elective or non-elective admission) within 30 days.	Blue if latest month rate < LCL, Green if latest month rate < HDFT average for 2015/16, Amber if latest month rate > HDFT average for 2015/16 but below UCL, red if latest month rate > UCL.	Locally agreed improvement trajectory based on comparison with HDFT performance last year.
Finance and efficiency	**Readmissions - standardised**	Standardised emergency readmission rate within 30 days from HED	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.
Finance and efficiency	**Length of stay - elective**	Average LOS for elective patients	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.
Finance and efficiency	**Length of stay - non-elective**	Average LOS for non-elective patients		

Section	Indicator	Further detail	Traffic light criteria	Rationale/source of traffic light criteria
Finance and efficiency	Non-elective bed days for patients aged 18+	Non-elective bed days at HDFT for HARD CCG patients aged 18+, per 100,000 population	Green if latest month < 2016/17 trajectory, amber if latest month below 2015/16 level plus 0.5% demographic growth but above 2016/17 trajectory, red if above 2015/16 level plus 0.5% demographic growth.	A 2016/17 trajectory has been added this month - this is based on allowing for demographic growth and reducing by the non-elective reductions identified in the Value Proposition.
Finance and efficiency	Theatre utilisation	% of theatre time utilised for elective operating sessions	Green = >=85%, Amber = between 75% and 85%, Red = <75%	A utilisation rate of around 85% is often viewed as optimal.
Finance and efficiency	Delayed transfers of care	% acute beds occupied by patients whose transfer is delayed - snapshot on last Thursday of the month.	Red if latest month >3.5%, Green <=3.5%	Contractual requirement
Finance and efficiency	Outpatient DNA rate	% first OP appointments DNA'd		
Finance and efficiency	Outpatient new to follow up ratio	No. follow up appointments per new appointment.	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.
Finance and efficiency	Day case rate	% elective admissions that are day case		
Finance and efficiency	Surplus / deficit and variance to plan	Monthly Surplus/Deficit (£'000s)	Green if on plan, amber <1% behind plan, red >1% behind plan	Locally agreed targets.
Finance and efficiency	Cash balance	Monthly cash balance (£'000s)	Green if on plan, amber <10% behind plan, red >10% behind plan	Locally agreed targets.
Finance and efficiency	NHS Improvement Financial Performance Assessment	An overall rating is calculated ranging from 4 (no concerns) to 1 (significant concerns). This indicator monitors our position against plan.	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
Finance and efficiency	CIP achievement	Cost Improvement Programme performance	Green if achieving stretch CIP target, amber if achieving standard CIP target, red if not achieving standard CIP target.	Locally agreed targets.
Finance and efficiency	Capital spend	Cumulative capital expenditure	Green if on plan or <10% below, amber if between 10% and 25% below plan, red if >25% below plan	Locally agreed targets.
Finance and efficiency	Agency spend in relation to pay spend	Expenditure in relation to Agency staff on a monthly basis (£'s).	Green if <1% of pay bill, amber if between 1% and 3% of pay bill, red if >3% of pay bill.	Locally agreed targets.
Finance and efficiency	Research - Invoiced research activity		to be agreed	
Operational Performance	NHS Improvement governance rating	Trust performance on Monitor's risk assessment framework.	As per defined governance rating	as defined by NHS Improvement
Operational Performance	RTT Incomplete pathways performance	% incomplete pathways within 18 weeks	Green if latest month >=92%, Red if latest month <92%.	NHS England
Operational Performance	A&E 4 hour standard	% patients spending 4 hours or less in A&E.	Blue if latest month >=97%, Green if >=95% but <97%, red if latest month <95%	NHS England, NHS Improvement and contractual requirement of 95% and a locally agreed stretch target of 97%.
Operational Performance	Cancer - 14 days maximum wait from urgent GP referral for all urgent suspect cancer referrals	% urgent GP referrals for suspected cancer seen within 14 days.	Green if latest month >=93%, Red if latest month <93%.	NHS England, NHS Improvement and contractual requirement
Operational Performance	Cancer - 14 days maximum wait from GP referral for symptomatic breast patients	% GP referrals for breast symptomatic patients seen within 14 days.	Green if latest month >=93%, Red if latest month <93%.	NHS England, NHS Improvement and contractual requirement
Operational Performance	Cancer - 31 days maximum wait from diagnosis to treatment for all cancers	% cancer patients starting first treatment within 31 days of diagnosis	Green if latest month >=96%, Red if latest month <96%.	NHS England, NHS Improvement and contractual requirement
Operational Performance	Cancer - 31 day wait for second or subsequent treatment: Surgery	% cancer patients starting subsequent surgical treatment within 31 days	Green if latest month >=94%, Red if latest month <94%.	NHS England, NHS Improvement and contractual requirement
Operational Performance	Cancer - 31 day wait for second or subsequent treatment: Anti-Cancer drug	% cancer patients starting subsequent anti-cancer drug treatment within 31 days	Green if latest month >=96%, Red if latest month <96%.	NHS England, NHS Improvement and contractual requirement
Operational Performance	Cancer - 62 day wait for first treatment from urgent GP referral to treatment	% cancer patients starting first treatment within 62 days of urgent GP referral	Green if latest month >=85%, Red if latest month <85%.	NHS England, NHS Improvement and contractual requirement
Operational Performance	Cancer - 62 day wait for first treatment from consultant screening service referral	% cancer patients starting first treatment within 62 days of referral from a consultant screening service	Green if latest month >=90%, Red if latest month <90%.	NHS England, NHS Improvement and contractual requirement
Operational Performance	Cancer - 62 day wait for first treatment from consultant upgrade	% cancer patients starting first treatment within 62 days of consultant upgrade	Green if latest month >=85%, Red if latest month <85%.	NHS England, NHS Improvement and contractual requirement
Operational Performance	GP OOH - NQR 9	% telephone clinical assessments for urgent cases that are carried out within 20 minutes of call prioritisation	Green if latest month >=95%, Red if latest month <95%.	Contractual requirement
Operational Performance	GP OOH - NQR 12	% face to face consultations started for urgent cases within 2 hours	Green if latest month >=95%, Red if latest month <95%.	Contractual requirement
Operational Performance	Children's Services - 10-14 day new birth visit	% new born visit within 14 days of birth	Green if latest month >=90%, Amber if between 75% and 90%, Red if <75%.	Contractual requirement
Operational Performance	Children's Services - 2.5 year review	% children who had a 2 and a half year review	Green if latest month >=90%, Amber if between 75% and 90%, Red if <75%.	Contractual requirement
Operational Performance	Community equipment - deliveries within 7 days	% standard items delivered within 7 days	Green if latest month >=95%, Red if latest month <95%.	Contractual requirement
Operational Performance	CQUIN - dementia screening	% emergency admissions aged 75+ who are screened for dementia within 72 hours of admission	Green if latest month >=90%, Red if latest month <90%.	CQUIN contractual requirement
Operational Performance	Recruitment to NIHR adopted research studies	No. patients recruited to trials	Green if above or on target, red if below target.	
Operational Performance	Directorate research activity	The number of studies within each of the directorates	to be agreed	

Data quality assessment

Green		No known issues of data quality - High confidence in data
Amber		On-going minor data quality issue identified - improvements being made/ no major quality issues
Red		New data quality issue/on-going major data quality issue with no improvement as yet/ data confidence low/ figures not reportable

Report to the Trust Board of Directors: 26 April 2017	**Paper No: 8.0**

Title	Finance Report
Sponsoring Director	Director of Finance
Author(s)	Finance Department
Report Purpose	Review of the Trusts financial position

Key Issues for Board Focus:

1. The Trust achieved a surplus of £3,688k for 2016/17.
2. Despite the financial pressures on the Trust, efficiency schemes were actioned to the targeted value.
3. The Trust reported a cash balance of £4.6m, £5.5m behind plan

Related Trust Objectives	
1. To deliver high quality care	Yes
2. To work with partners to deliver integrated care	Yes
3. To ensure clinical and financial sustainability	Yes

Risk and Assurance	There is a risk to delivery of the 2016/17 financial plan if budgetary control is not improved. Mitigation is in place through regular monthly monitoring, and discussions on improving this process are ongoing.
Legal implications/ Regulatory Requirements	

Action Required by the Board of Directors

The Board of Directors is asked to note the contents of this report

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March 2017 Financial Position

Financial Performance

- The Trust achieved a surplus of £3,688k for 2016/17. This position is summarised in the table below –

	Plan	Actual	Variance
Net Surplus (pre S&T)	2,200	238	-1,962
S&T funding	4,600	3,450	-1,150
Trust Position	**6,800**	**3,688**	**-3,112**
Consolidation of Charitable Funds	0	329	329
Group Position	6,800	4,017	-2,783

- Despite being behind plan, achievement of a surplus in what has been a challenging year reflects the hard work undertaken across all directorates. Aligned with the quality and operational performance across the Trust, this is an excellent achievement.

- Clearly the adverse position to the Trust plan carries forward risk into 2017/18. Work must continue to improve the current run rate to ensure we meet the control total set by NHS Improvement and receive further Sustainability and Transformation (S&T) funding.

- Across the Trust the CIP target for 2016/17 has been achieved. Details of this are included on page 7 and 8. The delivery of the Trust efficiency requirement is extremely positive. 26% of the schemes actioned were non recurrent, adding risk to the 2017/18 programme.

- Planning for 2017/18 efficiency programme is outlined on page 9 and 10. The level of risk contained in the current programme remains high and therefore focus is required on ensuring these schemes are fully developed and implemented.

- The Trust year end cash balance was £4.6m. This is £5.5m behind plan. Although there is a link to the Trusts financial performance, there is a significant number of outstanding debts. Work is being undertaken to address this. More detail on the cash position is outlined on page 11.

Financial Position Cont.

NHS Improvement Use of Resource Metric

- From 1st October 2016, NHS Improvement introduced the Single Oversight Framework. As part of this the Use of Resource Metric was introduced to replace the previous Financial Sustainability Risk Rating (FSRR). This is the product of five elements which are rated between 1 (best) to 4. The Trust position for February is outlined below.

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

- The improvement to a rating of 1 from last month is positive. As mentioned on page 1 work must continue to improve the run rate as clearly the I&E position will impact on the above ratings. The Board is asked to confirm and approve the financial return and associated Use of Resource metric that will be submitted for quarter 4.

Annual Plan

- As previously outlined to the Board, an updated annual plan for 2017/18 was submitted to NHS Improvement at the end of March. This included updated activity profiles and confirmation of improvement trajectories, a requirement of the planning process.

Financial Position Cont.

Summary Income & Expenditure 2016/17

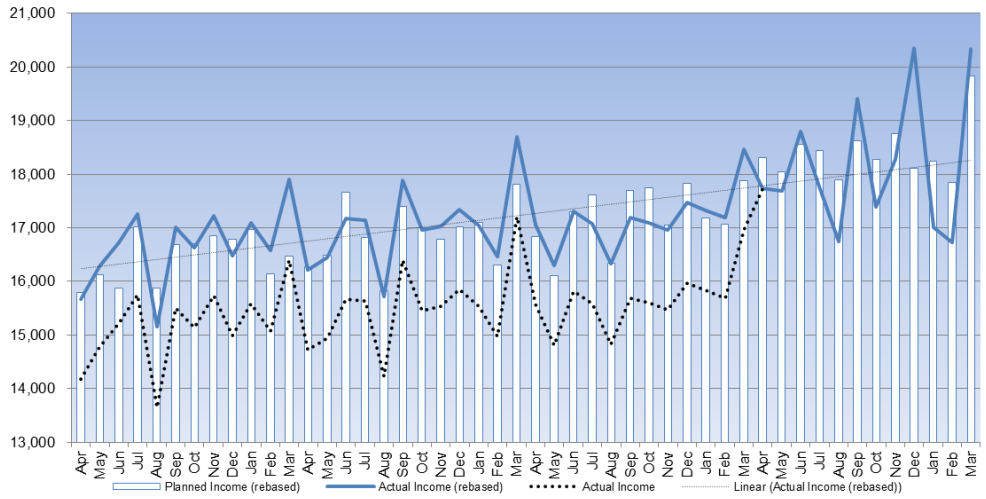
For the month ending 31st March 2017

	Budget		Actual	Cumulative	Change in
	Annual Budget £000	Proportion To Date £000	To Date £000	Variance £000	Variance £'000
INCOME					
NHS Clinical Income (Commissioners)					
NHS Clinical Income - Acute	143,286	143,286	140,744	(2,542)	(188)
NHS Clinical Income - Community	55,163	55,163	54,797	(366)	76
System Resilience & Better Care Funding	561	561	561	0	1
Non NHS Clinical Income					0
Private Patient & Amenity Bed Income	1,922	1,922	1,468	(455)	(38)
Other Non-Protected Clinical Income (RTA)	523	523	548	25	66
Other Income					0
Non Clinical Income	14,220	14,220	14,668	448	198
Hosted Services	522	522	1,079	557	84
TOTAL INCOME	**216,198**	**216,198**	**213,864**	**(2,333)**	**199**
EXPENSES					
Pay					
Pay Expenditure	(152,847)	(152,847)	(151,795)	1,052	(10)
Non Pay					0
Drugs	(14,116)	(14,116)	(14,061)	55	49
Clinical Services & Supplies	(17,678)	(17,678)	(17,764)	(87)	(50)
Other Costs	(20,342)	(20,342)	(22,099)	(1,758)	156
					0
Reserves	(700)	(700)	0	700	236
Other Finance Costs	(18)	(18)	(8)	10	1
Hosted Services	(522)	(522)	(516)	6	13
TOTAL COSTS	(206,222)	(206,222)	(206,243)	(21)	396
EBITDA	**9,976**	**9,976**	**7,622**	**(2,355)**	**595**
Profit / (Loss) on disposal of assets	0	0	0	0	0
Depreciation	(5,081)	(5,081)	(4,657)	424	(53)
Interest Payable	(90)	(90)	(233)	(143)	(23)
Interest Receivable	41	41	16	(25)	(3)
Dividend Payable	(2,646)	(2,646)	(2,746)	(100)	41
Net Surplus/(Deficit) before donations and impairmen	**2,200**	**2,200**	**2**	**(2,198)**	**557**
Donated Asset Income	0	0	236	236	33
Net Surplus/(Deficit)	**2,200**	**2,200**	**238**	**(1,962)**	**590**
Sustainability and Transformation Fund	4,600	4,600	3,450	(1,150)	(383)
Trust Total Surplus/(Deficit)	**6,800**	**6,800**	**3,688**	**(3,112)**	**207**
Consolidation of Charitable Fund Accounts	0	0	329	329	329
Consolidated Net Surplus/(Deficit)	**6,800**	**6,800**	**4,017**	**(2,783)**	**536**

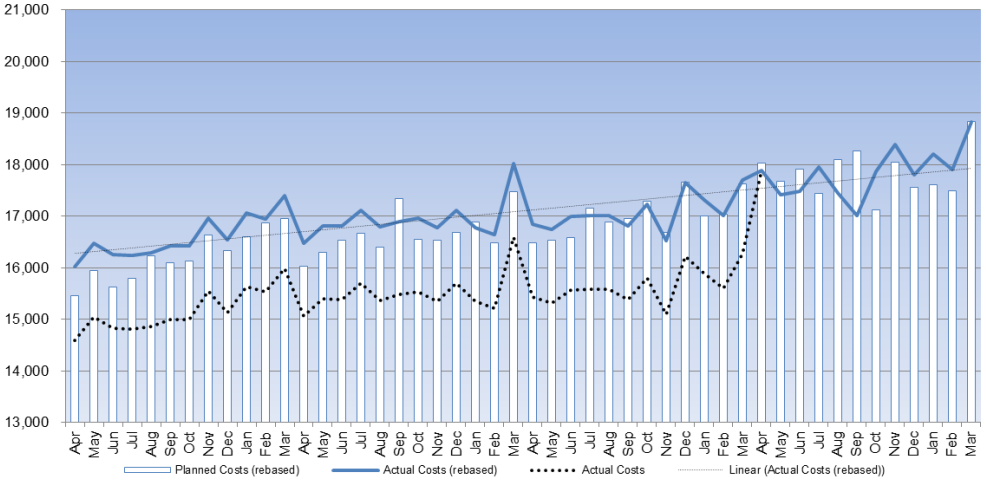
Negative sign under variance indicates an UNDER-recovery of forecast income, or an OVER-spending against budget

Financial Position Cont.

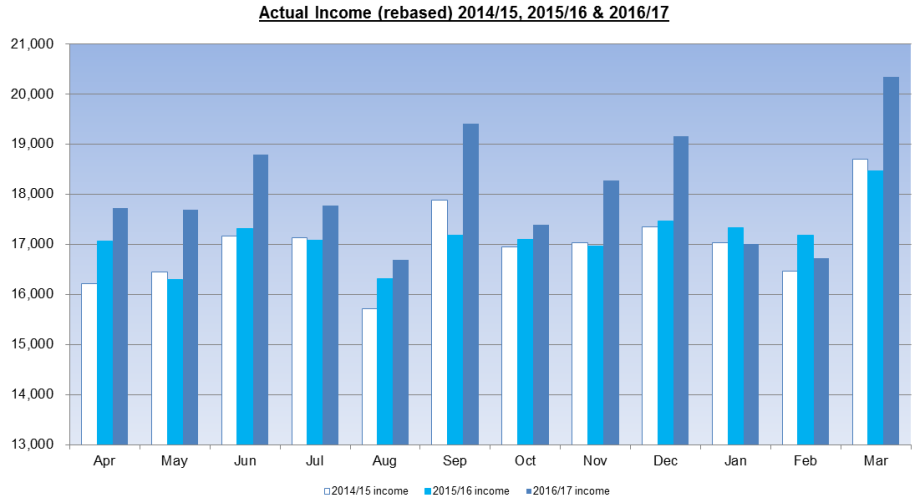
Planned and Actual Income Apr 2013 - Mar 2017 (rebased for new contracts)

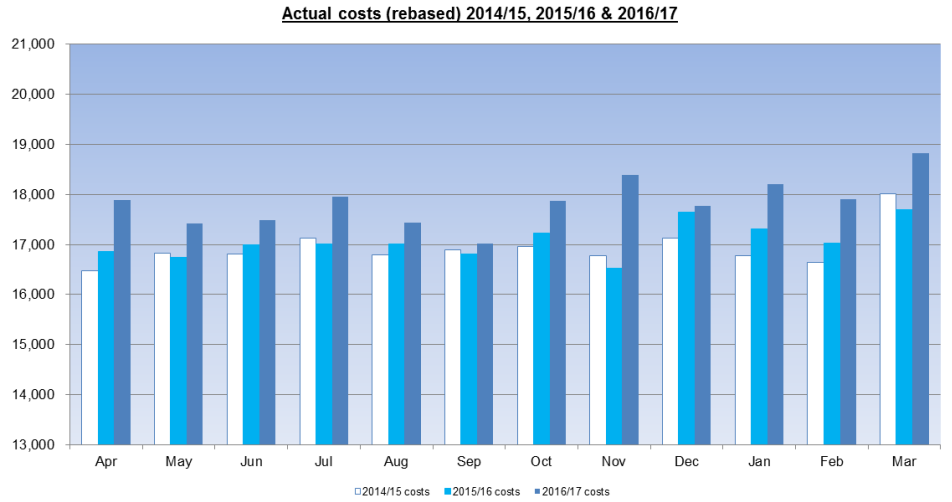


Planned and Actual Costs Apr 2013 - Mar 2017 (rebased for new contracts)



Financial Position Cont.

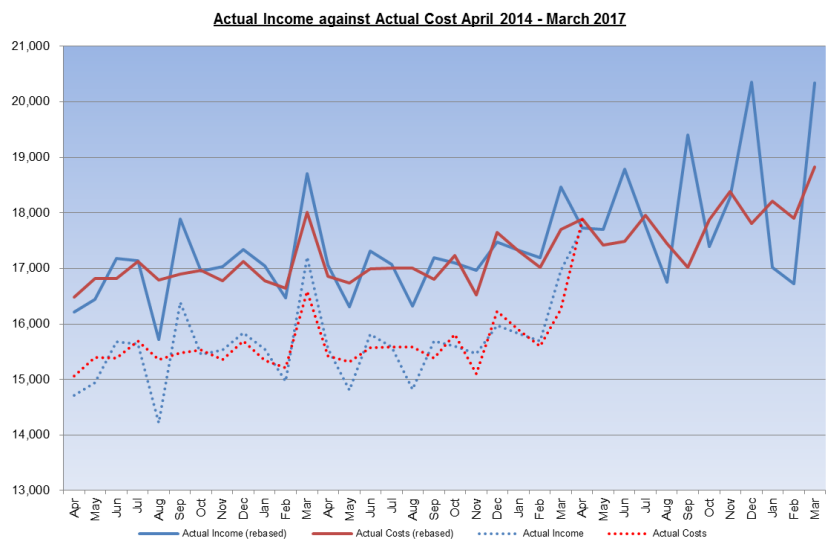


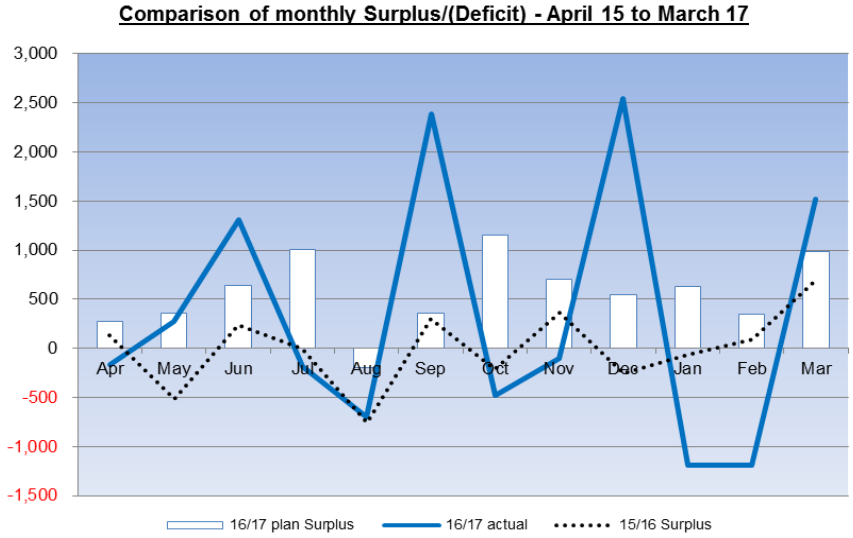


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2014/15 income plan	14,779	14,981	16,165	15,325	14,332	15,901	15,506	15,293	15,523	15,606	14,809	16,305
2014/15 income actual	14,717	14,945	15,674	15,637	14,221	16,388	15,451	15,533	15,845	15,539	14,967	17,201
2014/15 variance	**-62**	**-36**	**-491**	**312**	**-111**	**487**	**-55**	**240**	**322**	**-67**	**158**	**896**
2014/15 % variance	-0.4%	-0.2%	-3.0%	2.0%	-0.8%	3.1%	-0.4%	1.6%	2.1%	-0.4%	1.1%	5.5%
2015/16 income plan	15,335	14,610	15,799	16,105	14,830	16,202	16,245	15,554	16,329	15,677	15,560	16,385
2015/16 income actual	15,564	14,802	15,810	15,578	14,826	15,689	15,595	15,467	15,968	15,828	15,686	16,967
2015/16 variance	**229**	**192**	**11**	**-527**	**-4**	**-513**	**-650**	**-87**	**-361**	**151**	**126**	**582**
2015/16 % variance	1.5%	1.3%	0.1%	-3.3%	0.0%	-3.2%	-4.0%	-0.6%	-2.2%	1.0%	0.8%	3.6%
2016/17 income plan	18,302	18,042	18,556	18,447	17,898	18,625	18,270	18,750	18,107	18,235	17,849	19,824
2016/17 income actual	17,733	17,695	18,792	17,770	16,750	19,407	17,389	18,280	20,352	17,014	16,721	20,339
2016/17 variance	**-569**	**-346**	**236**	**-678**	**-1,149**	**782**	**-881**	**-470**	**2,245**	**-1,221**	**-1,128**	**515**
2016/17 % variance	-3.1%	-1.9%	1.3%	-3.7%	-6.4%	4.2%	-4.8%	-2.5%	12.4%	-6.7%	-6.3%	2.6%

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2014/15 expenditure plan	14,602	14,875	15,107	15,236	14,983	15,912	15,128	15,105	15,268	15,465	15,052	16,051
2014/15 expenditure actual	15,058	15,394	15,387	15,695	15,362	15,476	15,533	15,358	15,695	15,346	15,214	16,591
2014/15 variance	**456**	**519**	**280**	**459**	**379**	**-436**	**405**	**253**	**427**	**-119**	**162**	**540**
2014/15 % variance	3.1%	3.5%	1.9%	3.0%	2.5%	-2.7%	2.7%	1.7%	2.8%	-0.8%	1.1%	3.4%
2015/16 expenditure plan	15,052	15,109	15,164	15,739	15,466	15,536	15,874	15,267	16,229	15,581	15,615	16,204
2015/16 expenditure actual	15,427	15,314	15,572	15,584	15,584	15,384	15,807	15,099	16,222	15,890	15,597	16,275
2015/16 variance	**375**	**205**	**408**	**-155**	**118**	**-152**	**-67**	**-168**	**-7**	**309**	**-18**	**70**
2015/16 % variance	2.5%	1.4%	2.7%	-1.0%	0.8%	-1.0%	-0.4%	-1.1%	0.0%	2.0%	-0.1%	0.4%
2016/17 expenditure plan	18,030	17,684	17,913	17,442	18,093	18,272	17,119	18,051	17,557	17,604	17,499	18,843
2016/17 expenditure actual	17,895	17,423	17,482	17,959	17,444	17,017	17,872	18,387	17,807	18,207	17,908	18,823
2016/17 variance	**-136**	**-262**	**-430**	**518**	**-649**	**-1,255**	**753**	**336**	**251**	**603**	**409**	**-20**
2016/17 % variance	-0.8%	-1.5%	-2.4%	3.0%	-3.6%	-6.9%	4.4%	1.9%	1.4%	3.4%	2.3%	-0.1%

Financial Position Cont.





	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2014/15 income	14,717	14,945	15,674	15,637	14,221	16,388	15,451	15,533	15,845	15,539	14,967	17,201
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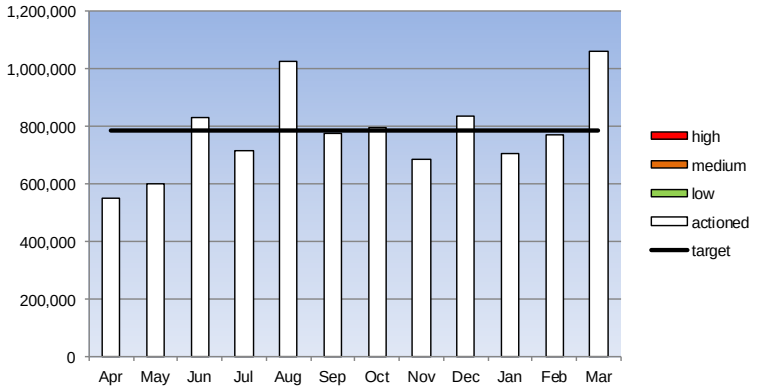
2015/16 costs	15,427	15,314	15,572	15,584	15,584	15,384	15,807	15,099	16,222	15,890	15,597	16,275
2016/17 costs	17,895	17,423	17,482	17,959	17,444	17,017	17,872	18,387	17,807	18,207	17,908	18,823
14/15 Surplus	-341	-449	287	-58	-1,141	912	-82	175	150	193	-247	610
15/16 Surplus	137	-512	238	-6	-758	305	-212	368	-254	-62	90	693
16/17 Surplus	-162	273	1,309	-190	-694	2,391	-483	-107	2,545	-1,194	-1,187	1,516

2016/17 Efficiency Performance

Positive overall performance

Risk moving into 2017/18

Trustwide Cost Improvement Programme 2016/17

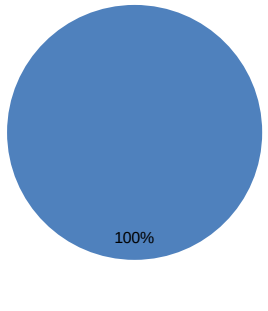


Summary	Target	Actioned	Low	Medium	High	Total	Total %age	Risk Adjust	Risk Adj %age
Trustwide	9,400,000	9,426,200	0	0	0	9,426,200	100%	9,426,200	100%
		% age of target	0%	0%	0%				

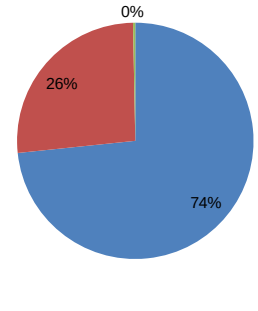
Top 10 unactioned schemes Top 10 as % of schemes - 0%

No.	Scheme	Value	Risk
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

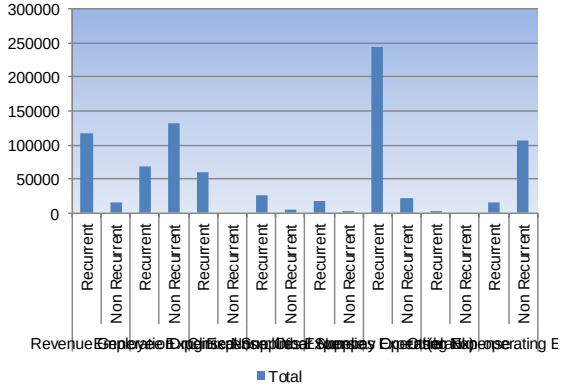
CIP schemes by Risk



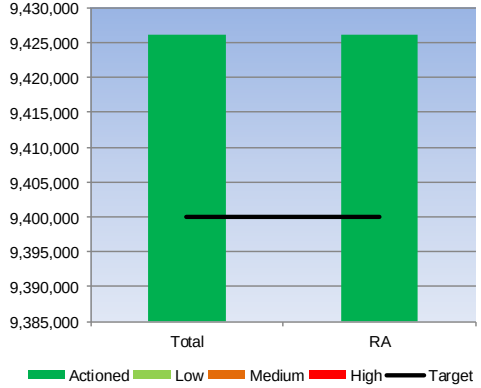
Recurrent V Non Recurrent Plans



Efficiency Category



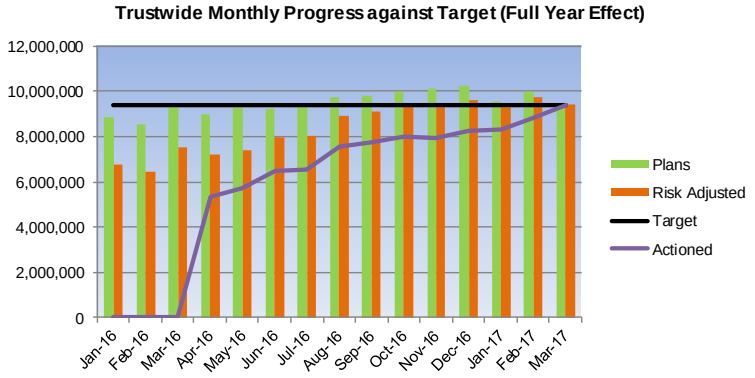
Risk Profile

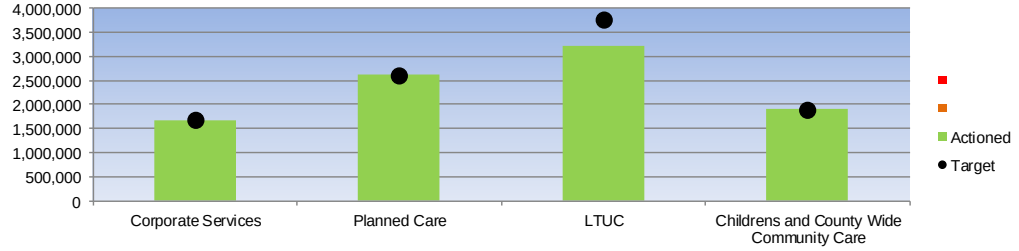


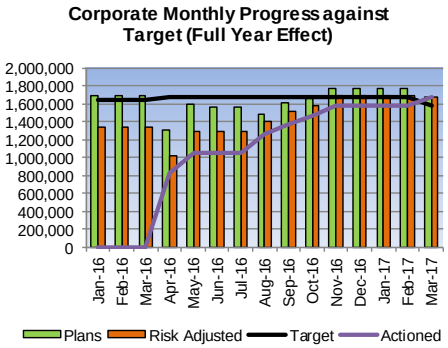
2016/17 Efficiency Performance

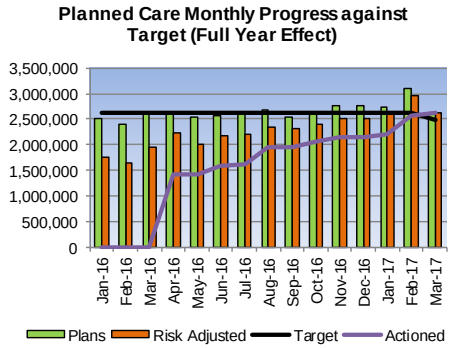
Trustwide Cost Improvement Programme — 2016/17

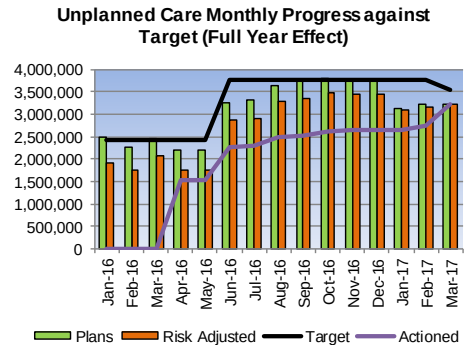
Summary	Target	Target Adjusted	Actioned			Total	Total %age	Risk Adjust	Risk Adj %age
Corporate Services	1,675,100	1,580,251	1,675,100			1,675,100	106%	1,675,100	106%
Planned Care	2,620,400	2,472,026	2,620,400			2,620,400	106%	2,620,400	106%
LTUC	3,761,800	3,548,797	3,224,600			3,224,600	91%	3,224,600	91%
Childrens and County	1,906,900	1,798,926	1,906,100			1,906,100	106%	1,906,100	106%

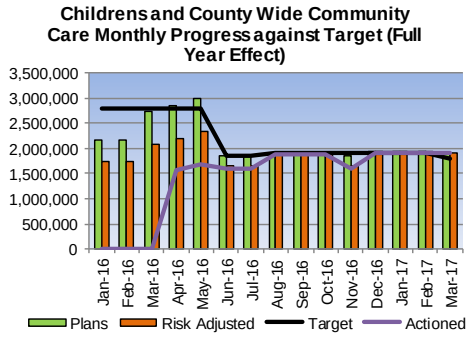


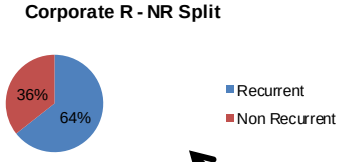


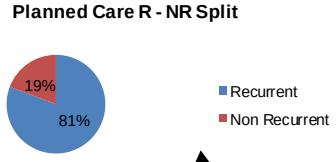


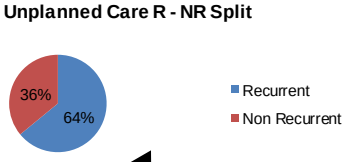


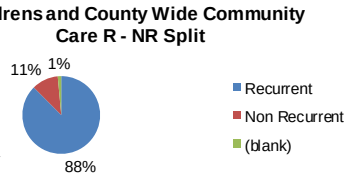








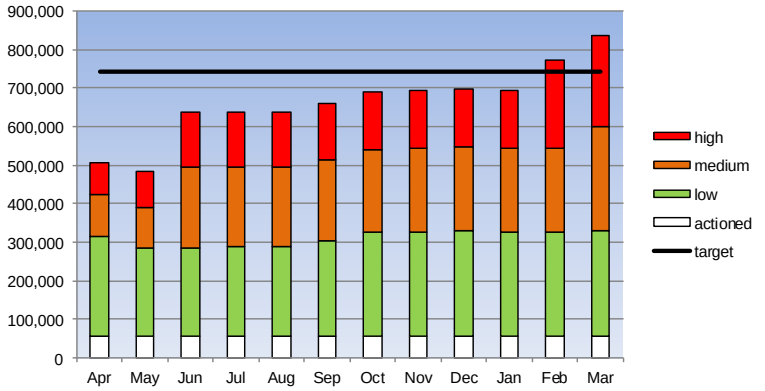




Proportions of non recurrent achievement have increased – potential pressure for 2017/18

2017/18 Efficiency Planning

Trustwide Cost Improvement Programme 2017/18

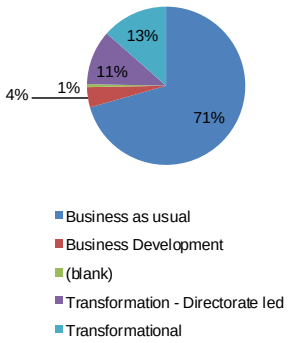


Summary	Target	Actioned	Low	Medium	High	Total	Total %age	Risk Adjust	Risk Adj %age
Trustwide	8,900,000	669,010	3,975,115	2,410,389	2,359,676	9,414,190	106%	6,845,615	77%
	% age of target	45%	27%	27%					

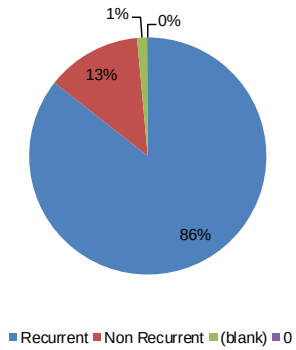
Top 10 unactioned schemes Top 10 as % of schemes - 29%

No.	Scheme	Value	Risk
1	Internal Bank plans	471,000	High
2	Vacancy Factor	291,400	Low
3	Non Recurrent Schemes carried forward	271,200	Low
4	Transformation - discharge	250,000	Medium
5	Transformation - inpatient flow	250,000	Medium
6	Pathology review	250,000	Low
7	Transformation - SAFER	250,000	Medium
8	Outliers	250,000	Medium
9	Review of Recruitment Process	240,000	Medium
10	CTB - Theatre utilisation	208,333	High

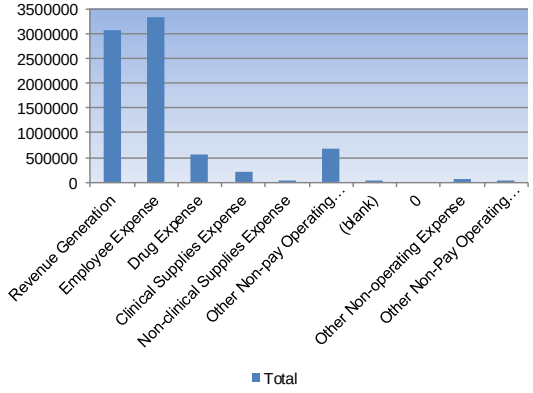
CIP schemes by internal category



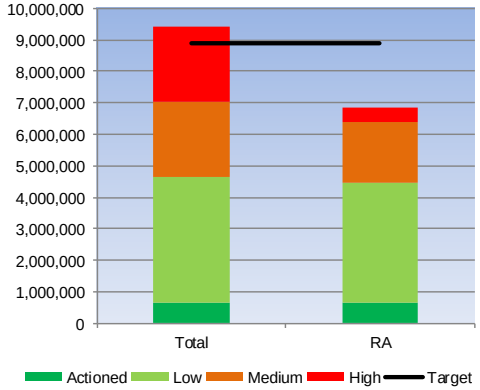
Recurrent V Non Recurrent Plans



Efficiency Category

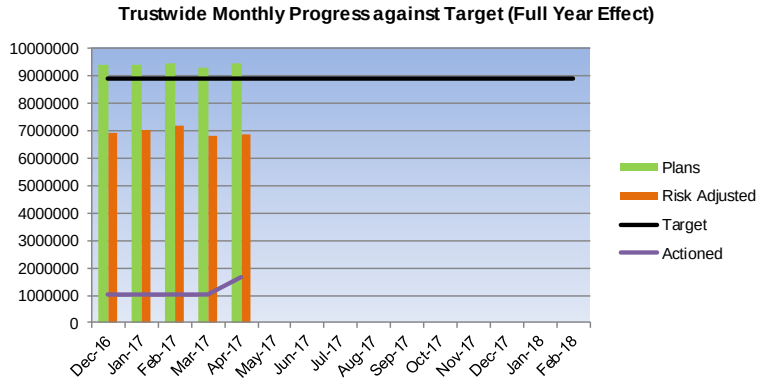


Risk Profile

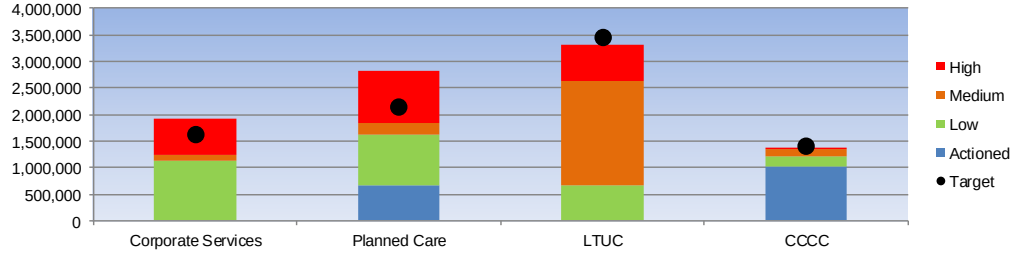


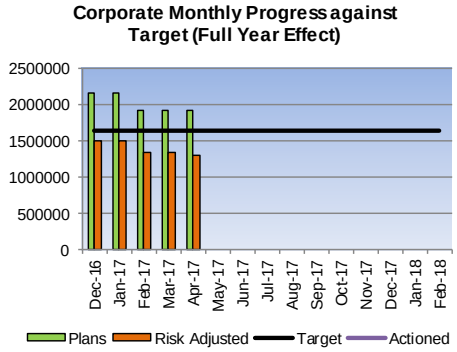
2017/18 Efficiency Planning

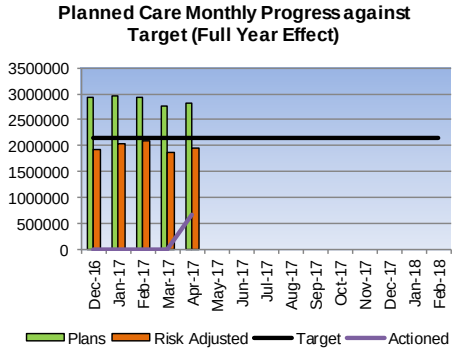
Trustwide Cost Improvement Programme 2017/18

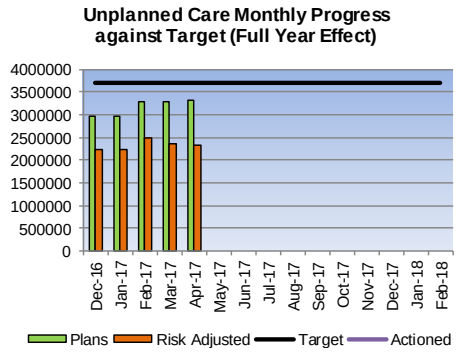


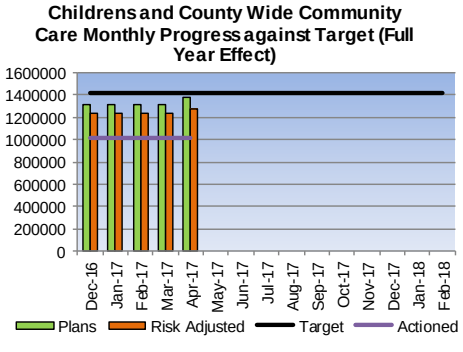
Summary	Target	Actioned	Low	Medium	High	Total	Total %age	Risk Adjust	Risk Adj %age
Corporate Services	1,633,000	0	1,121,760	108,700	686,200	1,916,660	117%	1,289,872	79%
Planned Care	2,155,000	669,010	957,481	223,900	968,276	2,818,667	131%	1,951,392	91%
LTUC	3,450,100	0	680,000	1,937,400	685,200	3,302,600	96%	2,332,960	68%
CCCC	1,417,000	1,014,946	200,928	140,389	20,000	1,376,263	97%	1,271,391	90%

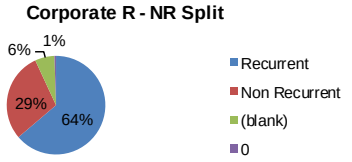


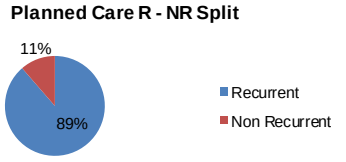


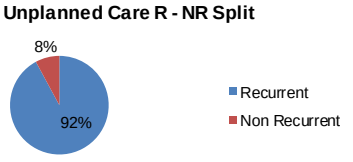


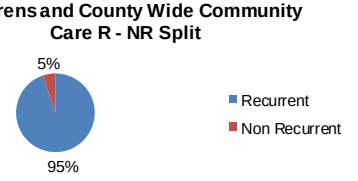






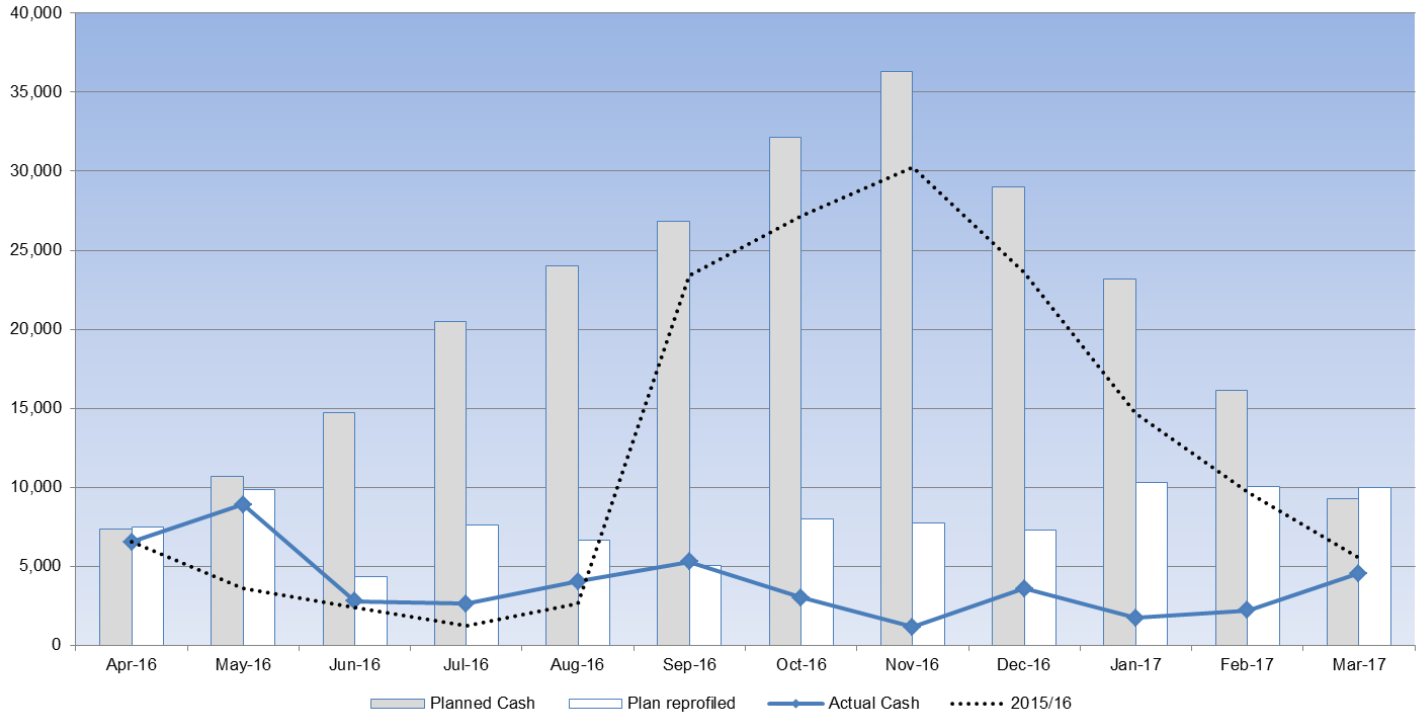






2016/17 Cash Position

- The Trust reported a cash balance of £4.6m in March, £5.5m behind plan. The monthly position is outlined in the graph below.



- Clearly the financial position of the Trust and subsequent impact on S&T funding has caused part of this variance. As well as this there remains a high level of outstanding debts. Actions are continuing in this area to improve the position. Key to this has been a agreed contract profile for 2017/18 with NHS Harrogate and Rural District CCG to support the current trading position.

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Harrogate and District NHS
NHS Foundation Trust

Report to the Trust Board of Directors: 26 April 2017	Paper No: 9.0

Title	**Chief Operating Officer's Report**
Sponsoring Director	Mr Robert Harrison, Chief Operating Officer
Author(s)	Ms Rachel McDonald, Head of Performance & Analysis Mr Jonathan Green, Information Analyst Specialist
Report Purpose	To provide the Board with an update on operational issues during the period for information

Key Issues for Board Focus:

The Board of Directors are asked to note that:

- Provisional results from the national Emergency Department Survey have been published by Picker. A summary is contained within this report.
- The Trust achieved the 4 hour Emergency Department standard for Q4 2016/17 and delivered a cumulative position of 95.1% for the year.
- The Trust has been working with other local Trusts to look at the reporting of inter provider cancer pathways, in light of new guidance recently published by NHS England.

Related Trust Objectives

To deliver high quality care	Yes – the report provides updates to the Board on progress with regard to work to improve the efficiency and effectiveness of high quality care deliver within the Trust. The report provides detail on operational issues and delivery against national performance standards.
To work with partners to deliver integrated care	Yes – the report provides updates on the collaborative work with partners across the region and our commissioners to improve delivery of care and treatment to patients.
To ensure clinical and financial sustainability	Yes – the report provides the Board with assurance on progress of work across the region to ensure sustainable delivery of clinical models across the system.
Risk and Assurance	Risks associated with the content of the report are reflected in the Board Assurance Framework via: BAF 4: risk of a lack of interoperable systems across New Care Models partners; BAF 9: risk of a failure to deliver the operational plan; BAF 10: risk of a breach of the terms of the NHS Provider licence; BAF 16: risk to delivery of integrated care models.
Legal/regulatory implications	The report does not highlight any legal/regulatory implications for the period.

Action Required by the Board of Directors

The Board of Directors are asked to receive and note the content of the report.

1.0 NATIONAL EMERGENCY DEPARTMENT SURVEY 2016

Picker shared the provisional results of the 2016 Emergency Department survey with trusts in April. Picker was commissioned by 75 UK trusts to undertake the Emergency Department Survey 2016, which is 55% of all eligible Trusts in England. The survey is based on a random sample of patients who attended Emergency Department(s), including Minor injury Units, in September 2016. The CQC report, which unlike the Picker report is based on standardised data and will include all Trusts in the country, will be published in the next few months.

A total of 1,182 eligible patients from HDFT were asked to participate in the survey, of which 420 returned a completed questionnaire, giving a response rate of 36%. This compares to an average response rate of 26% for the 75 'Picker Trusts'.

The survey was last conducted in 2014. For the 35 survey questions that were included in both the 2014 and 2016 survey, HDFT performed "significantly better than average" for 33 out of 35 questions. Two questions were rated as "average" and none were "significantly worse than average".

When compared to the last survey in 2014, HDFT has seen significant improvements in seven questions and there were no questions that were significantly worse than the 2014 survey.

The survey has highlighted the many positive aspects of the patient experience:

- Overall - 92% of patients scored 7+ out of 10.
- Overall - patients felt treated with respect and dignity - 88%.
- Doctors/nurses - always had confidence and trust - 85%.
- The Accident and Emergency Department was fairly clean/very clean - 99%.
- Received test results before leaving the trust - 80%.
- Care: always enough privacy when being examined or treated - 89%.

2.0 EMERGENCY DEPARTMENT PERFORMANCE

The Trust achieved the 4 hour Emergency Department standard for Q4 2016/17 and delivered a cumulative position of 95.1% for the year. The performance in March was the highest of any month in 2016/17 at 97.2%. This performance improvement was supported by the WYAZ (West Yorkshire Acceleration Zone) schemes, many of which came into effect in March, specifically the additional cubical capacity in the Emergency Department. The 'Every Hour Matters' week at the start of the month also helped improve focus on patient flow and provided some valuable learning.

3.0 CANCER SERVICES

<u>Consultant Oncologist</u>

The Board is aware of the continuing inability to recruit to substantive Consultant Oncologist posts; this is a national issue which is having a significant impact locally. The Trust had 1 WTE vacancy which it has been unable to fill as part of the Alliance with York for a number of years. The situation has been compounded further by the imminent departure of the full time Consultant Oncologist who is leaving the Trust at the end of April to work in Leeds. This has a potential impact upon activity and the ability to manage the Trust's Acute Oncology Service as the only substantive staff will be those who are shared with York and visit the Harrogate site to provide specific clinics. To mitigate this risk, an agency Consultant Oncologist has been appointed and will be joining the Trust in May. The service is working with Leeds and York to ensure that the agency

consultant is well supported and that we are able to continue to provide the current level of service to our patients.

62 Day Performance Reporting

The Trust has been working with other local Trusts to look at the reporting of inter provider cancer pathways, in light of new guidance recently published by NHS England. Many cancer pathways involve two or more acute providers. Current cancer waiting times reporting automatically allocates equal accountability for shared pathways between the provider of the 'first seen' appointment and the 'treating' provider, irrespective of where the majority of delay to the patient's pathway occurs.

A National Cancer Breach Allocation Policy was published by NHS England in April 2016 with the aim of providing a fairer method of cancer breach allocation when treatment is delayed between referring and treating providers. The national policy recommends a collaborative approach at local network level in order to support the development of local breach allocation polices alongside agreement of the minimum data sets required to define a single clear handover date for the transfer of patient care. Analysis of performance in 2016/17 demonstrates that the impact of inter provider pathways on performance for smaller acute providers such as HDFT is minimal, whereas the impact on the larger specialist centres is more pronounced.

In response to the national policy document, an Inter Provider Transfer (IPT) Operating Framework has been developed by Leeds Teaching Hospitals. This framework covers all cancers and organisations in the region and the implications arising from the adoption of this framework will be taken forward through the West Yorkshire Cancer Alliance (WYCA).

In March, the proposed regional framework was discussed at a meeting attended by representatives from all WYCA providers, and the recommendation was for continued monitoring of re-allocation performance over the next few months (i.e. reporting performance in shadow form). Alongside this, the plan is to collate all WYCA performance data in order to identify those pathways where performance is poor regionally. By understanding common themes where shared pathways are delayed, the aim would be to develop a more collaborative approach to the delivery of care for all cancer patients in our region.

4.0 SERVICE REVIEWS AND MOBILISATION

The Children's and County Wide Directorate are trialling a new approach to service reviews which the Operational Director has used in previous roles. The Chronic Pain and Fatigue Team launched their service review this month with support from the service improvement facilitator and the options paper is hoped to be developed by mid-July. Similarly, the Speech and Language Therapy Service will start their service review process and methodology on 20 May 2017. This approach will be reviewed and may then be utilised further for other service areas.

Podiatry services, alongside the Business Development Team, are continuing to work intensively to ensure that the new contract for podiatry for Scarborough & Rydale and Vale of York is fully mobilised for 1 May 2017.

5.0 SERVICE ENGAGEMENT

County Durham Children's Services recently had a "management take over day" where 15 to 18 clinical staff took on the roles of a manager and worked through a number of pre-prepared issues and challenges set by services. This was facilitated by the commissioner and the outcomes will inform commissioning decisions and service improvement initiatives. Similarly, the Specialist Children's Services held a highly creative service development session to ensure a "one team" approach which received an excellent evaluation.

6.0 SERVICE ACTIVITY

Variances above or below 3% are as follows – at the end of March, new outpatient activity was 3.3% below plan, elective admissions were 9.9% below plan, and ED attendances were 3.9% below plan. In 2016/17 there has been an increase in all areas of activity when compared to the previous year (new outpatients - 3.2%, follow up outpatients - 3.3%, elective admissions - 1.6%, non-elective admissions - 4.8%, ED attendances - 1.6%).

For Leeds North CCG, new outpatient activity was 18.7% above plan, follow-up outpatient activity was 5.8% above plan, non-elective admissions were 5.7% above plan, and ED attendances were 9.3% below plan. In 2016/17 there has been an increase in all areas of activity when compared to the previous year, apart from ED (new outpatients – 6.1%, follow up outpatients – 5.5%, elective admissions – 4.0%, non-elective admissions – 1.6%, ED – down by 6.7%).

Harrogate and District NHS
NHS Foundation Trust

Report to the Trust Board of Directors: 26 April 2017	Paper No: 10.0

Title	**Workforce and Organisational Development Update**
Sponsoring Director	Mr Phillip Marshall, Director of Workforce and Organisational Development
Author(s)	Mr Phillip Marshall, Director of Workforce and Organisational Development
Report Purpose	To provide a summary of performance against key workforce matters
Key Issues for Board Focus: **1. Recruitment and Retention update** **2. Investors in People – Bronze Award** **3. NHS Workforce matters related to the Five Year Forward View** **4. Recruitment of the Chair and Non-Executive Director**	
Related Trust Objectives	
1. To deliver high quality care	Through the pro-active management and development of the workforce, including recruitment, retention, the introduction of new roles/skills and staff engagement.
2. To work with partners to deliver integrated care	Working with external organisations (local, national and international) including NYCC, Health Education England, Higher and Further Education institutions and NHS Employers, to provide a qualified and professional workforce fit to deliver services.
3. To ensure clinical and financial sustainability	By seeking to recruit and retain our workforce to full establishment and minimise the use of agency staff, and continuously improve the health and wellbeing of our workforce.
Risk and Assurance	Any identified risks are included in the Directorate and Corporate Risk Registers and the Board Assurance Framework.
Legal implications/ Regulatory Requirements	Health Education England and the Local Education and Training Board have access to the Trust's workforce data via the Electronic Staff Records system. Providing access to this data for these organisations is a mandatory requirement for the Trust.
Action Required by the Board of Directors The Board is asked to **note** and comment on the update on matters specific to Workforce, Training and Education, Service Improvement and Innovation and Organisational Development.	

a) Recruitment and Retention

The Trust's Recruitment and Retention Working Group is continuing efforts to increase the number of registered nurses employed by the Trust, whilst supporting wards to improve the retention on their wards.

During the past year the Trust has attended a series of university careers fairs and a Royal College of Nursing jobs fair in Glasgow. These events, combined with monthly HDFT recruitment evenings, continuous NHS jobs adverts and the progressive development of social media platforms, has enabled the working group to both increase the number of student nurses offered a position at HDFT and increase the number of nurses starting with the Trust each month. In 2015, on average 2.3 Whole Time Equivalent (WTE) nurses commenced work each month: in 2016 this figure rose to 3.8.

At a recent 'Keep in Touch' event for student nurses, 19 of the 38 students offered a position at HDFT attended. This is higher than last year's attendance at the same event. The Trust will continue to support the student nurses offered a position with the Trust and will host a further event later in the year.

A specific Facebook campaign and recruitment evening schedule has been created to support the requirement for registered nurses on the elderly care wards. Named 'Later in Life' care team, the campaign targets students and nurses working in local care homes with direct messages and staff photographs promoting HDFT as a place of work. The recruitment evenings are structured around a series of talks conducted by HDFT staff, informing potential applicants about the opportunities available at HDFT including the Trust's approach to multi-disciplinary working.

Following the first 'Later in Life' recruitment evening, five of the nine applicants offered nursing positions with the Trust were for elderly care wards. All of those who attended the event stated they first heard of the campaign via Facebook. The second recruitment event is scheduled for 20 June.

b) Global Health Exchange Programme

The Global Health Exchange project is progressing following the first English language tests (IELTS) for all the nurses. Of the cohort of 10 nurses, one successfully passed all the required tests at the desired level. This applicant is currently preparing to take their NMC competency tests before applying to come to the UK, should they be successful.

Of the nine remaining nurses, two have undertaken a second English language test and are currently awaiting their results. The final seven nurses are undertaking a comprehensive training package to support them before embarking on their next IELTS test.

The Trust is currently working with Health Education England and Apollo Healthcare to identify a second cohort of potential nurse recruits to the scheme and arrange a date later in 2017 to conduct face-to-face interviews in India. Representatives from the Trust will also take the opportunity to meet with the nurses currently engaged in the project to discuss living and working in Harrogate.

c) Recruitment of Chair of the Trust

Applications for the role closed on 3 April and seven people applied. The interview panel delegated by the Nominations Committee met on 12 April and long-listed six out of the seven applicants. One of the long-listed candidates has subsequently withdrawn from the process. The remaining five candidates will now be interviewed by Gatenby Sanderson, the recruitment consultants retained by the Trust, and detailed reports will be prepared for the short-listing meeting of the interview panel on 2 May. The independent member of the interview panel, Mr Martin Havenhand, Chair of The Rotherham NHS Foundation Trust, will join the meeting by telephone.

Arrangements for the final interviews on 22 May have been agreed. Each candidate will make a presentation on an agreed topic to an audience composed of representatives from all parts of HDFT and in addition will attend two discussion groups with separate topics covering governance and external relationships. They will then be interviewed by the interview panel. Feedback from both the presentations and the discussion groups will be available to the interview panel before it makes a final decision on the candidates. It is intended to make a final selection with a view to ratification at an Extraordinary Council of Governors' meeting on 16 June.

d) Recruitment of new Non-Executive Director

A Nominations Committee meeting was held on 12 April to finalise the process for the replacement of Professor Sue Proctor as a Non-Executive Director, following her appointment as Chair of Leeds and York Partnership NHS Foundation Trust. The Governors approved the role description, ideal personal criteria and the wording of an advertisement, as well as the timetable for the appointment. The advertisements will be placed in the week commencing 24 April and interviews, including a focus group, are scheduled for Thursday 29 June. The selection will be ratified at a subsequent Extraordinary Council of Governors' meeting.

e) Job Planning

The latest job planning figures for Consultants and Specialty Doctor and Associate Specialist (SAS) grades as at 31 March 2017 are shown in the table below. Overall progress in completed job plans month on month is shown as a RAG rating. As last month there has been a slight increase in the overall percentage of doctors with job plans although the overall percentage remains below the required standard. Following a decision at the LNC on 12 March it is intended to apply the provisions of Schedule 15 of the Terms and Conditions of Service. Schedule 15 requires Consultants and SAS doctors to have a current job plan, appraisal and up to date mandatory and essential training record in order to receive their annual increment or to progress towards their pay threshold. The Job Planning Group meeting scheduled for 13 April was cancelled due to the low number of members available. Clinical Leads have been invited to the May meeting, primarily to discuss the proposed change of leave calculations for doctors to be based on PAs rather than days, as at present, and the allocation of time in job plans for administrative work arising from clinics.

APRIL 2017 JOB PLANNING CENTRAL REPORT - CONSULTANTS										
Directorate	**Number of Consultants**	**Job Plans within 12 months**	**%**	**Job Plans older than 12 months**	**%**	**Number of Consultant with no Job Plans recorded**	**%**	**In progress**	**Notes**	**RAG**
C & CWCC	10	9	90.00%	1	10.00%	0	0.00%	0	Ex Mat Lve	
LT & UC	59	43	72.88%	13	22.03%	3	5.08%	0		
P & SC	67	44	65.67%	22	45.90%	1	1.49%	0		
Total	**136**	**96**	**70.59%**	**36**	**26.47%**	**4**	**2.94%**	0		

APRIL 2017 JOB PLANNING CENTRAL REPORT - SAS GRADES										
Directorate	**Number of SAS Doctors**	**Job Plans within 12 months**	**%**	**Job Plans older than 12 months**	**%**	**Number of SAS Doctors with no Job Plans recorded**	**%**	**In progress**	**Notes**	**RAG**
C & CWCC	6	6	100.00%	0	0.00%	0	0.00%	0		
LT & UC	12	8	66.67%	1	8.33%	3	25.00%	0		
P & SC	35	7	35.30%	7	20.00%	21	60.00%	0		
Total	**53**	**21**	**39.62%**	**8**	**15.09%**	**24**	**45.28%**	0		

Change from previous month (in-date JPs)		**Improved**		**No change**		**Worse**				
Excludes locums, maternity leave, bank and new starters										

f) Sickness Absence

Sickness absence across the organisation has shown a significant increase for a further month in February and, at 4.57%, sits above the Trust target and above the position at an equivalent period during 2016. The year to date figure is 4.13%. This is the fourth month in a row that absence has shown an increase and with the exception of the Children's & County Wide Community Care Directorate, all Directorates have seen absence levels increase. The highest level of absence can be seen in Planned and Surgical Care, where absence is now being reported at 5.55%.

Whilst absence due to anxiety-related issues has decreased both proportionally and in terms of total hours lost, there has been a significant increase during February of absence due to Gastrointestinal issues – this had been observed anecdotally during the month and steps were immediately put in place to remind employees of the importance of infection control and following appropriate reporting procedures in relation to absences of this nature.

The Managing Attendance and Promoting Health & Wellbeing policy is currently under review at the Policy Advisory Group; once approved there will be an opportunity for a focus on a relaunch of the policy, awareness of the support available for staff and also encouragement for managers to act promptly in addressing concerns.

g) NHS Improvement Locum Agency Cost Target

The instruction from NHS Improvement (NHSI) issued at the end of February, for Trusts to require agencies supplying locum staff to ensure that those staff did not have substantive NHS contracts from 1 April, was communicated to those agencies supplying the Trust. This met a significant degree of resistance from the agencies, who had been otherwise informed that this was 'guidance' from NHSI. Despite agreement across the West Yorkshire and Harrogate STP being reached to implement the instruction, NHSI 'paused' the implementation nationally on 31 March. It is not clear at this stage whether the intention to reintroduce it later, after modification, is likely to be taken forward.

h) Investors in People (IiP) Bronze Award

Harrogate and District NHS Foundation Trust has been awarded Bronze accreditation against the Investors in People Standard, demonstrating its commitment to high performance through good people management.

Investors in People is the international standard for people management, defining what it takes to lead, support and manage people effectively to achieve sustainable results. It enables organisations to benchmark against the best in the business on an international scale.

The Trust has held Investors in People accreditation for six years. Accreditation is 'for life' subject to reviews at least every three years and the Trust was required to undergo a second review by 31 March 2017.

As part of the process, a sample of staff was selected at random and invited to attend an interview or focus group conducted by an external reviewer. The reviewer asked staff to discuss their role and responsibilities, learning and development, management effectiveness, recognition and communication and their views on these topics.

This is a Trust-wide achievement, not an individual one, so it is something for everyone to be proud of. The Trust should aspire for excellence every time – both for our patients and their families and carers and within our own organisation – and the Bronze IIP accreditation is a testament to this ambition.

Bronze accreditation represents a significant amount of development work by the Trust since our original achievement of the standard level of IiP accreditation. It is recognition of a significant change in the standard of our leadership and management practices and another step on the Trust's journey to reach the highest standard of IiP accreditation that is possible.

Paul Devoy, the Head of Investors in People, said: "We'd like to congratulate Harrogate and District NHS Foundation Trust, Investors in People accreditation is the sign of a great employer, an outperforming place to work and a clear commitment to success. The Trust should be extremely proud of their achievement."

Steve Burrows, Managing Director of Investors in People North of England said:
"This is a fantastic achievement for the Trust and I would like to congratulate all of the team. We believe that your people make the difference and by investing in them you are looking to create sustainable success. Investors in People is designed to help organisations and their people to realise potential, providing a simple road map for excellence. With their accreditation success, the Trust is certainly working to realise their people potential."

j) NHS Employers and the Five Year Forward View

NHS Employers has issued a brief on the NHS England report, *Next Steps for the Five Year Forward View*, which lays out the deliverables that will make the health and care service more sustainable for the future.

Importantly, it recognises the enormous pressure that staff are under and acknowledges the improvements in the engagement scores reported in the staff survey.

The document's principal focus is on the delivery of the previously outlined service priorities in emergency care, primary care, cancer, mental health and integration with a particular prioritisation of the delivery of urgent and emergency care (at the expense of elective care). This is supported by chapters on patient safety and a description of a 10-point efficiency plan for the NHS.

The plan reinforces the importance of the STP process and confirms that a number have been identified to implement new arrangements. These 'accountable care systems' will effectively bring to an end the purchaser/provider split in place since the late 1980s.

Key points for the NHS workforce:

- Continue to improve productivity and grow the frontline workforce, in particular in nursing, mental health, urgent and primary care. A clear message is given that there will be more registered nurses in 2020 than today, for health and social care.
- A ‘Nurse First’ programme, similar to the Teach First scheme, will encourage people to enter careers in nursing and will, in a very welcome move, prioritise access to roles in mental health and learning disability.
- New professional roles will continue to develop, including doubling the number of Nursing Associates to 2,000 this year and a commitment to invest in Physicians Associates. There is also a welcome emphasis on investment in advancing clinical practice, though this seems focused only on nursing at present. HEE will publish its workforce plan for the NHS in April.
- As announced by the Secretary of State in the autumn, undergraduate medical school places will grow by 25 per cent adding an extra 1,500 places, starting with 500 extra places in 2018.
- Specific staff shortages will be addressed, including:
    - emergency medicine
    - endoscopy
    - ultrasonography
    - radiology
- Action on NHS staff health and wellbeing will be extended, and the report proposes that all in 2017/18 trusts will have a plan in place to improve the health and wellbeing of their workforce.
- There will be a programme to support the 30 organisations with the biggest retention challenges. We look forward to sharing the experiences and lessons of our own programme with NHS Improvement colleagues.
- The efficiency plan (point 2) maintains the focus on agency use with a particular focus on reduction in medical locum spend. It also makes clear the importance (point 6) of reducing unwarranted clinical variation and maintains the focus on better planning of diagnostic services (point 7) and corporate services (point 8).

- Over the next two years, Trusts will need to show year-on-year improvements in closing the gap between white and BME staff being appointed from shortlisting, and reduce the level of BME staff being bullied by colleagues.
- Leading STPs and accountable care systems will work with staff and trade unions to encourage flexible working, and find ways to de-risk service change and support a proposed 'staff passport' to facilitate collaboration between primary and hospital care. We will work to co-ordinate this effort with national trade union colleagues.
- An NHS staff passport will enable and support team-based working, for example, by enabling nurses to work in both primary care and in hospital.
- £2bn of surplus NHS assets will, the efficiency plan makes clear (point 7), create investment to free-up land. We continue to argue that this focus must include greater provision of affordable housing for NHS staff, particularly in high-cost areas and believe that this will be reflected in the forthcoming 'Naylor Plan' for NHS Estates.
- The importance of the Developing People, Improving Care framework published before Christmas is stressed, with particular emphasis on greater local development, tackling discrimination, talent management and service improvement capability.

Doctors in training

- The plan summarises the range of actions that the NHS committed to in May 2016 and November 2015, as it sought to address the BMA JDC dispute. This includes confirmation of the steps that HEE is taking to improve deployment of doctors, which are awaited by employers also. Some additional investment in engagement with doctors in training is proposed, and we will argue for this to be placed in local employers.

The delivery plan places a greater focus on the NHS workforce than its predecessor document, though there is still much to do to ensure that this translates into consistent set of national priorities which best support employers.

Phillip Marshall
Director of Workforce and Organisational Development

April 2017

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Report to the Trust Board of Directors: 26 April 2017	**Paper No: 11.0**

Title	Chief Nurse Report
Sponsoring Director	Chief Nurse
Author(s)	Jill Foster, Chief Nurse
Report Purpose	To receive, note and approve the contents of the report.

Key Issues for Board Focus:

- Monitoring of nurse recruitment and retention continues to show a challenging but improving position
- Three follow up Patient Safety Visits have resulted in 'green' ratings. One follow up visit remains red.
- Complaints in the last two months have been higher than the average for the first 10 months of the year.
- a local CQUIN project to improve integration of services of the End of Life Care pathway has achieved its year end objectives

Related Trust Objectives	
1. To deliver high quality care	Yes – the report provides assurance that staffing levels are maintained throughout the Trust and the actions taken for areas where staffing levels have not been maintained
2. To work with partners to deliver integrated care	Yes – the report supports the Trust's objective to work with partners to improve quality of care at End of Life
3. To ensure clinical and financial sustainability	Yes – the report supports Trust's quality objective to ensure quality of care is not compromised to insufficient clinical staff

Risk and Assurance	Risks associated with the content of the report are reflected in the Board Assurance Framework via: BAF 1 : risk of a lack of medical, nursing and clinical staff; BAF 3: risk of failure to learn from feedback and incidents and BAF 13: risk of insufficient focus on quality in the Trust.
Legal implications/ Regulatory Requirements	No additional legal/regulatory implications for the period,

Action Required by the Board of Directors

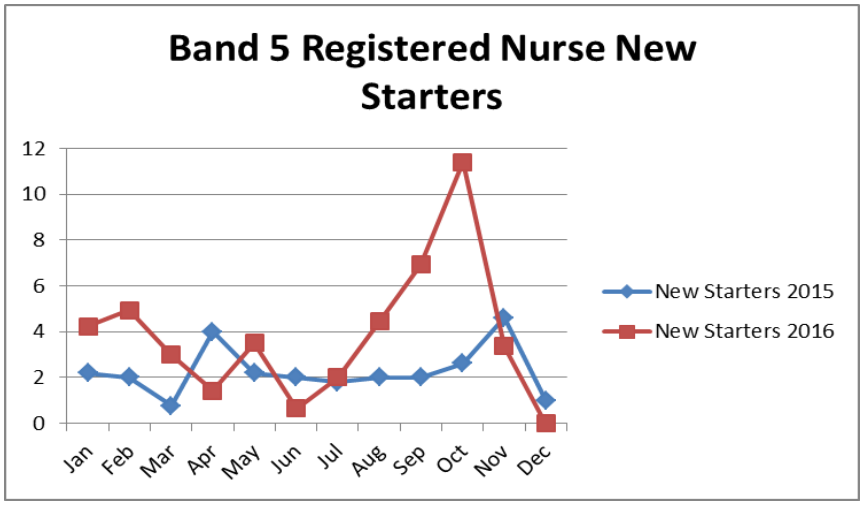
- Be **assured** by the monitoring of nurse recruitment and retention and the governance process for assuring safe staffing levels
- **Note** the results and changes to the reporting of Director Inspections
- **Note** the number of increased numbers of complaints received by the Trust in the last two months of the year.
- **Acknowledge** the excellent work to improve care at the End of Life
- Be **assured** there is a robust process to support nurse revalidation

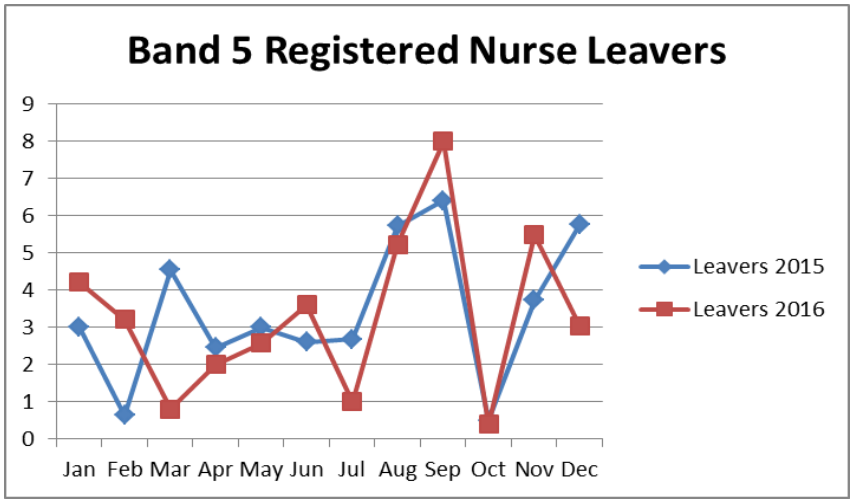
The Chief Nurse report provides an overview of care quality, activities underpinning care and assurances on staffing arrangements. More details on key performance metrics are provided in the Integrated Board Report.

1. Nurse Recruitment

1.1 I have reported throughout last year on the activities of the Trust's Recruitment and Retention working group. During the past year the Trust has attended a series of university careers fairs and a Royal College of Nursing jobs fair in Glasgow. These events, combined with monthly HDFT recruitment evenings, continuous NHS jobs adverts and the progressive development of social media platforms, has enabled the working group to both increase the number of student nurses offered a position at HDFT and increase the number of nurses starting with the Trust each month. This has ensured the number of nurses starting each month is consistently greater than those leaving every month. The tables and charts below represent the effect the recruitment campaign has had on Band 5 starters and leavers from 2015 to 2016.

	2015	2016
New Starters (WTE)	27.2	45.87
Average per Month	2.26	3.82
Leavers (WTE)	41.01	39.56
Average per Month	3.42	3.29





In 2015, on average 2.3 Whole Time Equivalent (WTE) nurses commenced work each month: in 2016 this figure rose to 3.8.

1.2 The current vacancies across wards and hospital departments are listed below.

Ward/Department	RN Vacancies
CATT	5.84
AMU	4.20
Granby	1.27
Oakdale	3.49
Byland	10.49
Jervaulx	10.34
Lascelles	0
Trinity	3.0
Emergency Department	0
Littondale	2.73
Nidderdale	2.13
Wensleydale	2.51
Farndale	2.55
Harlow	1.49
ITU	0
Main Theatres	25.0
Day Surgery	0
Woodlands	0
SCBU	0
Labour Ward	0
Pannal	0
total	75.04

1.3 These RN gaps, when rostered for shifts in inpatient areas for the next roster (14 May – 10 June 2017) result in 741 sessions which will require cover through a combination of additional hours, bank or agency use or bed reductions.

Ward	RN Gaps
CATT	131
AMU	73
Jervaulx	123
Byland	116
Oakdale	52
Granby	39
Trinity Ward	50
Lascelles	1
Farndale	62
Harlow	26
Wensleydale	26
Nidderdale	18
Littondale	24
TOTAL	741

Actions being taken to mitigate the risk of the number of gaps in next month's roster:

- Maximise effective rostering
- All shifts out to NHSP and agencies within cap
- All shift gaps published at ward level
- Incentive scheme offered
- Staffing gaps reviewed daily and staff moved to minimise risk
- Bed closures where feasible

In addition to actual vacancies there are additional gaps due to maternity leave and sickness absence.

2 Actual versus planned Nurse Staffing - Inpatient areas

2.1 The government response to the Francis Report 'Hard Truths: the journey to putting patients first' led to fundamental changes in how NHS Providers Boards are expected to assure they are making safe staffing decisions. The National Quality Board (NQB) in November 2013 set out these expectations in relation to getting nursing, midwifery and care staffing right by providing a clear governance and oversight framework which require NHS Provider Boards to receive monthly information regarding actual versus planned nurses staffing levels. The NQB has updated its guidance in July 2016 and this remains a requirement. Therefore the monthly actual versus planned nurse staffing levels and the accompanying narrative is published in Appendix One.

2.2 The NQB also recommends Trust Boards are provided assurance on its quality monitoring systems in use for safe nurse and care staffing levels on adult in-patient wards through the use of an evidenced based tool that enables nurses to assess patient acuity and dependency. The Trust's most recent patient acuity and dependency study was undertaken from 30 January to 19 February 2017. The paper with results of this most recent study, results of previous studies and recommendations can be found in Appendix Two. This most recent study continues to suggest nurse staffing levels on CATT, Byland, Jervaulx, Farndale and Trinity are reviewed and may require further investment. The review of staffing levels in these areas is currently being undertaken utilising the Calderdale Framework methodology.

3 Unannounced Directors' Inspections 2016-2017

3.1 The rolling programme of unannounced Directors Inspections is designed to provide assurance on care standards with particular regard to infection prevention and control.

3.2 The following services have been inspected and rated as 'green' during 2016/17:

Date of inspection	Ward/Dept. visited	Risk Rating
14/04/16	Mortuary	Green
26/04/16	Endoscopy	Green
06/05/16	Day Surgery Unit *(follow up visit)*	Green
14/07/16	Whitby Dental Clinic	Green
16/08/16	Dental Clinic, Settle Health Centre	Green
12/05/16 & 09/09/16	Acute Medical Unit. Rated 'red' at first inspection due to lack of cannula VIP scores. Successful audit now compliant	Green
24/06/16	Harlow. Rated 'red' at first inspection due to lack of cannula VIP scores. Successful audit now compliant	Green
31/10/16	Operating Theatres	Green
23/08/16 & 02/11/16	Lascelles. Rated 'red' at initial inspection due to lack of 'nurse in charge' badges. Now compliant.	Green
21/11/16	Monkgate Dental Clinic, York	Green

3.3 Services which are rated amber or red at the time of inspection are reviewed at a later date, until a green rating is achieved. The table below summarises services which are yet to achieve a green rating and the key issues to be addressed:

Date of initial inspection	Ward/Dept.	Risk Rating at initial inspection	Critical Issues identified	Review Date	Outcome of re-inspection	Critical Issues at re-inspection
06/06/16	Medical Day Unit	Amber	Largely relating to the non-compliant chairs in the treatment room and waiting room.	**Update Feb 2017** Treatment room chairs now replaced.	Amber	Waiting room chairs remain non-compliant
16/06/16	Pannal	Red	Further review to be undertaken (Lack of cannula VIP scores)	21 February 2017	Red	Lack of IV Cannula VIP scores
29/07/16	Integrated Community Equipment Loan Store, Knaresbro*	Red				
10/11/16	Farndale	Red	Controlled Drug Book had gaps in daily checks	21 February 2017	Red	Controlled Drug Book had daily gaps
02/12/16	Littondale	Red	Controlled Drug Book check and lack of IV Cannula Care	21 February 2017	Red	Had 21/02 gaps in Controlled Drug Book. Lack of IV Cannula VIPS score
03/02/17	Nidderdale	Red	Controlled Drug Book had gaps in daily checks	19 April 2017	Green	
21/02/17	Farndale	Red	Controlled Drug Book had gaps in daily checks	19 April 2017	Green	
21/02/17	Littondale	Red	Controlled Drug Book had gaps in daily checks	19 April 2017	Red	Controlled Drug Book had gaps in daily checks
17/03/17	CATT	Red	Commodes failed hygiene inspection	19 April 2017	Green	CATT re-inspected on 3 separate dates – commodes met hygiene standard each time
29/03/17	Pannal	Red	Lack of IV Cannula VIP scores	19 April 2017	Green	

*the Integrated Community Equipment Loan Store is no longer operated by the Trust and this entry will be removed from future reports.

- Pannal - Failed inspections in July 2016, February and March 2017 due to lack of evidencing IV Cannula care. Passed spot check for cannula care on 19 April 2017.

- Farndale – Failed inspections in Nov 2016 and Feb 2017 due to gaps in daily checking of controlled drug book. Passed for controlled drug book daily checking 19 April 2017.

- Littondale - Failed inspections in Dec 2016 and Feb 2017 due to gaps in daily checking of controlled drug book and lack of evidencing IV Cannula care. Failed on both counts in April 2017. Issues being addressed with Ward Manager and Matron.

4 Patient Safety Visits

4.1 Patient Safety visits are scheduled visits designed to provide assurance regarding patient safety. They have a unique purpose and value in encouraging a positive safety culture. Visits are designed to encourage staff to raise any concerns in a forum which is supportive, building good communication and establishing local solutions to minimise risk whenever possible. Key findings are followed up by the directorate teams, any high priority actions are considered through the appropriate corporate group such as the 'Improving Patient Safety Group'.

4.2 Since the last Board Meeting there have been no new Patient Safety Visits. A summary of prior PSVs is provided below.

Date	Area	Key Findings
01/07/16	Orthopaedic Outpatients	
13/07/16	Byland/ Jervaulx	
02/08/16	Maternity	
13/10/16	Kingswood Dental Surgery	
25/11/16	Stanley Education Centre	
06/12/16	CATT	
06/01/17	Antenatal Clinic	No high priority actions but a number of issues including: • Heavy reliance on Band 2 Clerks for a complicated booking process which requires basic clinical knowledge. • IT issues • Clinic issues
09/02/17	Farndale	Issues included: • ePMA system – prescribing once only drug treatments – prescription can disappear if delayed • High number of patients with challenging behaviour
28/02/17	Trinity and Minor Injuries Unit - Ripon	No. of high priority actions identified including: • Enough staff for 1:1 care • Moving and handling training • Low staff morale • Band 2 tasks – confusion regarding tasks allowed to do • Band 2 staff feeling part of the team • Confusion over service offer – minor injuries/illness or both • X-ray not available at weekends • Compliance with mandatory training and access via IT system • Daily CD checking • PGD's out of date

5 Complaints

5.1 In March 2017 the Trust received 25 complaints.

Of the 25 complaints received, 22 were graded Yellow, and 3 green.

5.2 The total number of formal complaints received by the Trust during 2016/17 increased by approximately 8.9%; the proportion of complaints rated red/amber has reduced during the year. It should be noted that hospital activity increased in year (an almost 5% increase in non-elective care and 1.5% increase in elective care) and the addition of services in County Durham,

Darlington and Middlesbrough expanded the range and breadth of services considerably. While any increase in complaints is concerning, this scale of change and the nature of complaints, does not suggest a significant deterioration in the quality of care and service delivered by the Trust.

5.3 In March I reported that, unusually, over 50% of the formal complaints received in February 2017 had been generated by the Emergency Department (ED) and the Wards and I was concerned this might be an emerging trend. The number of formal complaints received in March 2017 relating to ED and the Wards is 44%, which is about average.

5.4 The number of complaints received by month and compared with 2015/16, is shown below.

Total number of complaints by month for 2016/17 compared to 2015/16													
	April	**May**	**June**	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**	**Total**
2016/17	18	16	24	21	25	19	19	18	9	14	26	25	**234**
2015/16	26	18	30	15	17	26	11	9	12	12	21	16	**213**

4.5 There have been no concerns, complaints or incidents in March relating to DNACPR status of patients or use of DNA CPR forms.

6 End of Life Care

6.1 This year the acute and community teams across the organisation have worked on a local CQUIN project to improve integration of services of the End of Life Care pathway. The aim of the project was to create transparency and increase the number of patients who actually die in their preferred place of death (PPD) and improve the number of patients who die having a recorded place of death.

Position at Q4

During Quarter 4 the objective was to:

1. Sustain PPD recorded for 95% of all deaths known to Specialist Palliative Care Team (SPCT) by end of Q4;

2. Sustain 50% patients who do not achieve PPD have a documented reason why not for the SPCT by end of Q4;

3. Commence importation of the SystmOne template used by the SPCT to record PPD and Actual Place of death APD (and reasons why this is not achieved) into the Community Care Team Unit.

Progress on these three objectives is summarised below:

Sustain preferred place of death (PPD) recorded for 95% of all deaths known to Specialist Palliative Care Team (SPCT) by end of Q4.

This target was met.

Specialist Palliative Care Team
Preferred Place of Death - CQUIN Reporting

	Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17
No. with preferred place of death recorded (or not applicable)	35	56	64	94
% with preferred place of death recorded (or not applicable)	44.9%	69.1%	97.0%	95.9%
Of those, no. who died in preferred place - yes	20.0%	64.3%	62.5%	62.8%
Of those, no. who died in preferred place - no	0.0%	8.9%	7.8%	12.8%

Sustain 50% patients who do not achieve PPD have a documented reason why not for the SPCT by end of Q4;

SPCT - Preferred place of death achieved April - March 2017

	Q1	Q2	Q3	Q4	Grand Total
Patients with a preferred place of death recorded	34	50	46	75	205
1. Yes	7	36	40	59	142
2. No		5	5	12	22
(Y15c1) Not achieved - move pt to hospital clinical reasons		1	1	1	3
(Y15c3) Not achieved - no capacity at pref location			3	2	5
(Y15c7) Not achieved - other			1	8	9
No reason given		4		1	5
3. Declined / Unable / Undecided / Discussion Inapprpiate	1	6	18	19	44
4. No place of death recorded	27	9	1	4	41
5. No preference stated	43	25	2	4	74
Grand Total	78	81	66	98	322

This target was met. Of those patients with a PPD recorded:

- 59 patients (84 %) achieved their Preferred Place of death
- 12 patients (16%) did not achieve their preferred PPD
- Of those who did not achieved their PPD 11 patients (91.6%) had reasons recorded.

The table below demonstrates that during the project there was an increase in patients on the caseload of the Specialist Palliative Care Team (SPCT) and respective location of patient death. More patients have been supported to die outside of hospital.

SPCT - Place of death April - March 2017

	Q1	Q2	Q3	Q4	Grand Total
(9491.) Patient died at home	6	21	24	43	94
(9495.) Patient died in hospital	4	11	24	25	64
(XaEK5) Patient died in hospice	3	9	9	12	33
(XaJ2g) Patient died in community hospital		1	1	2	4
(XaVwv) Patient died in care home		7	6	9	22
No place of death recorded	65	32	2	7	106
Grand Total	78	81	66	98	322

Commence importation of the SystmOne template used by the SPCT to record PPD and APD (and reasons why this is not achieved) into the Community Care Team Unit.

This target has been met.

The SystmOne template used by the SPCT is now accessible to all Community Care Teams. There are clearly more significant numbers of patients supported by our wider community

teams. As can be seen from the table below there has been a gradual but consistent increase in the number of patients recorded as having a PPD. Some work has been done to raise awareness within the Community Care Teams about the use of the template and this will continue over the next few months.

Preferred Place of Death - CQUIN Reporting

	Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17
No. with preferred place of death recorded (or not applicable)	92	126	130	161
% with preferred place of death recorded (or not applicable)	26.4%	36.3%	35.1%	44.0%
Of those, no. who died in preferred place - yes	15.2%	26.2%	33.1%	28.6%
Of those, no. who died in preferred place - no	7.6%	11.9%	5.4%	9.9%

All community Teams (exc SPCT) Preferred place of death achieved April - March 2017

	Q1	Q2	Q3	Q4	Grand Total
Patients with a preferred place of death recorded	90	117	106	131	444
1. Yes	14	33	43	46	136
2. No	7	15	7	16	45
(Y15c1) Pref place of death not achieved - move pt to hospital clinical reaso		3		2	5
(Y15c2) Pref place of death not achieved - pt changed mind		1			1
(Y15c3) Pref place of death not achieved - no capacity at pref location			1	1	2
(Y15c7) Pref place of death not achieved - other				4	4
No reason given	7	11	6	9	33
3. Declined / Unable / Undecided / Discussion Inappropriate	2	9	24	30	65
4. No place of death recorded	69	69	56	69	263
5. No preference stated	257	221	240	205	923
Grand Total	349	347	370	366	1432

This target was met. Of those patients with a PPD recorded:

- 46 patients (35 %) achieved their Preferred Place of death
- 16 patients (12%) did not achieve their preferred PPD
- Of those who did not achieved their PPD 7 patients (43%) had reasons recorded.

6.2 Continuing actions for improvement

The ability to accurately draw data to demonstrate preferred place (PPD) and actual place of death (APD) for all teams remains dependent upon the full development of an Electronic Palliative Care Coordination System (EPaCCS) and agreement to share data / records across the locality (between GP practices and secondary care). Development of EPaCCS is a key action within the New Care Models and also agreed within the Locality End of Life Strategy. Funding from the NHS England Harnessing Technology work-stream has been secured and the project will commence in June 2017.

In addition, on-going actions for the Trust to continue to support improvements in end of life care and enabling patients to achieve choices are contained within the HDFT End of Life Care Work Plan for 2017 – 2022.

6.3 Summary

This CQUIN has been achieved, and whilst is not identified as a CQUIN for 2017/18 will continue to be a key priority within the Trust's End of Life work plan.

7 Children's Services

7.1 For information, work has commenced on defining organisational responsibility for the undertaking of Review Health Assessments (RHA) for Looked after Children. It has been agreed in Middlesbrough and County Durham that HDFT would undertake and are responsible for all RHAs for children and young people who are cared for by their respective local authorities. There will be discussions taking place soon with Darlington and North Yorkshire commissioners to mirror this.

8 Nurse Revalidation

8.1 The requirement by the Nursing and Midwifery Council for registered nurses and midwives to revalidate every three years has now been in effect for one year. I am happy to report the nurse revalidation awareness programme and supporting framework has enabled all HDFT's nurses and midwives required to revalidate in 2016/17, to successfully revalidate.

8.2 The Chief Nurse has successfully revalidated in April 2017.

Jill Foster
Chief Nurse
April 2017

Appendix One - Actual versus planned nurse staffing - Inpatient areas

The table below summarises the average fill rate on each ward during **March 2017.** The fill rate is calculated by comparing planned staffing hours and actual staffing achieved.

In addition we are required to submit information on the total number of patients that were on each ward throughout the month – this is then used to calculate the new "Care Hours per Patient Day (CHPPD)" metric. Our overall CHPPD for **March** was **7.70** care hours per patient per day.

	Mar-2017						
	Day		**Night**		**Care hours per patient day (CHPPD)**		
Ward name	**Average fill rate - registered nurses/ midwives**	**Average fill rate - care staff**	**Average fill rate - registered nurses/ midwives**	**Average fill rate - care staff**	**Registered nurses/ midwives**	**Care Support Workers**	**Overall**
AMU	88.9%	108.6%	98.4%	126.9%	4.40	2.70	7.10
Byland	80.6%	122.0%	90.3%	97.8%	3.00	3.00	6.10
CATT	97.4%	101.9%	101.2%	144.1%	5.30	2.70	8.00
Farndale	91.1%	111.8%	104.8%	127.4%	3.30	3.80	7.10
Granby	82.1%	101.3%	100.0%	112.9%	3.00	3.00	6.00
Harlow	109.7%	96.8%	100.0%	-	6.90	1.80	8.70
ITU/HDU	95.7%	-	99.4%	-	25.80	1.80	27.50
Jervaulx	78.6%	150.5%	86.6%	106.7%	3.10	3.80	6.80
Lascelles	90.0%	100.0%	100.0%	100.0%	4.20	3.90	8.10
Littondale	89.0%	107.1%	100.0%	100.0%	3.30	1.90	5.20
Maternity wards	92.4%	86.7%	95.6%	87.5%	14.00	3.70	17.80
Nidderdale	94.0%	92.2%	97.8%	119.4%	3.50	2.30	5.80
Oakdale	94.5%	99.5%	99.2%	129.0%	4.30	2.70	7.00
SCBU	95.4%	93.3%	96.8%	-	15.60	4.00	19.60
Trinity	90.1%	115.3%	100.0%	141.9%	3.40	3.40	6.80
Wensleydale	93.2%	136.3%	100.0%	135.5%	3.50	3.10	6.60
Woodlands	83.2%	96.8%	88.2%	96.8%	9.00	3.00	12.00
Trust total	**90.5%**	**110.7%**	**97.3%**	**116.2%**	**4.80**	**3.00**	**7.70**

ED staffing	93%	218%	86%	87%			

Further information to support the March data:

On the medical wards Jervaulx, Byland and AMU, where the Registered Nurse (RN) fill rate was less than 100% against planned; this reflects current Band 5 Registered Nurse vacancies and is reflective of the local and national position, in particular regarding the difficulties in recruiting Registered Nurses. The Trust is engaged in an extensive recruitment plan in response to this. Extra care staff were deployed to support the wards during this period and this is shown in the enhanced care staff hours. Further care staff hours were also required at times in these areas to provide intensive 1:1 patient support.

On Granby ward although the daytime RN hours were less than planned, an assessment was undertaken on a shift by shift basis to ensure that the planned staffing matched the needs of the patients.

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

On Littondale the daytime RN hours in March were less than planned due to staff sickness.

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

In some wards the actual care staff hours show additional hours used for 1:1 care for those patients who require intensive support. In March this is reflected on the wards; AMU, CATT, Byland, Farndale, Oakdale, Jervaulx, Trinity and Wensleydale.

For the Special Care Baby Unit (SCBU) although the daytime RN and care staff hours and night time RN hours appear as less than planned, it is important to note that the bed occupancy levels fluctuate in this area and a professional assessment was undertaken on a shift by shift basis to ensure that the planned staffing matched the needs of both babies and families.

The staffing complement for the children's ward, Woodlands, is designed to reflect varying levels of occupancy. Although the day and night time RN hours are less than 100% in March due to staff sickness, the ward occupancy levels vary considerably which means that particularly in this area the number of planned and actual nurses is kept under constant review.

Appendix Two - Nursing Dependency Data – In-Patient Wards January/February 2017

Introduction

This report aims to provide an updated position status regarding the results of a recent dependency study using the Safer Nursing Care Tool (SNCT). The study was undertaken across the general adult inpatient wards (see Appendix 1 for areas included) for the period 30 January until 19 February 2017.

Background

Nurse staffing reviews at HDFT have all featured strong engagement of professional leaders including ward sisters, charge nurses and matrons. Nurse staffing tools (acuity tools) have been used to support decision making regarding required staffing levels and NICE (October 2014) has endorsed the Safer Nursing Care Tool (SNCT) which we use at HDFT in conjunction with professional judgement, patient feedback, patient safety incidents and key quality indicators.

Since June 2014 Trusts have been required to publish information about staffing levels for Registered Nurses / Midwives (RN) and Care Support Workers (CSW) for each inpatient ward "actual versus planned". In addition the daily actual versus planned staffing numbers are displayed in the inpatient ward areas.

From May 2016 all acute Trusts with inpatient wards/units began reporting monthly Care Hours Per Patient Day (CHPPD) data to NHS Improvement. This was a recommendation of the Lord Carter Review (2016) and Trusts are required to submit information on the total number of patients that were on each ward throughout the month – this is then used to calculate the new CHPPD metric.

The information regarding "safer staffing" and CHPPD is received monthly at the Trust Board as part of the Chief Nurse report.

Nursing dependency / acuity studies

"The Safer Nursing Care Tool (SNCT) was originally developed in conjunction with the Association of UK University Hospitals (AUKUH), when it was known as the "AUKUH Patient Care Portfolio". It has been widely used across the NHS, private sector and in some overseas hospitals. The Shelford Group commissioned a review of the tool and it has recently been relaunched as the Safer Nursing Care Tool (SNCT)" NQB 2013. NICE have recently endorsed this tool to be used alongside the NICE guidelines on safe staffing.

The tool comprises two parts: An acuity and dependency tool which can be used alongside nurse sensitive indicators which have been identified as quality indicators of care with specific sensitivity to nursing intervention or lack of intervention.

The SNCT is an evidence based tool that enables nurses to assess patient acuity and dependency, incorporating a staffing multiplier to ensure that nursing establishments reflect patient needs in acuity/dependency terms. The multiplier allows 22% uplift for annual leave/ study leave etc. At HDFT the multipliers have been adjusted slightly to accommodate for the 20.78% uplift which is inbuilt into the ward establishments.

To date six acuity studies using the SNCT have been undertaken, the latest study being January/February 2017, the results of the last 4 studies are detailed in Appendix 1. A further study is scheduled for May 2017. The SNCT acuity studies have been undertaken across the general adult in patient wards with the exception of ITU/HDU.

Each study runs for 20 continuous days and each day a patient's level of care is determined based on their care needs for the last 24 hours.

Table 1: SNCT levels of care

Level 0	Patient requires hospitalisation. Needs met by provision of normal wards cares.
Level 1a	Acutely ill patients requiring intervention or those who are unstable with a greater potential to deteriorate.
Level 1b	Patients who are in a stable condition but are dependent on nursing care to meet most or all of the activities of daily living.
Level 2	May be managed within clearly identified, designated beds, resources with the required expertise and staffing level or may require transfer to a dedicated Level 2 facility/unit.
Level 3	Patients needing advanced respiratory support and/or therapeutic support of multiple organs.

January/February 2017 dependency study results

The table attached gives the results of the last four studies undertaken and the latest study gives detail regarding the current WTE establishment for each ward and the average recommended establishment based on the results of the study. Ward activity data is also included and data on the average number of empty beds per day has been added to reflect bed occupancy for the period of the study.

Based on the data “average of all days”, taken from the latest dependency study it is suggestive that CATT, Byland, Jervaulx, Farndale and Trinity wards may require further nursing investment. The average does not specify grade of nurse required and this is open to local determination based on professional judgement and skill mix requirements. It is recommended that the dependency studies are undertaken at different times of the year to identify seasonal trends and support workforce planning. This study should be viewed in conjunction with professional judgement and nurse sensitive indicators. Further studies are planned for May and September 2017.

Further points to note with regard to the dependency/acuity study - January/ February 2017

- Nutritional assistants, discharge coordinators and ward clerks are not included in the WTE establishment numbers.
- Specific Acute Admissions Unit multipliers from the SNCT have been used for CATT ward in this study.
- Lascelles used this tool for the first time in September /October 2016.
- Granby and CATT escalation activity data is incorporated into the base ward data.
- CATT escalation and Granby escalation do not have a budgeted establishment however additional staff were provided when additional escalation beds were required.

Recommendations

Ensure professional judgement exercised locally continues to be key determinant of safe staffing levels and continue to use this combined with RN: Patient ratios, skill mix, “Red flag events” (NICE 2014), dependency scoring and intelligence from Key Performance Indicators to determine the number of nurses required.

- Continue proactive nursing recruitment.
- The Trust should continue to use the NICE endorsed SNCT and undertake a further study in May 2017 across the adult in patient wards.
- Further consideration to undertaking daily dependency scoring to be led by the directorates.
- Continue to monitor key nurse sensitive indicators through the monthly quality and safety dashboard.
- Continue to display actual versus planned staffing levels in the ward areas and publish by ward data on the Trust website.
- Manage nursing agency staffing costs through use of approved frameworks.

Summary of safer nursing care tool data

Summary of safer nursing care tool data - Jan/Feb 2017

		Staffing levels indicated by tool			Average daily totals reported:												
Ward	Ward * Establishments	Average of all days	Maximum daily requirement	Minimum daily requirement	Empty Beds	Acute Admissions	Elective Admissions	Discharges	Transfers In	Transfers Out	Ward attenders	Deaths	Escorts on Site	Escorts off Site	Number Patients requiring 1-1 care	Patient Outliers
CATT	35.52	**46.07**	55.02	32.76	2.71	7.57	0.52	8.19	0.86	5.10	0.38	0.57	0.24	0.05	0.71	0.05
CATT Escalation		**6.31**	10.66	0.00	2.13	CATT Escalation patient flow data incorporate into CATT base ward data										
Byland	34.99	**45.23**	50.26	33.12	1.90	0.33	0.00	1.95	0.81	0.05	0.00	0.24	0.00	0.00	1.14	0.19
Farndale	31.24	**35.89**	39.09	29.66	1.29	1.90	0.00	1.86	0.62	0.62	0.00	0.05	0.00	0.00	2.67	3.95
AMU	39.34	**28.87**	37.99	20.82	3.65	2.25	0.00	3.75	1.60	0.80	0.00	0.15	0.05	0.05	0.10	0.00
Granby	22.8	**22.59**	24.38	19.73	0.05	0.29	0.00	2.00	1.29	0.19	3.48	0.19	0.71	0.14	2.43	0.00
Granby Escalation		**5.77**	7.79	0.98	1.10	Granby Escalation patient flow data incorporated into Granby base ward data										
Harlow	14.97	**10.37**	11.22	8.80	0.10	0.95	0.71	2.52	1.00	0.38	0.19	0.10	0.00	0.00	0.00	0.00
Jervaulx	35.02	**43.10**	46.73	36.93	1.67	0.33	0.00	2.38	1.05	0.14	0.43	0.00	0.00	0.00	5.00	0.00
Littondale	31	**31.67**	37.10	26.98	3.67	3.71	0.38	6.05	2.33	1.62	1.10	0.14	0.00	0.00	1.10	8.14
Nidderdale	34.24	**29.25**	35.50	24.66	2.81	2.90	0.52	6.05	2.57	0.43	2.52	0.00	0.00	0.00	0.00	5.10
Oakdale	41.76	**38.98**	46.15	32.34	2.26	0.37	0.00	1.37	1.00	0.42	0.00	0.00	0.11	0.11	0.95	0.00
Swaledale	Ward not open during Sept/Oct 16															
Trinity	19.74	**28.38**	31.82	24.30	1.52	0.05	0.00	0.00	0.10	0.48	0.00	0.10	0.00	0.00	2.57	0.00
Wensleydale	29.25	**29.80**	34.75	22.23	1.24	1.38	2.24	5.76	2.10	1.05	0.00	0.00	0.00	1.62	1.83	0.00
Lascelles	22.9	**19.50**	21.05	15.33	-0.62	0.10	0.05	0.38	0.10	0.05	0.00	0.00	0.00	0.00	0.00	0.00

*Nutritional assistants, discharge coordinators and ward clerks are not included in the establishment numbers

Summary of safer nursing care tool data - Sep/Oct 2016

		Staffing levels indicated by tool			Average daily totals reported:											
Ward	Ward ** Establishments	Average of all days	Maximum daily requirement	Minimum daily requirement	Empty Beds	Acute Admissions	Elective Admissions	Discharges	Transfers In	Transfers Out	Ward attenders	Deaths	Escorts on Site	Escorts off Site	Number Patients requiring 1-1 care	Patient Outliers
CATT	35.7	**39.68**	51.11	24.99	8.29	16.81	0.00	8.67	0.81	5.52	0.52	0.14	0.15	0.00	0.15	0.00
CATT Escalation	Ward not open during Sept/Oct 16															
Byland*	35	**37.50**	0.00	33.74	10.90	0.00	0.00	1.57	0.76	0.00	0.00	0.14	0.11	0.00	1.44	0.00
Farndale	29.2	**31.54**	36.52	25.90	3.24	1.10	0.48	2.05	0.71	0.43	0.14	0.00	0.00	0.00	1.37	1.71
AMU	39.3	**37.41**	44.79	31.83	4.00	1.86	0.10	4.95	3.24	1.14	0.05	0.00	0.05	0.00	0.25	0.71
Granby	22.8	**19.32**	22.88	18.38	1.67	0.05	0.00	1.81	1.14	0.00	1.95	0.24	0.25	0.00	0.90	0.00
Granby Escalation	Ward not open during Sept/Oct 16															
Harlow	15	Ward closed during period of study														
Jervaulx*	35	**32.62**	35.65	29.36	17.76	0.05	0.00	1.24	0.62	0.10	0.00	0.19	0.25	0.00	0.42	0.14
Littondale	31	**30.24**	33.35	23.38	7.81	4.00	0.43	7.57	3.38	1.57	0.62	0.05	0.00	0.00	1.26	1.67
Nidderdale	34.2	**26.51**	32.62	19.35	7.14	4.05	0.86	7.67	1.14	2.48	3.33	0.10	0.00	0.00	0.19	1.29
Oakdale	41.8	**35.06**	39.14	29.88	4.43	0.48	0.05	1.76	0.71	0.14	0.00	0.33	0.00	0.00	1.10	0.00
Swaledale	Ward not open during Sept/Oct 16															
Trinity	19.7	**23.27**	24.60	20.69	0.71	0.10	0.00	0.38	0.00	0.00	0.00	0.05	0.00	0.00	0.10	0.24
Wensleydale	29.3	**30.85**	35.02	25.24	3.00	0.90	2.29	4.67	1.52	1.76	0.00	0.00	0.00	0.00	2.88	0.00
Lascelles	22.9	**17.18**	19.91	14.54	3.05	0.10	0.00	0.19	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00

*Byland & Jervaulx did not have complete data due to the joining of the wards over this period

**Nutritional assistants, discharge coordinators and ward clerks are not included in the establishment numbers

Summary of safer nursing care tool data - Jul/Aug 2015

		Staffing levels indicated by tool			Average daily totals reported:												
Ward	Ward Establishments	Average of all days	Maximum daily requirement	Minimum daily requirement	Empty Beds	Acute Admissions	Elective Admissions	Discharges	Transfers In	Transfers Out	Ward attenders	Deaths	Escorts on Site	Escorts off Site	Number Patients requiring 1-1 care	Patient Outliers
Bolton	[40.34]	**38.38**	43.37	33.17	0.71	0.24	0.06	3.82	4.18	1.47	0.00	0.18	0.06	0.06	0.06	0.29
Bolton Escalation	ward not open during Jul/Aug 15															
Byland	35.6	**35.17**	46.01	29.07	0.56	0.11	0.00	1.61	0.50	0.11	0.00	0.22	0.00	0.11	2.44	0.00
Farndale	31.24	**26.40**	34.59	15.93	4.00	2.30	0.20	2.90	0.40	0.10	0.00	0.00	0.05	0.00	0.00	3.65
Fountains	[36.7]	**33.28**	40.99	19.66	3.83	19.22	0.00	9.06	1.00	7.22	0.33	0.39	3.61	0.06	0.22	0.00
Granby	23.79	**19.09**	20.68	17.31	0.27	0.09	0.00	1.00	1.09	0.18	3.18	0.09	0.00	0.00	0.00	0.00
Granby Escalation		**4.02**	4.71	3.33	2.50	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	0.00	0.00	0.00	0.00
Harlow	14.96	**6.75**	9.78	3.91	3.10	0.52	0.90	3.00	1.57	0.19	0.19	0.05	0.00	0.00	0.00	0.00
Jervaulx	36.4	**45.95**	51.07	38.62	0.90	0.14	0.00	1.67	0.71	0.14	0.00	0.24	0.00	0.00	4.00	0.00
Littondale	32.01	**26.90**	35.97	15.06	7.95	3.30	0.85	5.90	2.40	2.35	1.25	0.05	0.00	0.00	0.20	2.30
Nidderdale	33.48	**28.38**	31.17	24.44	2.45	3.35	0.85	5.85	2.15	1.55	3.20	0.10	0.00	0.00	0.15	2.15
Oakdale	42.75	**38.45**	42.79	34.29	2.38	0.38	0.00	1.76	1.19	0.48	0.00	0.33	0.00	0.05	0.67	0.00
Swaledale	ward not open during Jul/Aug 15															
Trinity	19.64	**25.59**	27.45	22.35	0.10	0.24	0.05	0.57	0.05	0.05	0.00	0.05	0.00	0.00	0.71	0.00
Wensleydale	30.24	**17.55**	25.88	11.73	10.90	0.76	2.86	4.81	1.00	0.33	0.05	0.00	0.00	0.00	0.38	0.00

Summary of safer nursing care tool data - Jan/Feb 2015

		Staffing levels indicated by tool			Average daily totals reported:											
Ward		Average of all days	Maximum daily requirement	Minimum daily requirement	Empty Beds	Acute Admissions	Elective Admissions	Discharges	Transfers In	Transfers Out	Ward attenders	Deaths	Escorts on Site	Escorts off Site	Number Patients requiring 1-1 care	Patient Outliers
Bolton		**38.87**	45.87	24.92	2.88	1.19	0.00	5.13	6.31	3.19	0.00	0.31	0.56	0.00	1.63	0.00
Bolton Escalation		**7.27**	9.25	5.67	0.40	0.10	0.00	1.00	1.90	1.40	0.00	0.00	0.10	0.00	0.00	0.00
Byland		**38.97**	46.67	29.13	1.13	0.06	0.00	1.44	1.00	0.25	0.00	0.19	0.13	0.00	1.44	0.06
Farndale		**35.99**	39.19	29.73	1.05	1.38	0.05	1.10	0.14	0.33	0.00	0.14	0.05	0.00	2.48	1.81
Fountains		**35.83**	44.30	23.32	3.52	19.05	0.00	7.95	0.71	9.86	0.43	0.33	1.81	0.86	0.52	0.00
Granby		**22.27**	23.84	20.15	0.40	0.20	0.05	2.00	1.35	0.35	2.30	0.05	0.00	0.00	0.95	0.00
Granby Escalation		**3.59**	5.93	0.00	2.37	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	0.00	0.00	0.00	0.00
Harlow		**8.68**	11.10	6.92	1.60	1.00	0.80	2.40	0.70	0.30	0.20	0.00	0.00	0.00	0.05	0.00
Jervaulx		**42.69**	46.99	31.68	0.90	0.10	0.00	2.10	1.70	0.15	0.00	0.40	0.60	0.00	2.35	0.00
Littondale		**35.21**	42.72	26.93	2.44	3.33	0.39	5.00	2.50	2.67	0.83	0.11	0.00	0.00	0.00	3.72
Nidderdale		**35.94**	42.03	28.37	4.82	3.06	0.82	7.06	2.94	1.41	3.06	0.12	0.00	0.31	0.56	5.94
Oakdale		**39.62**	42.27	35.66	1.80	0.30	0.05	1.40	1.20	0.50	0.00	0.20	0.10	0.10	0.25	0.05
Swaledale		**15.96**	21.39	5.93	2.24	0.00	0.00	0.00	3.24	0.88	0.00	0.00	0.18	0.00	0.00	4.65
Trinity		no data submitted yet (20/02/15)														
Wensleydale		**30.42**	45.45	21.70	3.62	1.43	2.86	5.57	2.05	1.19	0.00	0.14	0.00	0.00	0.00	2.90

Harrogate and District NHS Foundation Trust

Report to the Trust Board of Directors: 26 April 2017	Paper No: 12.0
Title	Medical Director Report
Sponsoring Director	Dr D Scullion, Medical Director
Author(s)	Dr D Scullion, Medical Director
Report Purpose	To receive an update on clinical issues

Key Issues for Board Focus:

The Board of Directors are asked to note:

- The proposed relaunch of the Trust's revised NG policy
- The new guidance from the Coroner on deaths of those in hospital under a Deprivation of Liberty Safeguard authorisation

Related Trust Objectives	
To deliver high quality care	Yes – the report provides an update on clinical issues which may impact on the delivery of high quality care
To work with partners to deliver integrated care	Yes – the report provides assurance that the Trust continues to work with partners and colleagues at a national and local level, in preparation for forthcoming changes to guidance of a clinical nature.
To ensure clinical and financial sustainability	Yes – the report provides assurance that the Trust continues to deliver clinically sustainable services.
Risk and Assurance	Risks associated with the content of the report are reflected in the Board Assurance Framework via: BAF 1: risk of a lack of medical, nursing and clinical staff; BAF 13: risk of insufficient focus on quality.
Legal/regulatory implications	The report does not highlight any legal/regulatory implications for the period.

Action Required by the Board of Directors

The Board of Directors are asked to receive and note the content of the report.

1. Mortality update

There have been no alerts generated for HSMR, SHMI or CUSUM for the cumulative period spanning December 2016 to January 2017.

HSMR decreased from 105.89 to 104.11 (Feb 2016 to Jan 2017). SHMI increased from 94.03 to 94.72 (Jan 2016 to Dec 2016). Both indices remain within expected levels.

2. New guidance from the Chief Coroner

As of 3 April 2017, deaths of those in hospital under a Deprivation of Liberty Safeguards (DoLS) authorisation will no longer be classified as a "death in state detention" and therefore will not automatically trigger a Coroner's inquest. The period 2013-2015 saw a significant increase in applications for DoLS, a proportion of whom subsequently died whilst still subject to the order. This resulted in a substantial increase in workload for Coroners, particularly as it was clear that a substantial proportion of those deaths were not unexpected and would not have normally triggered an inquest. This change in the law does not affect the normal statutory obligations of healthcare organisations, nor does it affect the discretion of the Coroner to call an inquest where appropriate. However it should ensure that the already stretched resources of the Coroner's office are used to maximum effect. I believe this a sensible and welcome change to the current regulations.

3. Quarterly report of the Guardian of Safe Working

This report is provided separately for consideration and discussion at item 12.1.

4. NPSA safety alert (nasogastric tubes)

This alert was signed off on 21/04/2017. I am mindful of the enormous amount of work that has gone into this project. It is important to emphasise that this is not the end point. A high profile re-launch of the revised policy will commence in early May. More importantly, steps have been taken to strengthen the safety critical measures that generated the alert in the first place, namely training and competencies for satisfactory placement of NG feeding tubes. These competencies will be subject to follow up audit.

5. Getting It Right First Time (GIRFT) update

A GIRFT visit for Obstetrics and Gynaecology is planned for the summer. A date is yet to be finalised. At an STP level, discussions are ongoing regarding pooling Orthopaedic data across the STP footprint in order to explore greater efficiency savings whilst improving quality and outcomes. This is an embryonic project and I will update Board as and when further information is received.

I have received an invitation from the GIRFT team to participate in a nationwide audit of surgical site infections in those specialties relevant to HDFT caseload. This will be a combined retrospective/prospective audit covering the period November 2016 to October 2017. I am currently liaising with relevant clinical leads to enlist the appropriate support with this project. It is anticipated that a report will be submitted for publication around year end 2017.

Harrogate and District NHS
NHS Foundation Trust

Report to the Trust Board of Directors: 26 April 2017	**Paper No: 12.1**
Title	**Second quarterly report on safe working hours for doctors and dentists in training**
Sponsoring Director	Dr D Scullion, Medical Director
Author(s)	Dr C Gray, Guardian of Safe Working Hours
Report Purpose	To receive an update on issues pertaining to the safe working hours for doctors in training

Key Issues for Board Focus:

The Board of Directors is asked to note:

1. **The Guardian has intervened in and resolved two systematic problems**
2. **The number of Exception Reports rendered is in line with the national average**
3. **The Guardian attended the second national conference, in London**

To deliver high quality care	Yes – the report provides an update on clinical issues which may impact on the delivery of high quality care
To work with partners to deliver integrated care	Yes – the report provides assurance that the Trust continues to work with partners and colleagues at a national and local level, in preparation for forthcoming changes to guidance of a clinical nature.
To ensure clinical and financial sustainability	Yes – the report provides assurance that the Trust continues to deliver clinically sustainable services.
Risk and Assurance	Risks associated with the content of the report are reflected in the Board Assurance Framework
Legal/regulatory implications	The report does not highlight any legal/regulatory implications for the period.

Action Required by the Board of Directors

The Board of Directors is asked to **receive and note** the content of the report.
The Board of Directors is requested to **consider the points** at the end of the report.

Harrogate and District NHS Foundation Trust

Board of Directors 26th April 2017

Q4 2016-17 QUARTERLY REPORT ON SAFE WORKING HOURS: DOCTORS AND DENTISTS IN TRAINING

April 2017

Executive summary

This is the second quarterly report of the Guardian of Safe Working Hours. Its purpose is to report to the Board of Directors the state of safe working of doctors in training ('junior doctors') in relation to their working hours, gaps in rotas and their educational experience. This report covers the period 1st January- 31st March 2017.

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

The Trust is now in an intermediate phase with 36 trainee doctors presently transferred into the new 2016 TCS contract since its start in December 2016.

Forty eight exception reports have been received from trainees and dealt with. These have mainly concerned over-runs of working hours owing to the busy state of the wards and to individual patient matters. A few reports of educational deficiency have been received.

Two systematic problems have been identified. One FY1 doctor made 13 exception reports in 12 weeks. This was investigated, found to be problematic and relieved by managerial action. In another specialty, the BMA representative has reported problems with reluctance to submit exception reports. No service reviews have yet been necessary. No fine has yet been levied.

National trends in medical post-graduate training are adverse. There are gaps in rotas owing to non-recruitment. This is a worsening problem in almost all specialties across the country with a gradient worsening northwards. Locum provision is as always precarious. Gaps and no locum cover will inevitably impact upon working hours over time and are likely to have an adverse effect on patient safety.

The Guardian has attended the second national meeting and the first regional meeting. Trainee doctors' forums have been held bi-monthly, jointly with the Deputy Director of Medical Education.

National and regional concerns are discussed. There is informal national advice that the exception reporting process should be opened to trainees not yet on the 2016 TCS.

This is the key quality assurance statement for the board: the Board is advised that overall working hours across the organisation are satisfactory and that there are presently no unaddressed specific concerns in departments or directorates.

Introduction

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

Its purpose is to report to the Board of Directors the state of safe working of doctors in training ('junior doctors') in relation to their working hours, gaps in rotas and their educational experience.

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

The Trust is in an intermediate phase with 36 doctors presently transferred into the new 2016 Terms and Conditions of Service (TCS) contract since its start in December 2016. The rest of the doctors in training join the 2016 contract on changing jobs over the next two to three years.

High level data

Number of doctors / dentists in training (total):	110 [last quarter: 121]
Number of doctors / dentists in training on 2016 TCS (total):	36 [last quarter: 21]
Amount of time available in job plan for guardian to do the role:	1.5 PAs per week
Admin support provided to the Guardian (if any):	none [assistance from HR Department]
Amount of job-planned time for educational supervisors:	0.5 PAs per trainee

Exception reports

Exception reports are individual notifications by trainee doctors who have had a problem causing them to vary their working hours from the contracted rota. Exception reports have a time-limited process for response by the Trust. At any one time there will usually be reports awaiting attention by individual clinical supervisors although none are in this state on the date of writing.

This is a full quarter covering the period 1st January 2017-31st March 2017.

Exception reports by department				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
Gen Medicine	0	30	30	0
Gen Surgery	0	16	16	0
Anaesthetics	0	1	1	0
Emergency Med	0	1	1	0
Total	0	48	48	0

No exception reports have been received in April 2017 to date.

Work schedule reviews & interventions

Work schedule review

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

Interventions

Two problems requiring action have been identified by the exception-reporting process. This quarterly report is a document for the public domain so the identities of the doctors and specialties in these cases are withheld. The identities have been disclosed separately to the Director of Workforce Development and the Medical Director for managerial accountability.

Dr X

Dr X was an FY1 grade trainee in their second four-month attachment and just seven months into their first year of medical practice. Dr X submitted 13 exception reports in the period 16/12/2016 to 24/3/2017. 13 were for late working and 2 also mentioned poor educational opportunity/clinical supervision. The exception reports were generally not responded to on time or at all by the doctor's clinical supervisor. An example extract from an exception report by Dr X is given in Appendix 1, below.

The Guardian managed these reports himself. He interviewed the doctor on the ward on 21/2/2017 and was satisfied that the reports were true. The doctor was often left looking after too many patients with intermittent cover by middle grade doctors and twice-weekly ward rounds by the consultants. Consultants and middle grade doctors were generally available by telephone but were mostly pre-occupied with their own tasks in clinics and undertaking procedures. Other trainees stated that they often came to 'help out' Dr X with his or her excessive work load. In the February half-term week, matters came to a head. Both middle-grade doctors were absent on planned leave and Dr X had to go looking for other registrars to access medical supervisory advice on managing patients. A clinical incident occurred in which, owing to excessive workload, Dr X looked at an abdominal X-ray after some delay. This showed intra-peritoneal gas indicating perforation of a viscus. This was then actioned appropriately but after an unnecessary delay.

Dr X was himself or herself a self-possessed confident doctor without signs of agitation or exhaustion or any mental health issue. He or she was an efficient and articulate complainer and found the time to put in detailed exception reports, but the substance of the complaints was true.

Dr X's work schedule was reasonable; over-time working was not. However, there was no breach of Working Time Directive limits and so no fine is applicable.

The Guardian raised this case by emails and direct meetings with Deputy Director of Medical Education, Director of Medical Education, Medical Director, HR Manager, Director of Workforce Development, Clinical Director, Consultant [clinical supervisor] and Consultant [senior in specialty]. The education officers already knew of the post being problematic – with ups and downs - for 2½ years in responses to official surveys [Deanery, GMC]. They had had discussions with the specialty

and regional authorities. The possibility of 'pulling the post' [removing regional approval for the post] was under consideration but definitive action had not been taken. The consultants in the specialty either shrugged their shoulders or wrote long defensive e-mails. The consultants made clear that they were themselves over-worked in a busy specialty with insufficient time time-tabled in their job plans for ward work and supervision of trainees. One consultant commented: '…My view is the placement as currently constructed is not one where we as consultants, within current job plans, can provide the level of FY1 support expected. '

The Guardian decided that this trainee's situation was intolerable and showed evidence of high risk for the doctor and for patient safety. He insisted that something was done. Director of HR readily agreed to provide extra resources. The Clinical Director and their managers made a robust action plan. A temporary post was created and filled to assist in the ward work in this specialty. On Dr X's last day in this attachment, Dr X remarked that the difficulties of over-work had been relieved. But Dr X nevertheless submitted several further exception reports when patient-related events caused over-time working. Dr X remarked that he or she had no intention of ever working in this specialty again. Dr X has rotated to another FY1 attachment in the Trust and is seeking a career in primary care.

The Guardian reports his view that Dr X's case is exactly the circumstance which the Guardian concept and the new TCS were intended to identify and resolve. In conversation with other Guardians, this was an egregious example. The pre-existing managerial processes had not resolved the problem although it was known about. Pulling the post would have removed the problem for the post-holder but the unaddressed medical ward work would have added to the burden of other trainee doctors.

Dr X's situation showed close similarities to tragic cases which are of national concern [please see below].

Specialty Y

In this specialty, several exception reports were made of over-time working. In two instances – concerning one trainee – the consultant as clinical supervisor refused the exception, explaining that the trainee could have avoided overtime by doing things differently. This was reasonable philosophically but strictly any overtime does entitle over-time pay or time off in lieu. The consultant supervisors should indeed encourage and discuss efficient working. The trainees' BMA representative has now reported that trainees in Specialty Y feel reluctant to make exception reports even if they work overtime.

The Guardian has requested that trainees in Specialty Y keep diary records of start and finish times for a period.

Vacancies

Please see Appendix 2.

Fines

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

No fine has been necessary to date. These are early days.

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

Qualitative information

The Guardian attended the second NHS Employers national meeting for guardians on 14th March 2017 in London, please see below.

The Guardian attended the first NHS Employers regional meeting for guardians on 30th January 2017 in Leeds. This was a depressing occasion with much gloom. One guardian had already resigned. One had been reproved by her Board of Directors. The Deputy Dean was particularly negative: 'Welcome to my world of problems,' he remarked. Systematic problems of recruitment were intractable regionally and nationally.

The Guardian – jointly with the Deputy Director of Medical Education – has held the regular bi-monthly forums for doctors in training in the Doctors' Mess. The work of the Guardian in relation to safe working hours has been introduced. No substantial issue has ever been raised and the trainees in this Trust are subdued and low-key. Their BMA representative is reasonable and helpful.

National meeting for Guardians of Safe Working Hours: NHS Employers, London, 14th March 2017

Progress:

- Guardians are becoming established nationally.
- Guardians are not there to do detail but to change the culture: guardianship is seen as part of the learning culture of successful organisations.
- National standards are being applied at last.
- CQC inspectors will examine guardians' reports and will interview guardians during inspections.
- GMC and Health Education England regard exception reporting as a valuable source of real-time data.
- The BMA Junior Doctor's Committee has re-formed under new management. Its new Chairman is an impressive and open-minded individual keen to make the system work.

Concerns:

- GMC have regulatory responsibility for medical education. They are greatly concerned by two recent tragic cases of suicide [one definite, the other presumed] in young female trainee doctors. The exception reporting history of one was shown to the meeting. This was of repeated over-time working and deficient supervision by seniors. This evidence in the case was uncannily similar to that of our own Dr X [please see above].
- Exception reporting is very uneven across the country and specialties. BME doctors are thought culturally to be reluctant to complain.
- Clinical supervisors are generally poor at responding to exception reports. This task has been dropped upon them unexpectedly.
- Some trusts have large numbers of unaddressed exception reports.
- Failure of recruitment is progressively worsening.
- Of the 2016 FY2 qualifiers in UK – trainees having completed two years' foundation medical training - only 50 per cent have directly entered specialist training. One sixth have left medicine temporarily or permanently and another sixth have gone or intend to migrate abroad. The remaining sixth are in non-training posts in the NHS. Losing one third of trainees from specialist training is a dire situation and a worsening trend. Various causes are discussed. The recently announced 1800 new places for medical students will take eight years from now to reach FY2 qualification.
- Very few trainee doctors understand their 2016 TCS contract.
- Principal speakers from GMC, Health Education England and NHS Employers felt that it is ethically unfair to treat young doctors on the 2016 TCS differently from those not on the new contract; sometimes occupying places on the same rota. Many organisations are opening the exception reporting to all doctors in training and junior posts irrespective of their contractual terms.

The Guardian succeeded in speaking to all the principal speakers one-on-one. It is clear that medical post-graduate training is in a progressive crisis. The 2016 TCS are not seen as helping the situation.

Issues arising

1. The Trust is in comparatively good standing. We have had an average rate of exception reporting, lately reduced.
2. A bad example of overtime working and poor supervision in an FY1 doctor has been identified. There is no evidence of any other comparable case.
3. Reluctance to report exceptions may exist in one specialty.
4. Exception reports are being received and processed.
5. There are gaps in rotas owing to failed recruitment. This a worsening issue throughout medical specialties especially in the North of England.
6. National suggestions have been made that the exception reporting system should be opened to all trainee doctors and not only those on the 2016 TCS. This will create more work for HR medical managers, clinical supervisors and for the Guardian.

Actions taken to resolve issues

1. A robust intervention was necessarily made by the Guardian in the case of Dr X. This matter is currently resolved temporarily by the provision of a new post. The resilience of this response is yet to be seen.
2. A diary exercise has been requested in Specialty Y.

Assurance

On the date of reporting, the Board of Directors is assured from the evidence available that:

1. The exception reporting system is operation for 2016 TCS doctors.
2. Two problems have been identified and managed this quarter.
3. No systematic or individual problem of unsafe working hours is known to exist currently.

Questions for consideration by the Board of Directors

1. *The Board is asked to receive the report and to consider the assurances provided by the Guardian.*
2. *The Board is asked to consider whether it wishes the exception reporting system to be opened to trainee doctors not yet on the 2016 TCS.*
3. *There are presently no issues outlined in the report which are not being (or cannot be) tackled.*
4. *The Guardian makes no request for escalation, internally, externally or both, which might be recommended in order to ensure that safe working hours would not be compromised in the future.*

Appendices

Appendix 1: Extract of an exception report by Dr X.

Appendix 2: Current gaps in rotas.

Dr Carl Gray

Guardian of Safe Working Hours

21st April 2017

Appendix 1

Extract of an exception report by Dr X. [*Identifying details such as the ward names are redacted.]

‘6537: 20 Feb, 2017 Nature: Hours & Rest

2 members of the team not on the wards at all this week (CT2/Locum Reg). Only myself looking after all of [*WARD*] patients/male outliers (approx 15). Afternoon spent conducting jobs generated from morning Ward round. Wanted a senior opinion on a CXR as wasn't happy with it. Reg still on ward round for [*DIFFERENT WARD*] patients until after 5pm. Then came to review. Reg felt image could indicate pathology that needed actioning asap. Had to cannulate patient/conduct other jobs urgently whilst he contacted surgeons.

Steps taken to resolve

It has been known for some time that this week was going to be particularly understaffed yet nothing had been done in advance. It is unsafe for so many patients to be looked after by so few doctors. I cannot reiterate this enough! It isn't just about me being supervised by seniors as an F1, but actually having other colleagues that can help share the workload regardless of their seniority. ‘

Appendix 2

Current Gaps in Rotas

Data courtesy of HR Department.

Directorate	Department	ROTATES	Grade Establishment	Additional establishment	Deanery or Trust	April
LTUC	Cardiology	FEB/AUG	ST3+	N	Deanery	Gap
LTUC	Chemical Pathology	AUG/FEB	ST3+	N	Deanery	GAP
LTUC	Elderly Medicine	OCT	ST3+	N	Deanery	GAP
LTUC	Elderly Medicine	OCT	ST3+	N	Deanery	GAP
LTUC	Elderly Medicine	AUG/ FEB	CT1/ 2	N	Deanery	GAP
LTUC	Elderly Medicine	AUG/ FEB	CT1/ 2	N	Deanery	GAP
LTUC	Emergency Medicine	AUG	ST3+	N	Deanery	GAP
LTUC	Emergency Medicine	AUG	ST3+	N	Deanery	GAP
LTUC	GP-Kingswood	AUG/ DEC/ APR	FY2	N	Deanery	GAP
LTUC	Haematology/Oncology	AUG/ DEC/ APR	FY2	N	Deanery	GAP
PSC	Anaesthetics	AUG/FEB	ST2 (ACCS)	N	Deanery	Gap
PSC	Dermatology	AUG	CRF	Y	Trust	GAP
PSC	General Surgery	OCT	ST3+	N	Deanery	Gap
PSC	Obs and Gynae	AUG/ FEB	ST3+	N	Deanery	Gap
PSC	Rheumatology	FEB/AUG	ST3+	N	Deanery	GAP
CCWCC	Paediatrics	AUG/ FEB	ST1/2	N	Deanery	Gap

GAP	Confirmed GAP
GAP	Advertising LAS to fill GAP
GAP	Waiting for HEYH to confirm if can advertise for LAS
GAP - Supernumerary Post	GAP for supernumary posts
Awaiting rota	HEYH to confirm rotation

Board Committee report to the Board of Directors

Committee Name:	Quality Committee (QC)
Committee Chair:	Mrs L Webster
Date of last meeting:	5 April 2017
Date of Board meeting for which this report is prepared	26 April 2017

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

- **Hot Spots Discussed** – Concerns were noted in respect of Paediatric Middle Grade doctor's rotas, where significant gaps in rotational doctors training posts and specialist doctors leaving are challenging Paediatrics. Quality of care was being affected when outpatient clinics had to be cancelled as a consequence of consultants covering the previous night's rota. These concerns were heightened by the potential implications for the organisation if we comply with the IR35 recommendations. Similar gaps were noted across the Directorates and concerns were debated in respect of the reliance upon locum services. It was noted at the meeting that there was no immediate solution to these issues despite much work to try to mitigate the risks.

  A recent situation of a locum making demands for higher remuneration to retain their services was debated and QC felt the Board should be made aware of this issue.
- **Board request for QC to seek assurance on the Quality of Care Teams –** verbal update received from the directorates, where each described the focus being made upon the activities of the QCTs in their areas. More detailed reports due at May's meeting
- **Progress report received on action plans in relation to Trinity Ward and Minor Injuries Unit, Ripon** - good progress towards achieving planned objectives in the MIU. Ongoing development and implementation of action plan In Trinity. Update requested for September's meeting.

  Reports heard
- **Staff Friends and Family Test (FFT) and National Staff Survey 2016 Annual Report** – Further details on *1*, timing of action plan, *2*, response to reports of violence against staff and *3*, incident reporting to be returned next month.
- **Quality Account 2015/16 – First Draft** – good progress and next year's Quality Priorities noted.
- **Health and Safety Annual Report –** good assurance received from this report
- **Q3 Clinical Audit Report –** Majority of audits on track. 2 areas for scrutiny noted (Glaucoma patient lost to follow up and VTE thromboprophylaxis audits) QC will retain an interest in these areas going forwards. In addition QC noted

the potential implications to the delivery of elements of the clinical audit plan should there be a delay in recruiting to the pending vacancy in the Clinical Effectiveness Team.

- **CQC Action Plan – Update** – Good progress noted. A debate on how we retain this focus and treat this in a 'business as usual' way, the concept of introducing peer to peer review meetings was met with a positive response.
- **Draft Internal Audit Operational Plan 2017/18 –** Plan received from audit committee and noted.

Incident Policy – the newly revised incident policy was ratified by the committee.

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

Note first bullet point above.

Matters for decision

None.

Action Required by Board of Directors:

None.

Harrogate and District NHS

NHS Foundation Trust

INFECTION PREVENTION AND CONTROL REPORT

TRUST BOARD APRIL 2017 paper 15.0

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This is a summary report to the Board at the end of 2016/2017.
It is not the final Infection Prevention & Control Annual Report, which will follow later in the year, and will contain more information on the activities of the IPC, Gram negative bacteraemias, antimicrobial prescribing, and the results of the 2016 Point Prevalence Survey into HCAI and antimicrobial prescribing.

HCAI DASHBOARD 2016/2017

Table 1

Month	CDA		MRSA BSI assignment			MSSA BSI		*E. coli* BSI*		Confirmed 'flu	CPE carriers	D&V ward episodes
	Trust apportioned	non-Trust apportioned	Trust	CCG	third party	HAI	CAI	HAI	CAI			
April	3	0				2	1	4	5			
May	3	1				2	1	0	9			
June	2	1					2	1	6			
July	1	2					2	1	8			
August	4	0				1	2	1	9			
September	4	1				1	4	2	12			
October	4	2				1	3	0	12			
November	3	4					3	1	6			
December	2	6				1	3	2	12			
January	2	2				1		1	11	33		
February	1	1			1	1	4	1	11	17	0	6
March	0	2				1	1	3	10	5		
Annual total	**29**	**22**			**1**	**11**	**26**	**17**	**111**			

**E. coli* bacteraemias (blood-stream infections/BSI) although reportable since June 2011, have hitherto not been formally apportioned to acute Trusts/CCGs in the way that *C. difficile* is. The HDFT informatics department has however been categorising them as if they were. As of 2017/2018, it is probable that they will be apportioned in this way.

MRSA bacteraemias

We had a single case of MRSA bacteraemia in February, the first here since 2013. This was in a female patient who was known to be a MRSA carrier and who presented with a chest infection. A blood culture taken on admission in A&E grew MRSA. At first, it was suggested that the isolate might not have been clinically significant, which would mean that the episode would automatically be assigned to HDFT. It soon became apparent however that the blood culture isolate did represent a clinical infection, which was community-acquired. We have agreed with the CCG to request "third party" assignment and the case is being referred to the regional MRSA arbitration panel.

C. difficile infection (CDI)

We finished 2016/2017 with a total of 29 Trust-apportioned *C. difficile* infections (CDI), a 17% reduction on the previous year overall (Figure 1), although it was noticeable that the biggest reduction came in the second half of the year, from October onwards. This is all the more remarkable given the number of people admitted with viral gastroenteritis, most likely to be norovirus. Along with the number of confirmed 'flu cases admitted mainly through CATT ward, the probable norovirus patients put a huge pressure on side rooms, making it difficult to isolate all the patients with possible CDI. A winter peak of CDI is common for that reason.

The domestic staff worked tremendously hard to keep up with the peak in demand for deep cleans, and the number of deep cleans achieved the first quarter reached record levels (Figure 4).

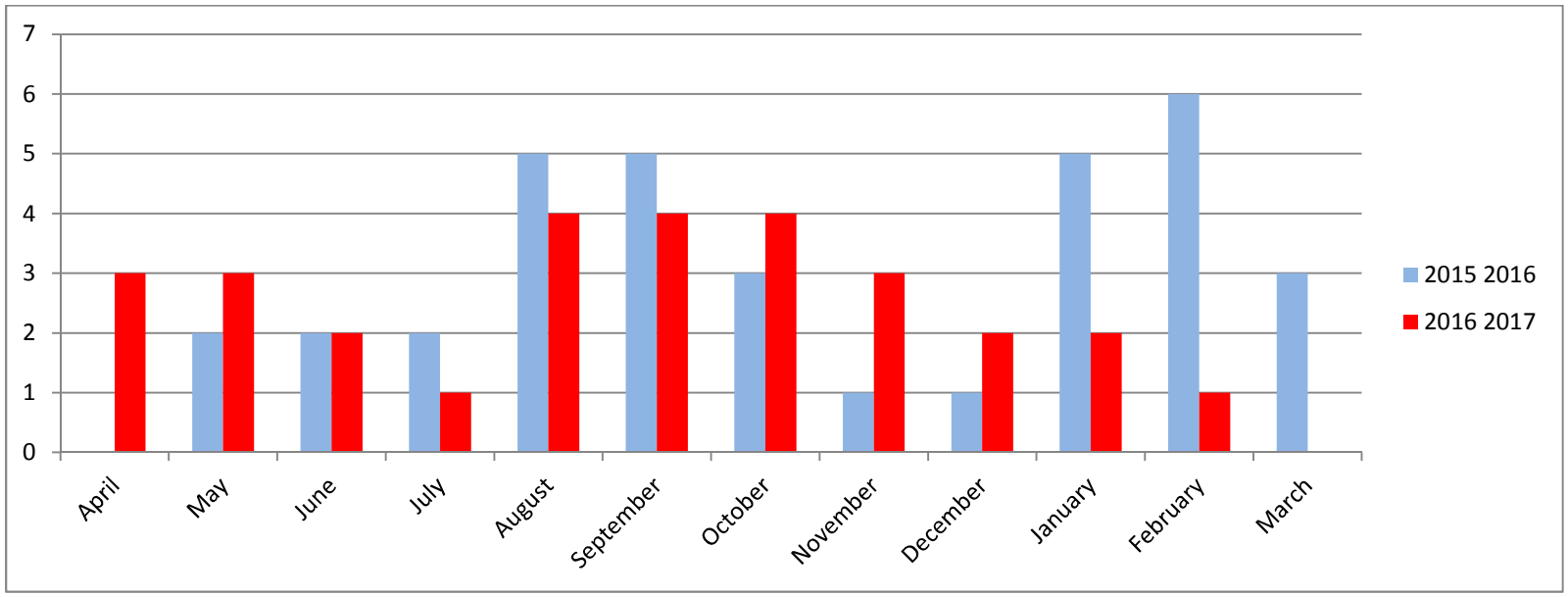
The rates and benchmark comparisons with other acute Trusts in the region will be received in a few months' time.

Lapses in Care

The number of lapses in care cases is provisionally seven, compared with 12 in 2016/2017, with one RCA still to be completed. We are still awaiting written confirmation from the coordinating commissioner on the cases discussed very recently.

The proportion of the total number of cases that were Trust assigned and likely to be hospital-acquired fell significantly over the year (Figures 1,2 &3)

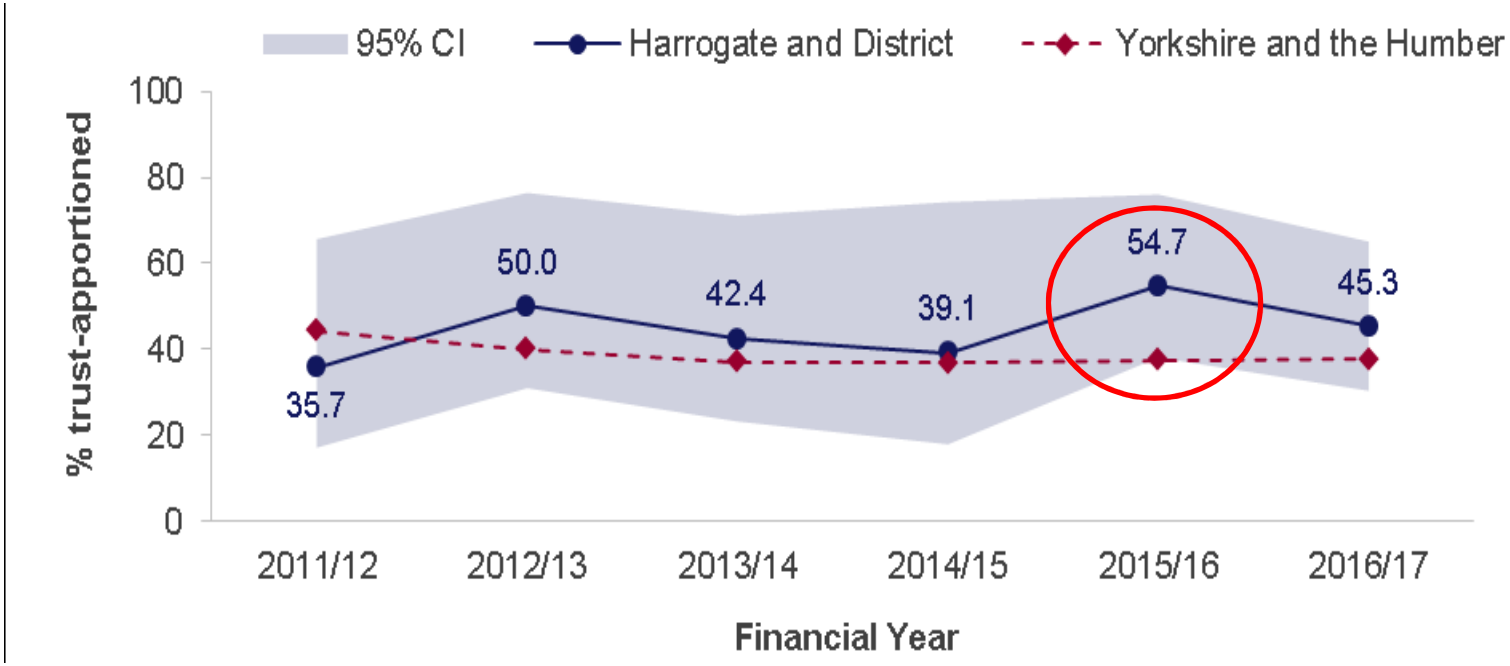
Figure 1 Trust-apportioned *C. difficile* infections (CDI), by month, compared with 2015/2016



Trust or non-Trust apportioned? Hospital-acquired or not?

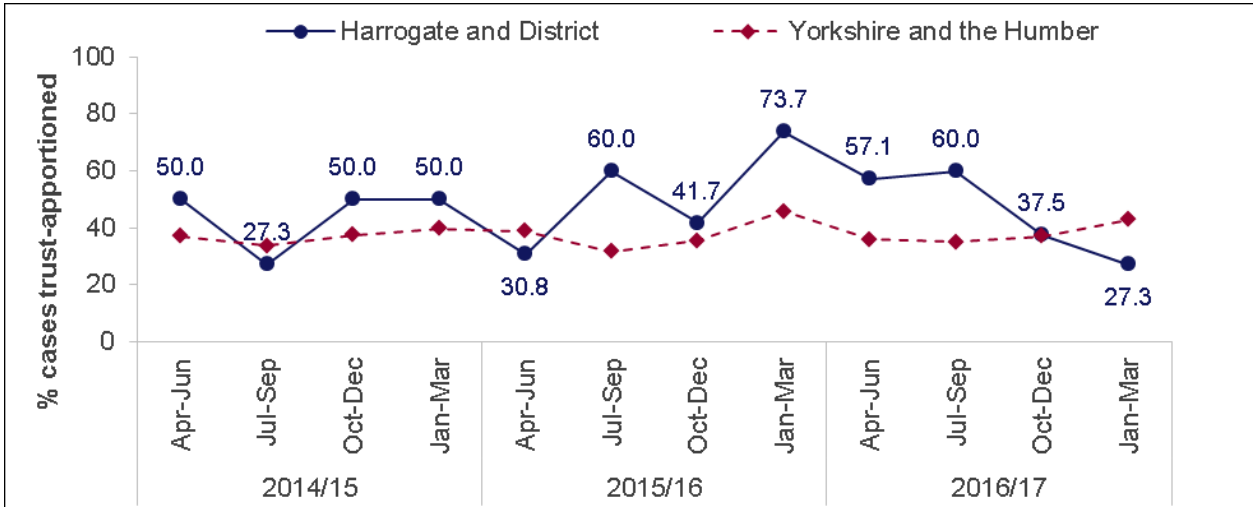
Currently, CDI cases are apportioned to the acute trust if a stool sample found to be cytotoxin positive was taken over 72 hours after the patient was admitted. That includes patients who were admitted with diarrhoea, but for whatever reason, there was a delay in sending a stool sample. Last October, the Regional Epidemiology Unit of the Yorkshire and Humber Public Unit confirmed that the proportion of CDI cases reported by HDFT which were apportioned to the acute Trust (ie probably hospital-acquired) was significantly greater than for the rest of the acute Trusts in the region (**Figure 2**) The conclusion was that not only did HDFT report more cases of CDI, but most of them were acquiring their infection during their hospital admission.

Figure 2 Annual percentage of *Clostridium difficile* infections (CDI) in patients aged ≥ 2 years apportioned to the acute trust HDFT, cf all acute trusts in Yorkshire and the Humber, 2011/12-2016/17



The difference between HDFT (54.7%(and the rest of the region (37.4%) by the end of 2015/2016 was statistically significant. Over the course of 2016/2017, the percentage of cases which were HDFT-apportioned fell steadily. The greatest change came in the last half of the year, i.e from October onwards (Figure 3). The end of year position for 2016/2017 is not significantly different from the Y&H average (HDFT 45.3%, 95% confidence interval 30.4-65.1%, Y&H 37.6)

Figure 3 ***Quarterly*** percentage of *Clostridium difficile* infections (CDI) in patients aged ≥2 years apportioned to HDFT and all acute trusts in Yorkshire and the Humber, 2011/12 - 2016/17



trust-apportioned = specimen date on or after the fourth day of admission to an acute trust; Data includes all cases reported from the trust including inpatients resident in out-of-area clinical commissioning groups regardless of apportioning.

Source (Figures 2 & 3): Lara Utsi, York & the Humber Regional Epidemiology Unit, Public Health England 18/4/17

Table 2 New episodes of CDI by ward: Trust-apportioned and (non-Trust apportioned)

MONTH	AMU	CATT	ED	Litt	Nidd	Wens	Farn	Harlow	Swale	Granby	Byland	Jervaulx	Oakdale	ITU/HDU	Wood	Pannal	SROMC	Lascelles	Ripon Trinity	TOTAL
April							1				1		1							3(0)
May				1						1(1)			1							3(1)
June					1		1						(1)							2(1)
July				(1)	(1)							1								1(2)
August	1						2					1								4(0)
September		1(1)										3								4(1)
October				1(1)	1		1						1	1						4(2)
November	1		(3)		(1)							1				1				3(4)
December		(2)		(1)								1	1(1)							2(4)
January		(1)		1			(1)	(1)					1							2(3)
February									(1)	1										1(1)
March		(1)															(1)			(2)

The point of breaking the figures down by ward and total number of confirmed CDI cases, including those which were not Trust- acquired is to identify wards that would benefit most from targeted cleaning, as they are likely to have the highest levels of environmental contamination with *C. difficile* spores.

Changes to mandatory HCA reporting scheme for 2017/2018

Gram-negative bacteraemias

As of April 2017, along with MRSA, MSSA, and *E. coli,* blood-culture isolates of Pseudomonas *aeruginosa* and Klebsiella species will probably be included under the national mandatory reporting scheme. There is currently a degree of uncertainty about exactly when this will come into force, or indeed if it already has, but no doubt all will become clear after the General Election.

The Government does appear to be committed to achieving a 50% reduction in Gram-negative bacteraemias by 2021. *E. coli* will now be **apportioned** to either an acute Trust or CCG, as will MSSA and *C. difficile*. Despite the reduction targets, details are as yet very sketchy, there is nothing yet to suggest having to report lapses in care as with *C. difficile*. *E. coli* will be apportioned to the trust along the same lines as MRSA and MSSA, ie whether or not the blood culture was taken on day 3 of admission or later, where the day of admission counts as day 1. The HDFT informatics team have been doing this routinely anyway, even although they have not actually been required to (table 1).

The mandatory dataset has now been expanded considerably, and the optional risk factor data, which was often not completed because it was too onerous to collect, was omitted. Entering this is probably to become mandatory soon, at the time of writing, we are still awaiting clarification. In practice, for most patients, this is going to involve a phone call to the GP with a request for extra data concerning leg ulcers, diabetic ulcers, urinary catheter history and care, and antibiotics prescribed in the preceding 28 days.

MRSA bacteraemias will continue to be assigned to the acute Trust, the CCG or "third party". All MRSA bacteraemias are required to have a formal root cause analysis (RCA).

Root cause analysis (RCAs) on Gram-negative bacteraemias

It will impossible for us to do RCAs on all *E. coli, Pseudomonas aeruginosa and Klebsiella spp* bacteraemias; the community team are not going to have the wherewithal to do them for all the North Yorkshire CCGs.

As an organisation, it is time to revisit which cases have RCAs. We will be expected to show a steady reduction across the whole healthcare economy, and therefore it seems reasonable that we do investigate cases that appear to have been hospital-acquired. As yet, it is unclear whether the performance management arrangements will require us to do RCA on all post 48h bacteraemias as currently happens with MRSA and *C. difficile.*

For example, should we do RCA on:

All Gram-negative bacteraemias taken on day 3 of admission or later- for cases which would appear to be hospital acquired.

Or

All case of reportable bacteraemias, regardless of whether pre- or post 48h of admission in which we have ticked yes to some of the mandatory risk factor questions including

- ERCP or MRCP in the last 28 days
- Prostatic biopsy in the last 28 days
- Surgery in the last 30 days (or a year if involving a prosthesis)

Probable changes to categorisation of *C. difficile:* 2017/2018 objective

In late 2016, PHE announced that as of April 2017, the categorisation of *C. difficile* was going to be changed to bring it more in line with European reporting.

The new categories were going to be:
HOHA- healthcare onset, healthcare associated. All those diagnosed >48hrs after admission. Currently known as "Trust apportioned"
COHA- community onset, healthcare associated. Diagnosed in the community, within four weeks of a previous admission- will presumably include readmissions within that time.
COIA- community onset/ indeterminate association. Diagnosed up to eight weeks after discharge from hospital.
COCA -community onset, community associated

This was apparently revoked at the last minute. The reporting is changing nonetheless in that it is now mandatory to report any previous hospital admissions in the previous 28 days, which would still allow PHE to analyse the figures in this way, which they have said they will now do informally. It would have been interesting to see how the hospital-associated group which would now include all the COHA would have increased.

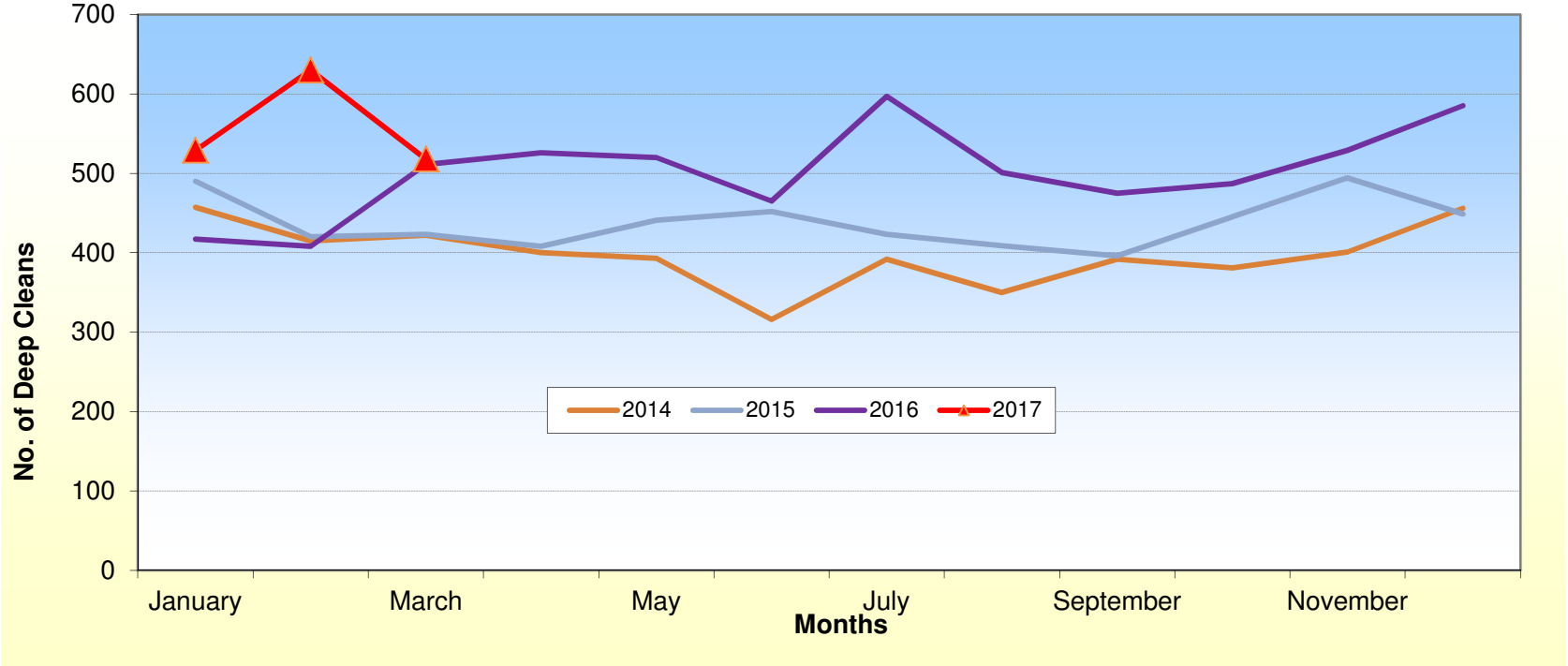
At the time of writing, it seems that the apportionment will continue to be done in the same way as before for performance management purposes, and the 2017/2018 objectives including sanctions are not going to change.

HDFT's 2017/2018 *C. difficile* objective will therefore remain at twelve.

Cleaning

Figure 4 **The number of deep cleans undertaken by the domestic department, by month, January 2014 – March 2017**

Source: Stuart Kelly, HDFT



The number of deep cleans undertaken by the domestic department has continued to rise year on year.
The record number of deep cleans requested in February was on account of the norovirus situation at the time.

Jervaulx had a period of increased incidence in the summer (table 2) and had a full decant, deep clean and HPV treatment in September 2016, since when there have only been two more cases

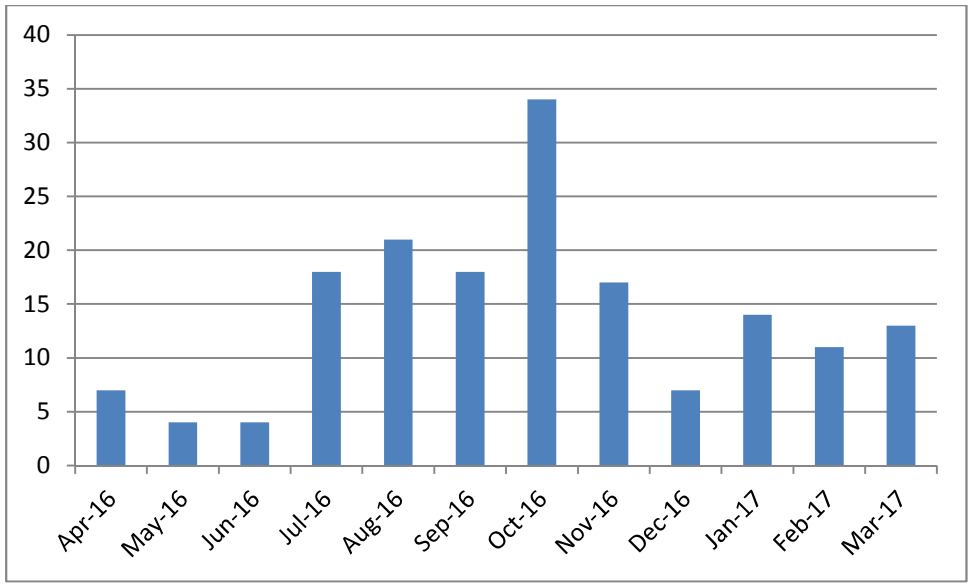
.

Environmental decontamination

The role of the contaminated environment in the transmission of HCAI, and therefore the importance of cleaning and decontamination is now beyond all reasonable doubt, with several large and well conducted studies published over the last two years. We reviewed our approach to decontamination, and agreed to renew our hydrogen peroxide vapour machines (Bioquell). We have now taken possession of two new HPV machines produced by another company (Hygiene Solutions) who as part of the deal have loaned us a UVC machine

The number of rooms treated with hydrogen peroxide vapour (HPV) increased by 32% from 74 in April-September 2016 to 96 in October 16-March 2017.

Figure 5 Number of rooms at HDFT treated with HPV, 2016/2017



Dr J Child Consultant Microbiologist/Director of Infection Prevention and Control
19th April 2017

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