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Harrogate and District NHS
NHS Foundation Trust

The meeting of the Board of Directors held in public will take place on Wednesday 25 January 2017 Boardroom, Harrogate District Hospital, HG2 7SX

Start: 09.15am Finish: 12.30pm

AGENDA			
Item No.	**Item**	**Lead**	**Paper No.**
Transformation Programme delivery update and Improvement Strategy implementation update		Mr D Plews, Deputy Director, Partnerships & Innovation	
8.45am Patient Story – IN PRIVATE			
9.15am – 11.00am			
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 30 November and 21 December 2016** *To review and approve the minutes*	Mrs S Dodson, Chairman	3.1 3.2
4.0	**Review Action Log and Matters Arising** *To provide updates on progress of actions*	Mrs S Dodson, Chairman	4.0
Overview by the Chairman		Mrs S Dodson, Chairman	-
5.0	**Report by the Chief Executive** *To receive the report for comment*	Dr R Tolcher, Chief Executive	5.0
10.15am – 10.25am – Break			
10.25am – 12.30pm			
6.0	**Integrated Board Report** *To receive the report for comment*	Dr R Tolcher, Chief Executive	6.0
7.0	**Report by the Finance Director** *To receive the report for comment and **approve** the quarterly use of resources declaration to NHS Improvement*	Mr J Coulter, Deputy Chief Executive/ Finance Director	7.0
8.0	**Report from the Chief Operating Officer** *To receive the report for comment and **approve** the quarterly governance declaration to NHS Improvement*	Mr R Harrison, Chief Operating Officer	8.0
8.1	**Information Technology Strategy** *To receive the strategy for comment*	Mr R Harrison, Chief Operating Officer	8.1

9.0	**Report from the Chief Nurse** *To receive the report for comment*	Mrs J Foster, Chief Nurse	9.0
9.1	**Patient Safety Visits Annual Report** *To receive the report for comment*	Mrs J Foster, Chief Nurse	9.1
10.0	**Report from the Medical Director** *To be considered for comment*	Dr D Scullion, Medical Director	10.0
10.1	**Guardian of Safe Working Hours Quarterly Report** *To receive the report for comment*	Dr D Scullion, Medical Director	10.1
11.0	**Report by the Director of Workforce and Organisational Development** *To receive the report for comment*	Mr P Marshall, Director of Workforce & Organisational Development	11.0
12.0	**Hospital Pharmacy Development Plan** *To approve the plan*	Mr A Alldred, Clinical Director	12.0
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** *To receive the report from the Quality Committee meeting held 7 December 2016* *To receive the report from the Audit Committee meeting held 8 December 2016 and **approve** the Audit Committee Terms of Reference* *To receive the report from the Finance Committee meeting held 19 December 2016 and **approve** the Finance Committee Terms of Reference*	Mrs L Webster, Non-Executive Director/ Quality Committee Chair Mr C Thompson, Non-Executive Director/ Audit Committee Chair Mrs M Taylor, Non-Executive Director/ Finance Committee Chair	14.1 14.2 14.3
15.0	**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	-
16.0	**Any other relevant business not included on the agenda** *By permission of the Chairman*	Mrs S Dodson, Chairman	-
17.0	**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
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
Professor Sue Proctor	Non-Executive Director	1. Director and owner of SR Proctor Consulting Ltd 2. Chair, Safeguarding Board, Diocese of York 3. Member – Council of NHS Staff College (UCLH) 4. Associate – Good Governance Institute 5. Associate – Capsticks
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

January 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 on Wednesday 30 November 2016 8.30am in the Derwent Room, The Pavilions, Great Yorkshire Showground, Harrogate, HG2 8NZ

Present:
Mrs Sandra Dodson, Chairman
Dr Ros Tolcher, Chief Executive
Mr Jonathan Coulter, Deputy Chief Executive/Finance Director
Mr Rob Harrison, Chief Operating Officer
Mrs Jill Foster, Chief Nurse
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:
Ms Debbie Henderson, 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 Johnson, Clinical Director for Planned and Surgical Care
Dr Jenny Child, Director of Infection Prevention and Control *(for Board pre-brief only)*
Ms Carly Parker, Clinical Lead and Ms Lisa Salmon, Health Visitor – *Patient Story*
Mrs Angie Colvin, Corporate Affairs and Membership Manager (minutes/observer)
Mr David Griffin, Non-Executive Director observer *(the Insight Programme)*
Ms Denise McConnell, Non-Executive Director observer *(the Insight Programme)*

Patient Story

Mrs Dodson introduced Mrs Salmon, Health Visitor and Mrs Parker, Clinical Lead for Community Services who attended the meeting to share a recent patient story involving the care and treatment of a Syrian Refugee family in the community.

On behalf of the Board, Mrs Dodson thanked Mrs Salmon and Mrs Parker for sharing their case study and acknowledged their personal resilience in dealing with such complex and sensitive issues. Mrs Dodson also referred to the likelihood of these cases becoming more frequent and the need to think about how the Trust can prepare colleagues and services in the future.

Board Briefing – Director of Infection Prevention and Control Update

Dr Child delivered a presentation to the Board on some of the challenges relating to Infection Prevention and Control (IPC), particularly following recent concerns highlighted by the Board of Directors in response to the recent increase in Clostridium difficile (C. diff) cases. The Board acknowledged that ongoing monitoring and oversight of the management of IPC would remain the delegated responsibility of the Quality Committee, but it was important for the Board to maintain oversight.

The Trust reported 24 cases of Hospital Acquired C. Diff to date for 2016/17. Five patients died within 30 days of C. diff infection diagnosis, but none of the deaths were found to have been attributable to C. diff. Dr Child reported that following root cause analysis, five cases of C. diff had been attributed to lapses in care, a majority of which related to antibiotic prescribing issues. It was noted that approximately 28% of inpatients require anti-biotic prescribing at any one time, which was considerably lower than the national average.

Dr Child provided an update on the Trust apportioned C. diff rates per 100,000 bed days from April – June 2016 for all Trusts nationally and noted HDFT as an outlier. These findings had also been raised by CCG colleagues and NHS England.

The Board noted the proportion of hospital acquired C. diff cases apportioned to HDFT and a recent discussion with Public Health England which confirmed the percentage of hospital acquired HDFT cases compared to the region as a whole was statically significant. Overall, the numbers of cases had tripled since 2011/12 and reflected a significant increase in community acquired C. diff cases. Dr Child suggested that the main cause of the increase related to environmental issues.

A discussion took place regarding the significant increase in deep cleans between January 2014 to October 2016 and Dr Child suggested that to maintain current levels of cleanliness and infection prevention and control would be challenging with the current level of resource. Dr Child stated that in-hospital transfer of patients had an impact on the requirement for deep cleaning and domestic staff.

Dr Child briefed the Board on forthcoming changes to regulation and classification for C. diff including a move toward case assessment as 'Healthcare Community' as a whole system approach.

A further development in 2017/18 would be targets relating to E-coli bacteraemia, and Dr Child noted approximately 85% of E-coli bacteraemia were community acquired and therefore a system-wide approach involving Primary Care and Social Care would be required.

Dr Tolcher reminded Board members that the purpose of data collection relating to infection prevention and control had been to drive forward continuous improvement for patients. Dr Tolcher emphasised the need to ensure the Trusts systems and processes were robust enough to protect patients from harm across the whole system. External discussions regarding changes to commissioning architecture had been recognised which would highlight the need to focus on how the system uses data to drive patient safety and high quality care.

Dr Tolcher asked Dr Child to expand on the proposals to improve and address the issues relating to environmental load. Dr Child referred to UV-C disinfection technology and the importance of ensuring up to date equipment. A business case had been submitted and a meeting held with domestic staff to explore the options available. Dr Child reassured members of the Board that the options had been subject to substantive study.

Mr Harrison referred to the significant increase in community acquired C. diff cases and asked if the IPC Team had considered options to further support residential and nursing homes. Dr Child stated that the number of community cases was relatively low and it had been the numbers of patients admitted to hospital with C. diff which had significantly increased. Mr Harrison reiterated that given the volume of patients admitted to hospital with C. diff had increased; further exploration of opportunities to address the community load would be beneficial.

Mr Thompson referred to the business case for new technology to support infection prevention and control and supported the need to consider it promptly, particularly given the continual increase in deep cleans across the Trust. Mr Thompson also queried the effective use of resource into root cause analysis (RCAs) for C. diff cases particularly given the Trusts acknowledgement of the fundamental issues. Dr Child confirmed that the process had significantly improved in terms of efficiency and timeliness including consultant involvement, and the RCAs also provided valuable outcomes in terms of lessons to be learnt.

Dr Scullion asked if the reason for admission for some patients had been due to C. diff. Dr Child stated that this was sometimes the case, but not the majority. Communication with GPs was in place regarding antibiotic prescribing.

In summary, Mrs Dodson emphasised the need to ensure avoidance of harm, but acknowledged that there appeared to be a disconnect between some of the data and causes of the increase in cases of C. diff. Via Quality Committee, the Board would continue to maintain a strong focus on understanding infection prevention and control. The Board also needed sufficient confidence that the systems and processes were in place to understand lessons learnt in cases of lapses in care, and that a different approach may be required in the future in terms of working as a system to drive down the number of infections.

Dr Tolcher also took an opportunity to reinforce that if the Trust maintained the status quo approach to infection prevention and control a similar trend would continue and therefore further work in terms of data interrogation would be required to drive forward improvements.

1. Welcome and Apologies for Absence

No apologies for absence had been received. Mrs Dodson welcomed to the meeting one Governor and two members of the public and welcomed Ms Denise McConnell and Mr David Griffin to the meeting as observers. Ms McConnell and Mr Griffin had been allocated a placement at the Trust for a period of six months as part of 'The Insight Programme' to learn about the role of Non-Executive Directors.

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 28 September 2016

The draft minutes of the meeting held 26 October 2016 were considered.

APPROVED:

- **The Board of Directors approved the minutes of the meeting held 26 October 2016 as an accurate record of proceedings**

4. Review of Action Log and Matters Arising

Completed actions were noted.

Item 2 – with regard to the methodology for reporting Serious Incidents Requiring Investigation (SIRIs) Dr Scullion suggested that a further discussion take place to ensure clarity around expectations of all Board members with a recommendation to the January 2017 meeting. Mrs Webster emphasised the need to ensure inclusion of SIRIs relating to pressure ulcers and falls. It was agreed to remove the item from the action log and delegate oversight of the action to the Quality Committee. Dr Tolcher also noted that strategic key performance indicators (KPIs) were in place regarding risks and incidents.

Item 3 – With regard to ensuring appropriate governance arrangements were in place for Board approvals of quarterly financial declarations, Mr Coulter had raised the issue with NHS Improvement. It was noted that the submission date for the 'governance' declaration would remain the last working day of the month. It was acknowledged that the Board would not require any additional reporting or assurance for the quarterly financial submissions and would continue to receive updates and assurance via the monthly Finance Director reports.

Item 4 – Mr Alldred confirmed that the metric relating to readmissions within 30 days remained in development. A case note review, via the Community Response and Overnight Service, had commenced which focused on patients referred with an acute need who are subsequently re-admitted.

With regard to Integrated Board Report (IBR) and reducing admissions in older people, Mr Alldred noted that although a reduction had been seen over the previous two months, it was too early to draw conclusions. Mr Harrison suggested that a secondary discussion take place regarding readmissions where the Trust had been identified as an outlier during the same period. Mr Harrison referred to a recent audit undertaken by Leeds Teaching Hospitals NHS Trust regarding the appropriateness of readmissions and noted that this work was due to commence in HDFT. It was envisaged that the results from the audit, as well as a case note review, would also help identify impact due to HDFT pressures and potential changes.

Item 5 – With regard to the Care of Frail Older People's Strategy Mr Alldred stated that engagement with a wide range of stakeholders had taken place and a Strategic Board had been developed to take forward the action plan work. An initial meeting had been held to set out the strategic direction and to overview each of the domains including how success would be measured. Mr Alldred also confirmed the agreement that the identification of a Non-Executive Lead was not necessary and that oversight of the strategy would be undertaken by the Board as a whole.

Mrs Dodson requested an update on the action plan and progress against the strategy at the Board of Directors' Strategy Day in March.

Mr Thompson referred to the completed action regarding a review of the Audit Committee annual survey questionnaire for auditees. It had been noted that only 22 out of 64 responses had been received in January 2016 and a review had been undertaken to streamline the questionnaire. Mr Thompson noted that the questionnaire would be issued in December and emphasised the importance of encouraging members of staff to complete the questionnaire, particularly following the recent changes to the audit service.

Mr Coulter referred to the Board approval of the acceptance of the Trust's Control Total at the October meeting, subject to confirmation from NHS Improvement and the impact of HGR4. Mr

Coulter informed Board members that the surplus had since reduced by £300k, resulting in the Trusts acceptance of a Control Total of £5.9m instead of £6.2m.

Dr Lyth referred to paper 4.1 previously circulated in advance of the meeting which provided detail of progress made with regard to the scoping process to determine more accurately what does and does not exist in terms of metrics for the Children's and County Wide Community Services Directorate, and the position of each service in relation to the ability to report KPIs.

Dr Lyth asked the Board to note the complexity of the work to establish clear metrics due to the inter-dependencies with IT, SystemOne, Electronic Paper Records (EPR), the diversity of services and the roll out of agile working. Dr Lyth stated that benchmarking had commenced to establish reporting, governance for reporting, and gaps in reporting, and a further recommendation would be submitted to the February meeting of the Board regarding metrics to be included in the IBR.

As Non-Executive Director lead for Children's Services, Mr McLean emphasised that the review of data and metrics represented a large and complex piece of work, particularly in terms of the level of input required from the Informatics Team. Mr McLean asked the executive to consider the risks in terms of ensuring adequate resource within the Informatics Team to support the directorate as well as maintaining the current service.

Mr Harrison confirmed that the team had benefited from investment in the service, but reminded Board members of the priorities of the Informatics Team to undertake the mandated workload required in terms of performance reporting, which fell largely in the acute side rather than the community. It was acknowledged that the Informatics Team had provided support to the directorate, and that the request had been to build on the current level of support to enhance visibility of the metrics at Board level.

Dr Tolcher referred to the challenges in balancing the data collection necessary for compliance and contractual purposes with information to enable the Board to run an efficient and sustainable business. Dr Tolcher advised that the risks be reflected on the Board Assurance Framework and suggested that the executive team review the resource and investment profile for the Informatics Team and report back to the Board in February 2017.

Mr Harrison also suggested publishing the quarterly performance reports generated for the Children's and County Wide Community Services directorate in the Reading Room to provide further assurance to the Board in the meantime.

ACTION:

- **Transfer action 2 to the action log of the Quality Committee**
- **Care of Frail Older People Strategy update to the Board Strategy Day in March 2017**
- **Recommendation to the February Board meeting clarifying metrics for inclusion in the IBR for the Children's and County Wide Community Services Directorate**
- **The Board of Directors acknowledged the change to the Trust's Control Total as £5.9m**
- **Executive Team to review the resource and investment profile for the Informatics Team and reflect the risks in the Board Assurance Framework**
- **Upload quarterly performance reports relating to the Children's and County Wide Community Services directorate into the Reading Room**

Overview by the Chairman

Mrs Dodson referred to the theme for the meeting as identified by the Non-Executive Directors as 'forecasting resilience' and ensuring that the Trust had the capability and capacity to robustly forecast in terms of income, activity and cost for the remainder of the 2016/17 year, as well as 2017/18 and 2018/19 via the Operational Plan. Mrs Dodson also stated that the importance of forecasting for resilience would also underpin the challenges of developing two-year contract negotiations.

5. West Yorkshire and Harrogate Sustainability and Transformation Plan (WYHSTP)

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

5.1 Mrs Dodson referred to the final West Yorkshire and Harrogate Sustainability and Transformation Plan (WYHSTP) and noted that the Board had taken an opportunity to discuss the draft plan in detail at the Extra-ordinary Board of Directors' meeting in October.

5.2 Dr Tolcher confirmed that the final plan had been submitted to NHS Improvement on 21 October in line with national requirements. System leaders felt strongly that the document should be publicly available and noted that the plan was available on the Trust's website. This would ensure transparency and allow any necessary engagement and consultation requirements to be undertaken as early as possible.

5.3 Dr Tolcher referred to concerns raised by North Yorkshire County Council colleagues who sat within three separate STPs which had resulted in challenges for NYCC from an engagement and governance structure point of view at North Yorkshire level. In response to correspondence from NYCC to the Secretary of State and Chief Executive Officers of NHS England and NHS Improvement, the Trust and other local partners had taken an opportunity to write to the regulators to confirm their belief that the Harrogate and rural district sat within the most appropriate STP footprint, based on patient flow and clinical alliances. The Trust also acknowledged the existing valuable clinical alliances with others including York, and advised that in terms of future structural commissioning; the needs of the population would be better met with HDFT in the existing WYHSTP footprint.

5.4 Mr McLean asked what the Boards position would be if the Trust was asked to move to another STP. Dr Tolcher advised that the assurance from NHS Improvement to date had been that boundaries could not be re-drawn without agreement from providers and commissioners, and confirmed that Harrogate and Rural District CCG shared the views of the Trust.

5.5 Mr McLean requested that the Board formally resolve their position. Mrs Dodson confirmed that the Board resolved that the placement of the Trust within the West Yorkshire and Harrogate Sustainability and Transformation Plan was considered to be the preferred placement for the benefit of the patients and service users of the Trust.

5.6 Professor Proctor supported the formal resolution of the Boards position and queried the position of the Leeds City region. Dr Tolcher confirmed that the Leeds CCGs sat within the West Yorkshire footprint and confirmed that Harrogate Borough Council were wholly supportive of Harrogate remaining within the WYHSTP.

5.7 Dr Tolcher referred to local media coverage of the recent discussion at the North Yorkshire Overview and Scrutiny Committee relating to STPs and speculation that some services across the three STPs which include the footprint of NYCC, may be subject to

downgrading or closure. Dr Tolcher took an opportunity to provide clarity there had been no reference in the WYHSTP to suggest downgrading of the Emergency Department or Maternity Services. It was acknowledged that some services may change but any changes would be subject to the appropriate engagement and consultation process.

RESOLVED:

- **That the Board resolved that the placement of the Trust within the West Yorkshire and Harrogate Sustainability and Transformation Plan was the preferred placement for the benefit of patients and service users of the Trust.**

6. Report by the Chief Executive

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

6.1 Dr Tolcher confirmed that the New Care Model was now live across the whole district and acknowledged the resilience, commitment and hard work of members of staff and partners across the system.

6.2 In respect of the WY ED Acceleration Zone following the work of Chief Operating Officers across the region to agree what actions would be required in order to achieve the ambition of delivering the Emergency Department (A&E) 95% 4-hour waiting time standard at West Yorkshire level by March 2017, Dr Tolcher confirmed that capital and revenue funding had now been agreed. Although the value of the funding was less than required, plans to implement the work had been accelerated. Dr Tolcher took an opportunity to thank Mr Harrison for his contribution in ensuring the funding was secured. Mr Harrison stated that the Emergency Department capital scheme would be complete in March 2017.

6.3 The Board of Directors were asked to confirm their support for the direction of travel to develop a Committee in Common for the West Yorkshire Association of Acute Trusts (WYAAT). A detailed paper would be discussed in private session.

6.4 With regard to the financial position, Dr Tolcher reported a position at the end of Month 7 (October) as a year to date operational surplus before Sustainability and Transformation (S&T) funding of £144k, a deterioration from Quarter 2 of £483k and £761k behind plan. As a result, no S&T funding had been assumed for October. The deterioration related primarily to activity and income shortfall. A detailed discussion had taken place at Senior Management Team with a particular focus on: theatre activity and productivity; the need for a more stringent approach to vacancy management; increased focus on agency medical staffing; and stopping further 'discretionary' spend.

6.5 Mr Coulter confirmed that a significant amount of work had commenced to address the shortfall, but also noted that performance had been stronger in comparison to the previous year. The Use of Resources Risk rating under the Single Oversight Framework remained a 1 for the year to October.

6.6 Mr Ward referred to the focus on income and the difference in trend in comparison to earlier years and asked if activity was available to meet the forecast. Mr Harrison stated that activity was available and confirmed that there had been a year-on-year increase in income of £3.5m in terms of activity when looking at like for like comparisons in acute, elective and non-elective income. Mr Harrison confirmed that the deteriorating position had been in 18 weeks for both inpatient and outpatient activity in some specialities where the Trust had not seen the expected level of activity, and further work would be required to address these areas including reviewing theatre utilisation and productivity in theatres.

6.7 Dr Johnson referred to weekend working, the use of bank and agency workers and the impact of this on the uptake of weekend lists, and noted nervousness expressed by some consultant staff regarding some of the initiatives being considered, particularly cancellation of Audit Days. Dr Johnson emphasised the need to be clear of the risks as well as the benefits of any initiatives being considered.

6.8 Mr Marshall referred to discussions with the British Medical Association who had been supportive of achieving productivity gains through various initiatives but the associated challenges and risks had also been acknowledged. Dr Scullion briefed the Board on the gains associated with cancellation of Audit Days. Dr Scullion felt that the consultant workforce remained unclear in their understanding of the financial impact they could have by embracing such initiatives, in terms of helping the Trust achieve its Control Total resulting in significant contribution to the capital plan and patient care.

6.9 Mr Ward took comfort in the reassurance given, but still expressed concern regarding the downward trend in shortfall of income. Dr Tolcher acknowledged the challenge and need for robust activity planning but also noted that historically NHS activity had always increased year on year, but in reality now had stabilised. Mr Marshall advised that an opportunity for further discussion could be taken at the Consultant Forum.

6.10 Dr Tolcher emphasised the need to remember that the end of year surplus would be driven by activity and margin. There was a need to moderate expectations and recognise that growing the margin on current activity was dependant on productivity improvement. Dr Tolcher advised that the financial position was retrievable but asked the Board to take a view of the approach to be taken internally. The Board agreed to take a firm approach to recovery during quarter 4, and acknowledged the potential ramifications in terms of discretionary spend.

6.11 Mr Thompson asked for further information as to why Health Education England (HEE) decided to extend the probationary period. Mr Marshall noted that the Trust had been given a clear message that core medicine would be removed from the probationary period however, following the visit; the HEE Quality Impact Assessment process required an extension until December.

6.12 With regard to the New Care Models, Mrs Webster asked when the national monitoring system would go live. Dr Tolcher was not aware of a firm date but noted that the driver in terms of cost would be bed occupancy.

6.13 Mrs Dodson referred to the reduction in falls of 23% for the year and asked for more information on the Limited Assurance Internal Audit rating for Falls Prevalence. Mrs Foster confirmed that the recommendations primarily focused on improvement required with regard to responding to call bells and the reflection of national guidance in Trust documentation. Mrs Foster stated that a significant amount of work had been undertaken and it had been disappointing to receive a Limited Assurance report.

AGREED:

- **The Board of Directors agreed the direction of travel to establish a Committee in Common for the West Yorkshire Association of Acute Trusts (WYAAT)**
- **The Board agreed to support the executive team in a firm approach to financial recovery, particularly with regard to the impact on discretionary spend.**

7. Integrated Board Report (IBR)

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

7.1 Professor Proctor referred to standardised readmissions and asked if the data represented a concerning trend, and what actions would be taken to address the specialities with the highest rates. Mr Harrison agreed that the data had flagged the Trust as an outlier and confirmed that work had commenced to undertake case note reviews of readmissions, alongside a larger project with commissioners to look at reducing readmissions. Mr Harrison also made reference to significant bed pressures and the need to ensure this was not impacting on readmissions. Professor Proctor requested a further update be provided to the February Board meeting.

7.2 Professor Proctor referred to Delayed Transfer of Care (DTOCs) and noted her attendance at a recent event and the message from the Chief Executive of NHS Improvement that DTOCs were unacceptable. Professor Proctor asked if any actions were within the gift of Trust to influence the reduction in DTOCs.

7.3 Mr Harrison noted that a significant proportion of DTOCs related to family choice. A significant proportion also related to delays in health care assessments. The Trust had commenced work via the A&E Acceleration Zone with Local Authorities and commissioners on 'Discharge to Assess' which aspires to undertake patient assessments regarding their longer term care out-with the hospital setting.

7.4 In response to a query from Mrs Taylor regarding elective length of stay, Dr Johnson briefed the Board on the issue of capacity for pre-assessment to address the long standing practice of orthopaedic patients being admitted to the Trust for pre-assessment the night before. Mr Harrison also highlighted the impact of personal choice made by consultants who choose to take this approach and the need to ensure systems are in place for consultants to have confidence to admit patients for pre-assessment on the morning of their procedure.

ACTION:

- **Update on the standardised readmissions to be submitted to the February Board**

8. Report by the Director of Finance

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

8.1 The Trust's financial position had been covered in detail under the Chief Executive's report (item 6).

8.2 Mr Coulter referred to the Trust's cash flow position and confirmed that performance was behind plan as at the end of month 7 (October) and would likely be reporting as being behind plan for Month 8 (November). Further discussion would take place in private session.

8.3 Mr Coulter noted that correspondence had been received from NHS Improvement regarding the delays in releasing the S&T funding secured for quarter 2. Mrs Webster asked if the delay would impact on the Trust's Single Oversight Framework Use of Resources rating for Quarter 3. Mr Coulter confirmed that the liquidity measure would not be affected.

8.1 Operational Planning 2017/18 and 2018/19 update

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

8.1.1 Mr Coulter asked the Board of Directors to note the submission of the Trust's draft Operational Plan for 2017/18 and 2018/19 on 24 November in line with NHS Improvement reporting requirements.

9. Report from the Chief Operating Officer

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

9.1 In terms of winter readiness, Mr Harrison noted that six beds on Nidderdale and seven beds on Farndale had been closed in October. However, week commencing 14th November the beds had been re-opened due to additional demand. In addition, eight additional Elderly Care beds had opened during this period. This had placed additional demands on nurse staffing and the increase in demand and occupancy had also had an impact on A&E performance in November.

9.2 Mr Harrison noted that the Trust had reported exceptional activity with over 50 Emergency Department admissions per day on occasion which compounded previous discussions regarding the need to reduce length of stay. Mr Harrison confirmed that the Trust achieved the October A&E 4-hour waiting time target, but reported that the despite the likelihood of the target for November not being achieved, the Trust would remain in the top 20 performers for the target in the country. The Board received reassurance that the Trust continued to maintain patient safety and quality of care, but Mr Harrison asked that the pressures on the ground floor not be underestimated by the Board.

9.3 Mr Alldred and Mr Harrison also provided an update with regard to team work between the Emergency Department and CATT and surgical wards to ensure maximisation of patient flow whilst minimising patient impact. From a patient safety perspective, Dr Tolcher asked if there had been any incidents or concerns in meeting the needs of patients in a timely way. Mr Alldred and Mr Harrison confirmed that no issues had been highlighted, although the Trust did report its first ever 12-hour trolley wait. It was acknowledged that this was unacceptable, and the team would continue to closely monitor activity and support the Emergency Department.

9.4 Dr Tolcher referred to the need to consider patient acuity as well as the number of admissions in the Emergency Department and whilst the Board acknowledged the increase in activity, the Trust would continue to target resources on the most unwell and clinically urgent patients.

9.5 Mr McLean suggested undertaking some positive publicity regarding the significant amount of work, effort and commitment from teams to meet the increasing demand in the Emergency Department. Dr Tolcher agreed to discuss opportunities further with the Communications and Marketing Team.

ACTION:

- **Explore opportunities for more proactive media regarding current system pressures**

10. Clinical Workforce Strategy

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

10.1 Mrs Dodson reminded everyone that the Board had an opportunity to review and contribute to the development of the Clinical Workforce Strategy in October. Mr Marshall stated that as of 1 April 2017 the workforce landscape would change with a move away from Health Education England (HEE) funded graduate programmes, to allow Sustainability and Transformation Plans to fund their own priorities. Mr Marshall noted that the strategy had been written by, and for staff, patients and service users and identified the key priorities and objectives for the Trust which would inform workforce plans in the future.

10.2 Mr Marshall made particular reference to: the three work streams; the need to complete consultation; and the need to align the strategy to the Clinical Transformation Board. Mr Marshall took an opportunity to thank Mr Harrison and Professor Proctor for their involvement in developing the strategy.

10.3 In terms of going forward, Professor Proctor asked how the Board would receive updates on progress on achievement of the strategy and objectives. Mr Marshall suggested that the Board receive a bi-annual update on the action plan in May and November each year.

APPROVAL:

- **The Board of Directors approved the Clinical Workforce Strategy**

ACTION:

- **To include a bi-annual report on progress against the Clinical Workforce Strategy action plan to the Board on the Board Forward Plan**

11. Report from the Chief Nurse (including the Trust's response to the Alan Wood Report)

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

11.1 Mrs Foster provided an update on the Director inspections and noted the continued red rating for Pannal Ward due to IV Cannula Care. Although a formal review had yet to be scheduled, Mrs Foster confirmed that an Internal Audit had been undertaken.

11.2 With regard to actual versus planned staffing levels, Mrs Foster referred to a patient safety visit undertaken following compilation of the report, and noted genuine concerns regarding current workload pressures, activity levels and vacancies. The concerns raised by staff members relating to their confidence of the level of care they are able to provide in light of the current pressures. Mrs Foster had been humbled to hear the concerns which demonstrated the commitment of staff to delivering high quality care.

12.3 Mrs Foster reported a number of ongoing Serious Case Reviews in County Durham, Darlington and Middlesbrough, and confirmed that all cases were subject to safeguarding input and were monitored and led by the safeguarding teams.

12.4 Mrs Foster referred to the Trust's response to the Alan Wood Report, commissioned to review the efficiency and effectiveness of local Safeguarding Boards, and confirmed that there were no material issues for the Board to note.

12.5 Mrs Webster referred to the last minute cancellation of patient safety visits, and noted the apathetic response from a ward when re-arranging a visit. It was therefore suggested that a review of patient safety visits be undertaken to include: a review of their purpose; perception of their value from wards/departments; and opportunities to strengthen their value. Mrs Dodson also asked that, in the absence of a strong material reason, patient safety visits were not to be cancelled. Dr Tolcher reminded members of the Board that the patient safety visits had been established to promote the culture of safety by engaging with those staff providing care.

12.6 With regard to the Middlesbrough learning event, Professor Proctor asked that further thought be given to sharing learning across the breadth of the Trust, particularly in areas caring for vulnerable patients and families, and in light of the patient story, those who suffer trauma.

12.7 Mr Thompson noted the value of the information provided in the Nurse Staffing Acuity Tool report and asked if the Board were required to receive the Chief Nurse Report on a monthly basis, given the clear disparity of information between the two reports. Mrs Foster confirmed that providers were required to publish safe staffing figures on a monthly basis, but emphasised that the figures and the acuity dependency tool were only one method used. It was acknowledged that the Chief Nurse report also included information regarding the environment, benchmarking, and qualitative information to ensure the Board remain sighted on the nuances of each service.

12.8 Mrs Webster suggested that e-rostering be included in the recommendations. Mrs Foster advised that e-rostering would be included in the Trust's suite of core metrics.

12.9 Mrs Webster asked if comparisons could be made to other Trusts. Mrs Foster confirmed that NHS Improvement remained undecided as to the purpose and use of the data, which resulted in an inability to benchmark with reliability.

12.10 Dr Tolcher noted that whilst benchmarking could be useful, the disparities between Trust's in ensuring safe staffing were significant and individual Boards required confidence in the Trust's ability to deliver high quality care. From a strategic point of view, Dr Tolcher referred to the Trust's ambition to reduce length of stay and bed numbers to ensure that patients are treated in the right place at the right time. As a result, patients would be of a higher acuity, thereby impacting on the Trust's current nursing establishment. It was agreed that a recommendation paper would be submitted to the March meeting of the Board on the Trust's substantive nursing workforce requirements.

ACTION:

- **To review the purpose and value of Patient Safety Visits and report back to January Board as part of the Chief Nurse Report**
- **A recommendation paper to be submitted to the March 2017 meeting of the Board on the Trust's substantive nursing workforce requirements.**

11.1 Bi-annual Safe Staffing Acuity Tool

The report had been circulated in advance of the meeting and was taken as read. The report was discussed in conjunction with agenda item 11.0

12. Report from the Medical Director

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

12.1 Dr Scullion referred to a National Patient Safety Alert on nasogastric tube misplacement: continuing risk of death and severe harm, and the recommendation that the alert be shared at Board level.

12.2 Dr Scullion noted that the Trust had received notification of its NHS Litigation Authority contribution for 2017/18 and confirmed that the cost to the Trust had increased over and above the national average. 17% of the 30% increase related to obstetrics resulting from two relatively high profile obstetrics cases which had resulted in a financial settlement during the year.

12.4 In response to a query from Mr Thompson regarding the impact of the increase in NHS Litigation Authority contribution, Mr Coulter confirmed that the cost would result in a genuine cost pressure, which had been reflected in the revised Control Total for the year.

12.5 Dr Johnson referred to the national publication of Safer Maternity Care and the requirement for Board's to appoint a Board level maternity champion. The Board agreed the appointment of Mrs Foster as the Board level maternity champion.

ACTION:

- **The Board acknowledged the NPSA alert relating to nasogastric tube misplacement**
- **The Board agreed the appointment of Mrs Jill Foster as the Trust's Board level Maternity Champion**

13. Report by the Director of Workforce and Organisational Development

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

13.1 Mr Marshall referred to NHS Improvement's request for Board approval of the self-certification checklist to ensure Board oversight that Trust's continue to scrutinise spend on agency staff. The self-certification had been designed for Trusts to show that there are robust processes in place, with appropriate oversight and senior and executive level approval. The checklist would be submitted to NHS Improvement by close of play on 30 November.

13.2 Mr Marshall referred to the workforce metrics contained in the IBR and reported improved performance relating to sickness absence, turnover, mandatory training and appraisal rates.

13.3 Mr Marshall briefed the Board on the recent visit to the Trust by the Apollo Group and Health Education England (HEE), which are running the Indian element of the Global Health Exchange initiative. The visit included Trust presentations and tours of the hospital. Interviews had taken place for the first cohort of nurses under the Initiative and work had commenced to move towards making conditional offers of employment to a number of candidates.

13.4 Mr Marshall referred to the introduction of the Schwartz Rounds which provided all members of staff with an opportunity to listen to the experiences of their colleagues. Mrs Dodson encouraged all Board members to attend sessions.

13.5 Professor Proctor asked what actions had been taken to encourage the uptake of flu vaccines by members of staff. Mr Marshall confirmed that drop-in sessions had taken place in November and December and noted that flu vaccination would be identified as a formal

CQUIN for 2017/18. Trust staff continued to be encouraged and Mrs Webster suggested combining a drop in session with the scheduled staff Christmas lunches.

APPROVED:

- **The Board of Directors approved the NHS Improvement Agency Self-Certification Checklist;**

ACTION:

- **To circulate dates of Schwartz round to Board members**

14. Oral Reports from Directorates

14.1 Children's and County Wide Community Services Directorate

14.1.1 Dr Lyth provided an update on the school readiness pathway launched in Middlesbrough recapping on the joint initiative between the Trust and the Local Authority.

14.1.2 Dr Lyth provided on update on the Syrian families re-settlement programme and noted that the Immigration Authority had been impressed by the approach taken in Harrogate following the work undertaken for looked after children. Positive feedback had also been received from the Care Quality Commission.

14.2 Long Term and Unscheduled Care Directorate

14.2.1 Mr Alldred provided an update on the work to improve discharge planning and a noted that a request had been made to the Operational Director to critically appraise the discharge programme. Work also continued with commissioning and Local Authority colleagues via the Discharge Group. A clear action plan and work streams had been developed to align to the implementation of the SAFER work, work to reduce DTOCs, and ensure patients were discharged in the safest and quickest manner possible. The Group would also consider exploring opportunities to medically assess patients for their longer term care needs out-with the hospital setting.

14.2.2 Further work continued at Ripon Hospital which had yielded positive outcomes relating to: documentation; reviewing admission criteria; rehabilitation; physiotherapy; occupational therapy resource; and CQC recommendations.

14.3 Planned and Surgical Care Directorate

14.3.1 Dr Johnson reported that the Maternity Service had been shortlisted for a national award for access to psychological therapies.

14.3.2 Dr Johnson provided an update to the Board following the conclusion of the Maternity Rapid Process Improvement Workshop which looking at missed appointments in maternity care, and confirmed that the actions identified would help reduce the risk of harm to patients.

14.3.3 Dr Johnson confirmed that a paper was in development for theatres using the principle of the Calderdale Framework. The report would be discussed at Senior Management Team with a view to continued improvements in theatre staffing.

14.3.4 Dr Johnson referred to an issue relating to ITU band 5 staff nurses only being required to provide six weeks' notice and the impact on timely recruitment of replacements.

14.3.5 With regard to surgical cover and supervision for Foundation Doctors, Dr Johnson referred to challenges of implementing actions identified by the Deanery due the level of investment required.

15. Committee Chair Reports

15.1 Report from the Quality Committee meeting held 2 November 2016

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

15.1.1 Mrs Webster noted that clarity regarding the role of Non-Executive Directors in the Serious Incident Requiring Investigation (SIRI) sign off process had been agreed.

15.1.2 The Board received the revised Terms of Reference and Mrs Webster stated that the key change related to the decision to remove the Chief Executive as a core member of the committee to ensure the appropriate level of accountability and responsibility was in place. The Chief Executive would attend one meeting per year to oversee the final review of the Quality Account.

ACTION:
- **The Board of Directors approve the Terms of Reference for the Quality Committee**

16. Council of Governor meeting 3 August 2016

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

17. Matters relating to compliance with the Trust's Licence or other exceptional items to report.

17.1 Well Led Review Action Plan Update

17.1.1 Mrs Dodson referred to the report which outlined the methodology to enable the Board to continually review and self-assess in the future, maintain oversight of broad governance issues and acknowledge the actions taken to date. Mrs Dodson referred to the outstanding action relating to Quality of Care Teams and it was agreed that a review of the consistency of the quality and value of Quality of Care Teams across all directorates be undertaken with a report to the January Board of Directors and February Council of Governors.

ACTION:
- **To undertake a review the effectiveness of individual Quality of Care Teams with a report to the January meeting of the Board**

18. Any other relevant business not included on the agenda

There being no other business, Mrs Dodson declared the meeting closed.

19. Board Evaluation

Professor Proctor suggested that the discussion reflected the pressures within the system as well as internally to the Trust, which had also been confirmed by the reports from directorate leads and Mr Harrison. It demonstrated that the high risks acknowledged by the Board were aligned to the risks highlighted on the ground floor.

Mrs Webster stated that the discussion sometimes felt slightly rushed. Mrs Dodson asked Board members to reflect on what could have been done differently with feedback to be provided directly to Mrs Dodson.

Mr McLean felt that the Board had continued to focus on, and discuss, the right issues.

Dr Tolcher suggested that more time had been spent on the action log paper than planned.

20. 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

Harrogate and District NHS
NHS Foundation Trust

Report Status: Open

BOARD OF DIRECTORS MEETING

Minutes of the Extra Ordinary Board of Directors' meeting held in public on Wednesday 21 December 2016 10.15 am in the Boardroom, Trust HQ, Harrogate District Hospital

Present:
Mrs Sandra Dodson, Chairman
Dr Ros Tolcher, Chief Executive
Mr Jonathan Coulter, Deputy Chief Executive/Finance Director
Mr Rob Harrison, Chief Operating Officer
Mrs Jill Foster, Chief Nurse
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
Mrs Maureen Taylor, Non-Executive Director

In attendance:
Mr Andrew Alldred, Clinical Director for Long Term and Unscheduled Care
Mr Jonny Hammond, Operational Director for Planned and Surgical Care (*deputising for Dr Kat Johnson, Clinical Director)*
Dr Natalie Lyth, Clinical Director for Children's and County Wide Community Care
Mrs Angie Colvin, Corporate Affairs and Membership Manager (minutes)

1. Welcome and Apologies for Absence

Apologies for absence had been received from Dr Kat Johnson, Clinical Director for Planned and Surgical Care, Mr Ian Ward, Non-Executive Director, and Mrs Lesley Webster, Non-Executive Director.

In addition, Cllr Phil Ireland, newly appointed Stakeholder Governor representing Harrogate Borough Council, requested his apologies to be noted.

Mrs Dodson confirmed she hadn't expected any Governors to attend the meeting today as this was an extra ordinary meeting.

Mrs Dodson welcomed Mr Hammond, Operational Director deputising for Dr Johnson.

There were no members of the public in attendance.

Mrs Dodson confirmed there was one main item to discuss on the agenda of this extra ordinary meeting and the minutes from the last public Board of Directors meeting in November would be approved in January 2017.

2. Declarations of Interest and Board Register of Interests

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

3. Harrogate and District NHS Foundation Trust Operational Plan 2017/18 and 2018/19

3.1 Mrs Dodson confirmed that the Board of Directors had previously considered a draft of the Operational Plan for 2017/18 – 2018/19 at its meeting on 30 November 2016. The aim of the discussion today was to note a number of areas which needed further work and to approve the final plan and associated assurance templates for submission to NHS Improvement on 30 December 2016.

3.2 Mr Coulter confirmed the draft plan was discussed at Finance Committee the previous week and, along with feedback from NHS Improvement following the submission of the draft plan on 24 November, Mr Coulter summarised the following amendments:

i. Page 3, activity table – minor narrative changes to reflect the range of community services across North Yorkshire and in relation to Children's Services, the requirement to assess the demand and capacity for community services, and an explanatory note regarding the increase in activity relating to the development of outreach services in North Leeds.

ii. Page 5, in response to Mr Thompson's comment regarding serious untoward incidents, Dr Tolcher suggested including a comment to take into account actions following the recent CQC inspection.

iii. Page 6, quality improvement plans – a sentence to confirm the Trust did not provide mental health services, but an explanation of support would be added.

iv. Page 7, flow chart outlining quality impact assessment – following feedback from NHS Improvement, further narrative would be added to summarise the process demonstrated in the flow chart.

v. Page 10, item 7.7, final bullet point, Board level workforce spend – change to executive level responsibility as not a sub-committee of the Board.

vi. Page 13, cost improvements – a correction of percentages was required.

vii. Page 15, item 8.4 – following review at Finance Committee, the Use of Resources rating for 2017/18 table was amended.

viii. Page 16, Briary Wing – Dr Tolcher commented on Tees, Esk and Wear Velley NHS Trust vacating the Briary Wing and stated that it could be later than 2017/18; the Plan would be amended to reflect this.

3.3 Mr Coulter summarised the contracting position detailed in the Plan and confirmed there had been no further progress to date.

3.4 A detailed discussion followed regarding the impact of HaRD CCG's introduction of a period of health optimisation before referral and commencement of non-urgent elective surgery; this was confirmed as being part of the strategic approach to improve the health and wellbeing of the population of Harrogate and Rural District.

3.5 To date, there had been no impact from any reduction in referrals and the Trust would continue to focus on waiting lists, particularly orthopaedic and general surgical work, and increase activity from other commissioners, in particular from Leeds.

3.6 Mrs Dodson commented on the need to assure Governors regarding public concerns about waiting lists, especially breaching 18 weeks for orthopaedics, and requested a detailed update for Governors at their next meeting in February 2017.

3.7 In response to Mr McLean's comment about the right to receive payment for providing a level of service, Dr Tolcher agreed but noted that there were insufficient funds in the system to sustain current levels of commissioner spending and expressed the importance for local sustainability and transformation planning to be progressed.

3.8 Mrs Taylor highlighted the risk to cash flow and confirmed this had been discussed by the Finance Committee.

3.9 Mr Coulter confirmed the situation in relation to submission of the Plan without a signed contract with HaRD CCG and stated that a pre-arbitration meeting with NHS England and NHS Improvement would be expected in early January. Mr Coulter was happy to take further questions regarding the Plan.

3.10 Professor Proctor referred to the activity table on page 3 of the Plan and asked how the figures had been estimated for growth in light of the implications of the CCG-commissioned referral management system. Mr Coulter clarified that the figures had been based on demographic growth plus additional Trust activity and not just HaRD CCG activity. Mr Harrison provided further detail confirming that increased activity growth included work in relation to the Ophthalmology pathway and a new bowel scope service commissioned by NHS England which would result in a significant increase in day case work.

3.11 Mr Harrison also confirmed that year on year historical growth, review of Office for National Statistics population estimates and impact of Vanguard work had been assessed.

3.12 Mr Coulter confirmed that the Harrogate Health and Transformation Board would be meeting the following day and he expected discussions to be challenging regarding the future commissioning of the Vanguard project. He stated there was considerable work to do in the next six weeks around contracts and this would be discussed at Board in January 2017.

3.13 Mrs Dodson thanked Mr Coulter and confirmed the Board of Directors approved the Operational Plan 2017/18 – 2018/19 and associated assurance templates, subject to the minor changes discussed, and noted the current position in relation to the contract negotiations with HaRD CCG.

APPROVED:

- **The Board of Directors approved the Operational Plan for 2017/18-2018/19 and associated statements to enable submission to NHS Improvement by no later than 30 December.**

- **The Board noted the current position in relation with the contract negotiations with HaRD CCG**

ACTION:

- **Mrs Dodson commented on the need to assure Governors regarding public concerns about waiting lists, especially breaching 18 weeks for orthopaedics and requested a detailed update for Governors at their next meeting in February 2017.**

4. Any other relevant business not included on the agenda

4.1 Mr Harrison provided an update on winter pressures and highlighted the national concern regarding an emergency flow system under stress. The Trust's situation was reviewed on a daily basis and Mr Harrison was pleased to report that, despite significant pressures and following one of the worst weeks in ED, the Trust was placed at 11th in the country.

4.2 Mr Harrison confirmed the West Yorkshire ED Acceleration Zone funding had been secured to progress schemes to allow the delivery of the performance improvement; to support the streaming of patients from ED to Primary Care, or GP Out of Hours, and to support increased provision of ambulatory care on weekends. In addition, funding of just over £300,000 would support a discharge scheme, however the response from North Yorkshire County Council confirmed ongoing challenges with transfer capacity in the nursing home sector and Dr Tolcher would raise this with the Harrogate Health and Transformation Board the following day. Work would commence in January 2017 to increase capacity in ED by creating additional cubicles and co-location of the GP Out of Hours Service. In addition, subject to capital funding available, the Trust would explore the development of a dedicated Surgical Assessment Unit.

4.3 Dr Tolcher highlighted a number of options to support discharge and confirmed Mr Forster, Operational Director for Long Term and Unscheduled Care, was leading on this project.

4.4 In terms of the current position in Harrogate Hospital, Mr Harrison confirmed bed occupancy was currently at 100%, significantly higher than expected at this time of year. He hoped to see this improve by the end of the week and provided assurance that robust arrangements were in place to cover the Christmas and New Year period.

4.5 Mr Harrison asked the Board for support in resisting a request from NHS Improvement to provide detailed daily information reports through the Christmas period. This would require key individuals coming in to work for this sole purpose. Following discussion, Mr Harrison was given the approval to inform NHS Improvement that the report would be available to them following the Bank Holiday.

4.6 Finally, the Board of Directors commended Dr Alison Walker who had led a debrief and supported staff in ED following a recent, very sensitive clinical incident.

5. Board Evaluation

There was no Board evaluation undertaken as this was an extra ordinary meeting.

6. Confidential Motion

There being no other business, Mrs Dodson declared the meeting closed at 11.00 am

Harrogate and District NHS
NHS Foundation Trust

HDFT Board of Directors Actions Schedule as at January 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
Verbal update to be provided as part of the Quality Committee Chair's report on performance relating to completion of complaint action plans (Jun 16)	Mrs L Webster, Non-Executive Director/ Quality Committee Chair	September 2016	Complete
Further detail on metrics relating to health visiting for new born visits to be provided in the IBR (Jun 16)	Dr N Lyth, Clinical Director	September 2016	Complete – paper included for July meeting
An update on the NHS Improvement consultation and proposals for a Single Oversight Framework to be provided (Jul 16)	Dr R Tolcher, Chief Executive	September 2016	Complete – included in CEO Report. Consultation response uploaded to reading room
Provide confirmation of the Trust's current compliance with legionella water testing (July 16)	Mr R Harrison, Chief Operating Officer	September 2016	Included on Board Assurance Framework
Clarity to be sought to ensure that the current compliance rates for Information Governance Mandatory training support the requirements of the July Information Toolkit submission (July 16)	Mr R Harrison, Chief Operating Officer	September 2016	Complete – response circulated to Board members via e-mail 8/8/16
An update on the review of the Staff Friends and Family Test narrative outcome for Q1 to be provided to the Board (Jul 16)	Mr P Marshall, Director of Workforce and Organisational Development	September 2016	Complete – included within DWOD report
Assurance in relation to service activity and recovery plans (Jul 16)	Mr R Harrison, Chief Operating Officer	September 2016	Complete – within COO report
Assurance from the contracts team that no penalties associated with the contract due to the absence of a threshold target for new birth visits by Health Visiting team within 14 days of birth (Jul 16)	Mr J Coulter, Deputy Chief Executive/ Finance Director	September 2016	Complete
E-rostering implementation update to be included in the Chief Nurse report (Jul 16)	Mrs J Foster, Chief Nurse	September 2016	Complete – verbal update provided
Progress with regard to the appointment of Consultant Elderly Care post as part of the oral directorate report (May and Jun 16)	Dr K Johnson, Clinical Director	September 2016	Complete – provided under Directorate reports at September meeting

Item Description	Director/ Manager Responsible	Date of completion/ progress update	Confirm action Complete
Proposal for the appointment of the Trust's Freedom to Speak Up Guardian to be submitted to the Board of Directors (Jul 16)	Mr P Marshall, Director of Workforce and OD	October 2016	Complete – reported as part of DWOD report at the September meeting
The Board of Directors approved the revisions to the wording of the Trust's vision, mission and objectives subject to the amendment to change 'endeavour' to 'strive' (Sep 16)	Dr R Tolcher, Chief Executive	October 2016	Complete
Explore feasibility of recruitment opportunities for ODPs and Theatre Nurses via the GHEP and international recruitment (Sep 16)	Mr P Marshall, Director of Workforce and Organisational Development	October 2016	Complete
Undertake a review of the Strategic Key Performance Indicators and submit a proposal to the October meeting of the Board for approval, giving consideration to input from the Shadow Board (Jul 16)	Mr J Coulter, Deputy Chief Executive/Finance Director	October 2016	Complete – agenda item
Include a 6-month financial forecast within the October Finance Director report (Sept 16)	Mr J Coulter, Deputy Chief Executive/Finance Director	October 2016	Complete – include in Finance Directors Report
Write to Gill Morgan, Chair of NHS Providers to outline concerns regarding the impact of STPs on executive capacity (6.29)	Mrs S Dodson, Chairman	October 2016	Complete
IBR – narrative associated with GP out of hours to be improved to reflect the level of activity undertaken for future reports (Sept 16)	Mr A Alldred, Clinical Director	October 2016	Complete – included in IBR
Report on actions undertaken to support the increase required in appraisal compliance rates as part of the October DWOD report (Sep 16)	Mr P Marshall, Director of Workforce and OD	October 2016	Included in DoWOD report October meeting
Revisit the Board Assurance Framework to ensure adequate reflection of executive team capacity to delivery wider strategic initiatives (Sep 16)	Dr R Tolcher, Chief Executive	October 2016	Complete
Circulation of the checklist for enhanced monitoring for agency and locum use and submit for Board approval (Oct 16)	Mr P Marshall, Director of Workforce & OD	November 2016	Complete – agenda item for November meeting
Update to be provided on actions to be in response to concerns raised relating to C. Diff (including sample audit outcome) (Oct 16)	Dr J Child, Director of Infection Prevention and Control	November 2016	Complete – agenda item for November meeting
Include community pressure ulcer figures in the IBR for 2015/16 to allow a year-on-year comparison (Oct 16)	Mrs J Foster, Chief Nurse	November 2016	Complete

Item Description	Director/ Manager Responsible	Date of completion/ progress update	Confirm action Complete
Update on the action plan following the Alan Wood Report into Local Safeguarding Boards (Jun 16)	Mrs J Foster, Chief Nurse	November 2016	Included in the Chief Nurse report
Update on management of risks associated with the wheelchair service to be provided at a future meeting of the Board (Sep 16)	Mr J Culter, Deputy Chief Executive/ Finance Director	November 2016	Included in Business Development Report
Review and revise questions in annual Audit Committee survey (Jan 16)	Mr C Thompson, Non-Executive Director/ Audit Committee Chair	November 2016	Complete – verbal update provided at November meeting
Review RAG rating approach to SIRIs and include analysis of trend over time (7.7)	Dr D Scullion, Medical Director		Complete - transferred to the Quality Committee Action Log
Clarify arrangements for seeking Board approval in light of requirements for mid-month submissions to NHS I (8.4)	Mr J Coulter, Deputy Chief Executive/ Finance Director	November 2016	Complete – dealt with under matters arising

Harrogate and District NHS
NHS Foundation Trust

HDFT Board of Directors Actions Schedule – Outstanding Actions as at January 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
1	November 2016	To undertake a review the effectiveness of individual Quality of Care Teams	Mrs J Foster – Chief Nurse	January 2017	
2	November 2016	To circulate dates of Schwartz round to Board members	Mrs J Foster – Chief Nurse	January 2017	
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	
5	November 2016	To review the purpose and value of Patient Safety Visits	Mrs J Foster – Chief Nurse	January 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	
7	November 2016	Explore opportunities for more proactive media regarding current system pressures	Dr R Tolcher, Chief Executive	January 2017	
8	November 2016	Update on the standardised readmissions	Mr R Harrison, Chief Operating Officer	February 2017	
9	November 2016	Upload quarterly performance reports relating to the Children's and County Wide Community Services directorate into the Reading Room	Dr N Lyth, Clinical Director	January 2017	
10	November 2016	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	
11	September 2016	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	**Recommendation clarifying metrics for inclusion in the IBR for the Children's and County Wide Community**

					Services Directorate
12	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	November 2016	**Verbal update to be provided under matters arising**
13	May 2016	Further update on progress of the Care of Frail Older People Strategy and confirm an NED Lead (11.2.3)	Mr A Alldred, Clinical Director	March 2017	**Care of Frail Older People Strategy update to the Board Strategy Day** (4.)
14	June 2016	Update on the programme of work to reduce hospital admissions (9.3)	Mr A Alldred, Clinical Director	January 2017	N/A
15	January 2016	Update Board on progress with EDS2 action plan (11.10)	Mrs J Foster – Chief Nurse	January 2017	N/A
16	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	January 2017	N/A
17	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	January 2017	N/A
18	March 2016	Submission of a Research and Development Strategy for Board comment	Dr A Layton - Associate Director for Research	January 2017	
19	March 2016	Additional information on learning from cases of C. Diff and associated action planning during 2015/16 to be included in the annual report (6.3)	Mrs J Foster, Chief Nurse	February 2017	N/A

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Harrogate and District NHS
NHS Foundation Trust

Report to the Trust Board of Directors: 25 January 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:

- High rates of emergency department attendances and non-elective admissions, combined with difficulties achieving timely discharge have led to significant operational pressures over the last month.
- Colleagues across all parts of the Trust are to be commended for their dedication in sustaining strong performance and high quality care during this time.
- A 'heads of Terms' between Harrogate and Rural District CCG and the Trust for the 2017/18 contract has been signed.
- Work continues to explore potential collaboration opportunities within the STP.
- Building work has commenced in the Hospital's Emergency Department as part of the ED Acceleration Zone programme.

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 HHTB 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.
- The Board is asked to note that the Trust is **asked to nominate a Non-Executive Director** to oversee progress on implementing actions arising from the CQC report: Learning, Candour and Accountability and make recommendations accordingly

1.0 MATTERS RELATING TO QUALITY AND PATIENT EXPERIENCE

1.1 Operational Pressures

In common with prior years the Trust experienced a notable increase in demand in the immediate post-Christmas and New Year period. Emergency department activity was 10% higher than the same period last year and non-elective admissions increased by 12%. The hospital site has been operating with extremely high levels of occupancy with escalation areas open. High numbers of delayed transfers of patients (DTOC's) and medically fit for discharge patients have contributed to extreme pressures. The Trusts was operating at OPEL level 4 for a short period.

Despite these challenges colleagues have worked tirelessly across community and hospital services to protect the quality of care provided and to sustain our usual high levels of performance. Members of the corporate team have been providing support to hard pressed areas, with appropriate supervision.

A lack of beds has led to a small amount of non-urgent elective in-patient work being deferred.

The Trust received a letter of thanks from NHS Improvement CEO Jim Mackey thanking staff for their achievement.

I would like to formally recognise the huge team effort and record my thanks to colleagues across the Trust for their dedication.

1.2 2017/18 – 2018/19 Contracts

The Trust submitted to NHS Improvement the 2-year Operating Plan approved by the Board of Directors at its extraordinary meeting in December by the required deadline of 23 December. A Heads of Terms for the contract with our main commissioner Harrogate and Rural District CCG has been agreed. A verbal update will be given at the meeting.

1.3 New Care Models update

The NHS England New Care Models team has provided formal feedback on the Q2 visit which took place on 10 November. The report recognises the progress which has recently been made after a difficult start to the year. It identifies specific challenges for the next phase of the programme, specifically the need to accelerate the pace at which the elements of the PAC's framework are adopted including gaps in the care model, and gaps in the business model. The NCM team is able to offer support in these areas. The need to objectively evaluate the impact of the model is also recognised.

Following agreement at the November HHTB, evaluation will be provided by collaboration between the University of Sheffield's School of Health and Related Research (ScHARR), Collaborations for Leadership in Applied Health Research and Care (CLAHRC) Yorkshire and Humber, York Health Economic Consortium (YHEC) and Centre for Health Economics (University of York). There will be 2 researchers embedded in the PMO. Regular updates on the evaluation will be provided once it is up and running.

An updated Value Proposition was submitted in November requesting ongoing funding for the final year of the Vanguard programme (2017/18). We understand that some funds are likely to be provided, subject to certain caveats in respect of progress, as above.

2.0 STRATEGIC UPDATE

2.1 West Yorkshire and Harrogate Sustainability and Transformation Plan (WYHSTP)

Feedback on the draft West Yorkshire and Harrogate Sustainability and Transformation Plan (WYHSTP) which submitted to NHS Improvement on 21 October 2016 is still awaited.

The WYH STP PMO is now fully resourced and the focus has shifted to implementation. NHS England has recently released details on the process for bidding for non-recurrent transformation funding for mental health, diabetes, learning disability and cancer services. The Trust is contributing to these bids, via the STP PMO.

Work continues amongst the eleven CCG's in the WYH STP footprint in respect of the future commissioning landscape. A strategic commissioning function remains the preferred option.

2.2 Urgent and Emergency Care (U&EC) Acceleration Zone

Following agreement on the capital funds available to support this initiative, plans are now in place to commence work in the Emergency Department in the week commencing 16 January. A revised trajectory for the aggregate performance on the ED 4 hour access target will be submitted. The revision is necessary because of the time elapsed between the WYAAT submission and confirmation of funding from NHS England, during which time the baseline position deteriorated. Further information will be provided by the Chief Operating Officer.

3.0 NATIONAL COMMUNICATIONS RECEIVED AND ACTED UPON

3.1 CQC Report: Learning, Candour and Accountability

The Care Quality Commission has published its report following a review of the way NHS Foundation Trusts and Trusts review and investigate the deaths of patients in England. The Secretary of State offered the Government's initial response to the House of Commons and announced a range of measures in response to the report's recommendations. For trusts, these will include:

From April 2017 the boards of all NHS Trusts and Foundation Trusts will be required to:

- Collect and report to NHS Improvement a range of specified information, to be published quarterly, on deaths that were potentially avoidable and consider what lessons need to be learned on a regular basis.
- Publish evidence of learning and action
- Identify a board-level leader as patient safety director to take responsibility for this agenda and ensure it is prioritised and resourced within their organisation.
- Appoint a non-executive director to take oversight of progress.
- Follow a new, standardised national framework to be developed for identifying potentially avoidable deaths, reviewing the care provided, and learning from mistakes.

The NHS National Quality Board will draw up guidance on reviewing and learning from the care provided to people who die, in consultation with Keith Conradi, Chief Investigator of Healthcare Safety. These guidelines will be published before the end of March 2017, for implementation by all Trusts in the year starting April 2017.

Health Education England will review the training for all doctors and nurses with respect both to engaging with patients and families after a tragedy and maintaining their own mental health and resilience in extremely challenging situations.

To address particular challenges for the investigations of deaths of people with learning disabilities:

- The Government will ensure that the NHS reviews and learns from all deaths of people with learning disabilities, in all settings.
- The Learning Disabilities Mortality Review Programme will provide support to both families and local NHS areas to enable reporting and independent, standardised review of all learning disability deaths between the ages of 4 to 74.
- As the programme develops, all learnings will be transferred to the national avoidable mortality programme.
- **In acute trusts:** particular priority will need to be given to identifying patients with a mental health problem or a learning disability to make sure their care responds to their needs; and that special effort is made during any mortality investigations to ensure wrong assumptions are not made about the inevitability of death for these patients.

The Trust Medical Director is the executive lead for Patient Safety and will oversee this work from an executive perspective. **The Board of Directors is asked to note the requirement for Non-Executive oversight and make a recommendation accordingly.**

3.2 CQC Consultation on new inspection regime

The CQC is seeking views on

- principles for how New Models Of Care and complex providers will be regulated
- changes to the assessment frameworks across all sectors to reduce complexity and create more consistency
- how services for people with learning disabilities will be registered
- the way in which NHS trusts and foundation trusts will be regulated from April 2017 This includes a review of how Trusts are rated and some joint work with NHS Improvement on the CQC's approach to leadership and use of resources.

This work is being coordinated by the Deputy Director of Governance. Comments are welcome until 14 February.

3.3 NHS Improvement CEO letter regarding oversight of A&E performance

Jim Mackey wrote to all provider CEOs on 19 December setting out plans to broaden the oversight of A&E. This includes the following:

- Focus on the sickest patients, for example my monitoring 'time to see relevant clinician' for key pathways (eg stroke PCI), or 'time to start a bundle' (eg Sepsis)
- Streaming for patients with minor conditions to the most appropriate solution.
- Aggregated metrics which include the current 95% 4 hour wait standard but also reflects clinical standards and staff/patient experience.
- Consistency of counting in respect of the 955 standard.

A further detail on the practical implementation of these changes is awaited.

3.4 NHS National Quality Account reporting arrangements

The Annual Quality Account must be published by June 30 in line with national guidance. There is a statutory duty to submit the Trust's Quality Account to the Secretary of State. Work is now underway to select areas to prioritise for quality improvement in 2017/18 for inclusion in the 2016/17 Quality Account. The timescale for ensuring appropriate engagement has been agreed at SMT, culminating in final reports to the Governors and Board of Directors in May.

For the June 2018 Quality Accounts, providers are expected to report how their investigation and learning's from death have informed their quality improvement plans. This would be an annual summary of monthly/quarterly trust board reports on reviewing and learning from deaths.

4.0 WORKING IN PARTNERSHIP

4.1 Harrogate Health Transformation Board (HHTB)

HHTB met on 22 December. The CCG and NYCC presented a discussion paper on the potential architecture for the joint commissioning and delivery of integrated community services. The proposal builds on the new care model developed to date and describes:

- Prevention
- Intermediate care
- Community services wrapped around primary care
- GP leadership
- Alignment /pooling of budgets

The potential scope is significant and remains confidential. The intention is to have new governance arrangements in place in shadow form from April 2017 and more formally later in the year.

The Key Messages from the meeting are in the Reading Room.

4.2 West Yorkshire Association of Acute Trusts (WYAAT)

Final amendments have been made to the Terms of Reference and MoU for the WYAAT Committee in Common. The next meeting is scheduled for March.

Additional work is now underway to understand the scale of opportunity in respect of collaborative solutions for a number of support functions. The nature and extent of collaboration is being explored on a case by case basis. The value proposition for each potential scheme will depend on the scale of efficiencies achievable and the complexity of the scheme. Early indications following WYAAT CEO discussion is that Trusts are all at differing stages in terms of appetite for collaboration. Any decision on formal commissioning of schemes will be made at the Committee in Common.

A further update will be provided in the confidential session of the Board due to its commercial and sensitive nature.

5.0 FINANCIAL POSITION

The Trust reported a surplus of £4,882k for the year to the end of December (including S&T funding) which is £44k ahead of plan. The Trust has therefore met the control total for quarter 3 which as well performance against improvement trajectories within acceptable tolerances, has resulted in the Trust receiving the full S&T funding for the year to date.

Despite this positive outcome, there are a number of underlying financial risks for the Trust which are set out within the report from the Finance Director.

6.0 SENIOR MANAGEMENT TEAM (SMT) MEETING

The SMT met on 14th December and 18th January.

The December meeting has a particular focus on care Quality and progress with the CQC Action plan. Feedback from the Chair of the Audit committee in respect of completion of recommendations was discussed and action agreed.

Key issues discussed in January for noting by the Board of Directors are as follows:

- Operational pressures and system responsiveness were discussed
- The Quarter 3 finance plan has been achieved. Actions required to secure the final Quarter of national Sustainability and Transformation Funding were discussed. This remains very challenging however any incentive funds secured could be passed directly back to services for investment.
- Progress is being made in raising the value of the risk adjusted CIP plan for 2017/18 which has now reached 80%. The total value of potential schemes is above the required level however Quality Impact Assessments are yet to be completed for all schemes.
- Response times for complaints has deteriorated and will be addressed by directorates.
- The rising trend in Delayed Transfers of Care (DTOC's) was discussed and underlying issues explored.
- SMT received a report from the Director of Medical Education on the General Medical Council National Trainee Survey Results 2016 and HEE Quality Management visit final report. Overall the Trusts feedback has improved in most areas. Arrangements to comply with the requirement for on-site supervision of Middle Grade doctors in surgical specialties will be implemented within the required timescale.
- The value and role of Patient Safety visits was reaffirmed and an approach the year ahead agreed.
- The EDS2 self-assessment was received and noted.
- The IM&T draft strategy was received and endorsed.

The Minutes from SMT meetings are available in the BoardPad Reading Room.

7.0 BOARD ASSURANCE AND CORPORATE RISK

The summary current position of the Board Assurance Framework (BAF) and Corporate Risk Register (CRR) is presented below. There will be a quarterly update on the BAF and CRR during the confidential session of the Board, due to the detail of their content. The full BAF is available for Board members in the BoardPad Reading Room.

7.1 Board Assurance Framework (BAF)

The BAF was reviewed by the Executive Directors during week commencing 11th January. Although no risks have been removed, all BAF entries have action plans to address the gaps in controls and all action plans have progress scores of 1 or 2, providing assurance that actions to mitigate existing gaps in controls are being progressed. A review of key controls has been undertaken as a result of the completion of actions, and additional actions have been added to mitigate increased levels of risk, where appropriate. A number of key controls have been added to BAF 6 - Senior Leadership Capacity

Changes to the Board Assurance Framework since September

There are no new risks to note and no risks have been removed during the period. There have been no changes to the residual risk scores since the October report.

Summary

Three risks (BAF numbers 2, 12, and 13) are currently assessed as having achieved their target risk score. There are six strategic risks (BAF numbers 1, 4, 9, 12, 14 and 15) which are assessed at a risk score of 'Red' 12. No BAF entries have scores greater than 12. The strategic risks are as follows:

Ref	Description	Risk score	Progress score
BAF 1	Risk of a lack of medical, nursing and clinical staff	*Red 12 ↔*	*Unchanged at 1*
BAF 2	Risk of a high level of frailty in the local population	*Amber 8 ↔*	*Unchanged at 2*
BAF 3	Risk of a failure to learn from feedback and Incidents	*Amber 9 ↔*	*Unchanged at 2*
BAF 4	Risk of a lack of integrated IT structure	*Red 12 ↔*	*Unchanged at 1*
BAF 5	Risk of maintaining service sustainability	*Amber 8 ↔*	*Unchanged at 2*
BAF 6	Risk to senior leadership capacity	*Amber 9*	*1 – new risk*
BAF 9	Risk of a failure to deliver the Operational Plan	*Red 12 ↔*	*Unchanged at 2*
BAF 10	Risk of breaching the terms of the Trust's Licence to operate	*Amber 10 ↔*	*Unchanged at 2*
BAF 12	Risk of external funding constraints	*Red 12 ↔*	*Unchanged at 2*
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	*Red 12 ↔*	*Unchanged at 1*
BAF 16	Risk that the Trust's critical infrastructure is not fit for purpose	*Amber 8 ↔*	*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*
4. *Actions defined – work not yet commenced/behind plan*

7.2 Corporate Risk Register (CRR)

The CRR was reviewed at the monthly meetings of the Corporate Risk Review Group on 13th January 2017. The Corporate Risk Register contains nine risks. Changes to the CRR since the October meeting of the Board of Directors are:

Risks removed

The risk score for CR8 - Risk of harm to ophthalmology patients as a result of being lost to follow up. The reduction in the risk score was as a result of reported good progress had been made, providing assurance that patients are on an appropriate waiting list. Risk C8 was removed from the Corporate Risk Register.

The risk score for CR16 – Risk of patient harm due to clinical risk of pressure sore, or deteriorating conditions due to delays in ordering equipment. Following the transfer of the Wheelchair Service to another provider with effect from 1 December 2016, this risk had resolved and could be removed from the corporate risk register.

Changes to the Corporate Risk Register

The risk score for CR9 – risk to sustainability of service delivery and acute rotas due to withdrawal of trainees by GMC/HEEYH. The Trust has now received the final report following the HEE visit and is required to implement actions to address recommendations by April. The report is due to be reviewed at SMT on 18th January. As a result the corporate risk score has been reduced 12.

The risk scores for CR7 – Risk of failure to meet the ED 4 hour national standard. The current risk of failing to meet the 4 hour national standard for the quarter had increased as a result of the recent operational pressures. As a result the corporate risk score increased to 16.

The risk score for CR11 – financial risk due to reduced activity due to shortages of Theatre staff as a result of the impact of the agency cap rules; and CR7 – Risk of failure to meet the ED 4 hour national standard remained the top scoring risks at Red 16. Risks CR12 and CR17 have reported actions behind plan with the progress score of 3.

There were no new risks added to the Corporate Risk Register during the period. The corporate risks are as follows:

Ref	Description	Risk score	Progress score
CR2	Risk to the quality of service delivery due to reduction in trainee numbers	*Red 12* ↔	*2*
CR5	Risk of patient harm due to national shortage of registered qualified nurses	*Red 12* ↔	*2*
CR7	Risk of failure to meet the 4-hour A&E waiting time national standard and poor patient experience	*Red 12* ↔	*2*
CR9	Risk to sustainability of service delivery and acute rotas due to withdrawal of trainees by GMC/HEEYH	*Red 16* ↑	*2*
CR11	Financial risk due to reduced activity due to shortages of Theatre staff as a result of the impact of the agency cap rules	*Red 16* ↔	*2*
CR12	Risk to financial sustainability from failure to deliver the Clinical Transformation Programme at pace and scale	*Red 12* ↔	*3*
CR13	Risk to quality of service as a result of the changes to the community contract	*Red 12* ↔	*2*
CR14	Risk to delivery of the Trust's Operational Plan	*Red 12* ↔	*2*
CR17	Risk of patient harm as a result of being lost to follow-up	*Red 12* ↔	*3*

Dr Ros Tolcher
Chief Executive
January 2017

Harrogate and District NHS
NHS Foundation Trust

Report to the Trust Board of Directors: 25 January 2017	Paper No: 6.0

Title	Integrated Board Report
Sponsoring Director	Dr Ros Tolcher, Chief Executive
Author(s)	Ms Rachel McDonald, Head of Performance & Analysis
Report Purpose	To provide the Board with an update on performance relating to: operational performance; quality; and finance and efficiency.

Key Issues for Board Focus:

The Trust is required to report its operational performance to NHS Improvement and to routinely submit performance data to NHS England and Harrogate and Rural District CCG. The Board of Directors are asked to note that:

- In December, HDFT was above the required level for 3 of the 4 key operational performance metrics in the NHS Improvement Single Oversight Framework (with the A&E 4-hour standard being below the required level at 92.5%) and also reported a rating of 1 (where 1 is best) for the "Use of Resource Metric".
- The Trust reported a cash position of £3,589k at the end of December. This remains significantly behind the re-profiled plan.
- Performance against the A&E 4 hour standard deteriorated further in December. Despite this, HDFT remains one of the best performing Trusts in the country in relation to this standard.
- Non-elective bed days increased significantly in December, reflective of the serious winter pressures experienced by the Trust during this period. Delayed transfers of care also remain high and were at 4.8% when the snapshot was taken.
- Elective theatre utilisation reduced in December. The number of lists cancelled increased due to operational pressures, including a lack of beds and staffing issues.
- Inpatient falls increased during December. However there were no falls that resulted in moderate or severe harm.
- Staff appraisal rates increased to 79.8% in December - the highest level reported since 2014.

Related Trust Objectives	
To deliver high quality care	Yes – the report triangulates key performance metrics covering quality, finance and efficiency and operational performance, presenting trends over time to enable identification of improvements and deteriorations in the delivery of high quality care.
To work with partners to deliver integrated care	Yes – key performance metrics allow the Board to receive assurance in terms of the delivery of high quality care, often underpinned by collaboration and partnership working, particularly when developing new care models.
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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Integrated board report - December 2016

Key points this month

1. In December, HDFT was above the required level for 3 of the 4 key operational performance metrics in the NHS Improvement Single Oversight Framework (with the A&E 4-hour standard being below the required level at 92.5%) and also reported a rating of 1 (where 1 is best) for the "Use of Resource Metric".

2. The Trust reported a cash position of £3,589k at the end of December. This remains significantly behind the reprofiled plan.

3. Performance against the A&E 4 hour standard deteriorated further in December. Despite this, HDFT remains one of the best performing Trusts in the country in relation to this standard.

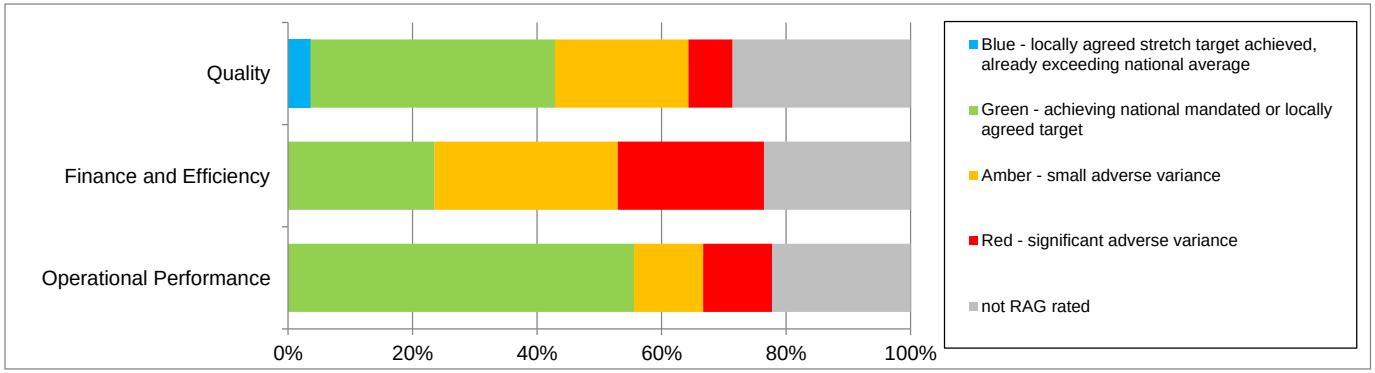
4. Non-elective bed days increased significantly in December, reflective of the serious winter pressures experienced by the Trust during this period. Delayed transfers of care also remain high and were at 4.8% when the snapshot was taken.

5. Elective theatre utilisation reduced in December. The number of lists cancelled increased due to operational pressures, including a lack of beds and staffing issues.

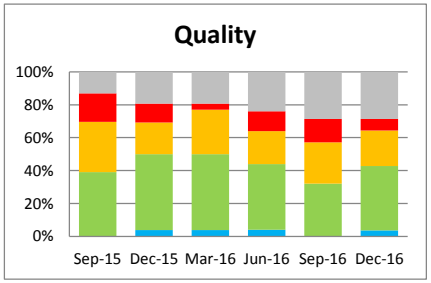
6. Inpatient falls increased during December. However there were no falls that resulted in moderate or severe harm.

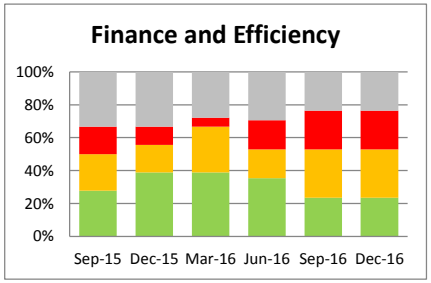
7. Staff appraisal rates increased to 79.8% in December - the highest level reported since 2014.

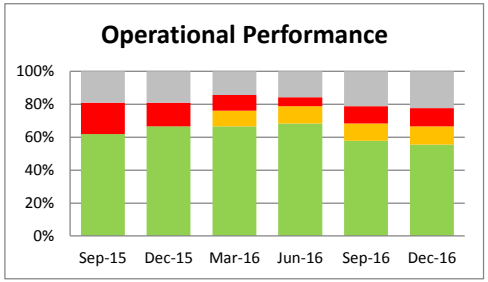
Summary of indicators - current month



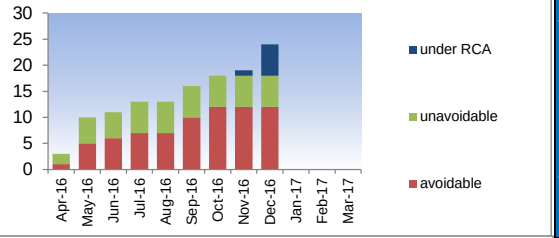
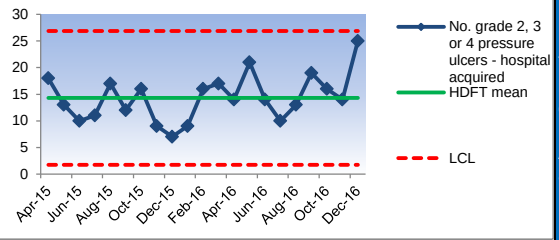
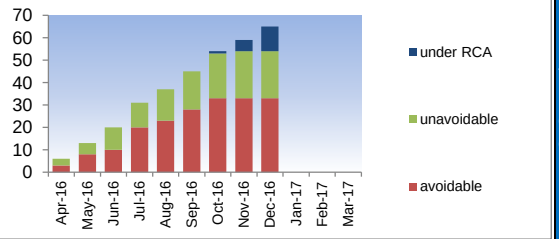
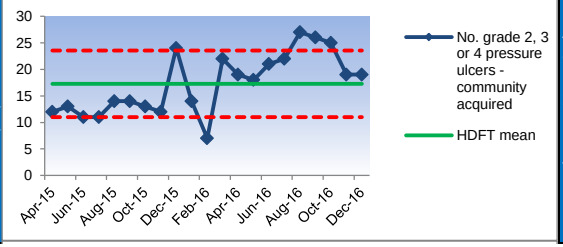
Summary of indicators - recent trends



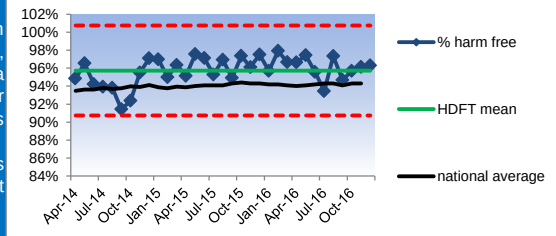
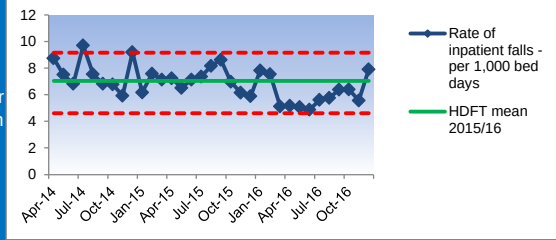
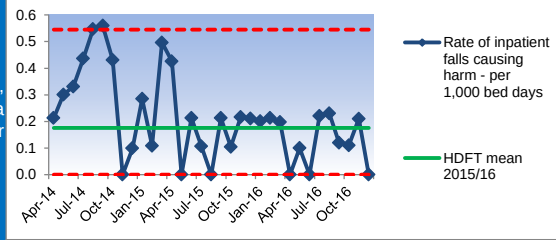
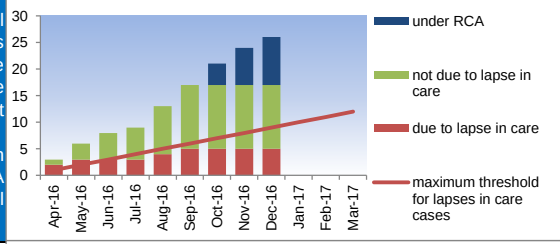




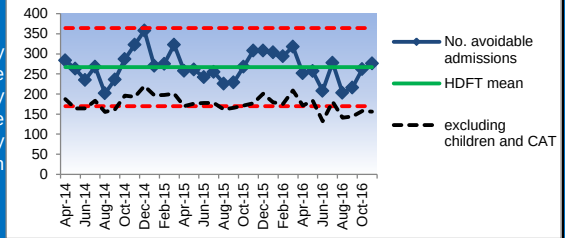
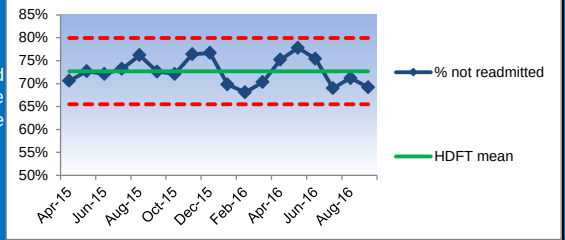
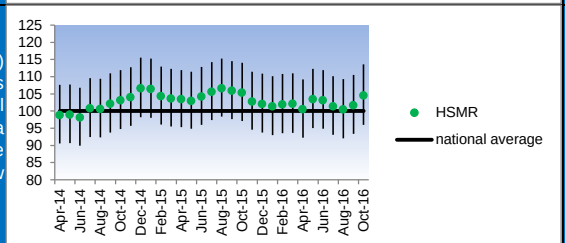
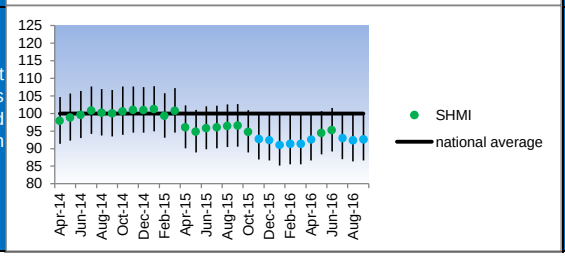
Quality - December 2016

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 data includes hospital teams only.		There were 5 hospital acquired category 3 or 4 pressure ulcers reported in December. In the year to date, 24 hospital acquired category 3 pressure ulcers have been reported. Of these, 12 were deemed to be avoidable, 6 unavoidable and 6 cases are still under root cause analysis (RCA). There have been no hospital acquired category 4 pressure ulcers reported in the year to date. The Trust has set a local trajectory for 2016/17 of zero avoidable hospital acquired category 3 or category 4 pressure ulcers.
✓	The chart includes category 2, 3 and 4 hospital acquired pressure ulcers. The data includes hospital teams only.		The number of hospital acquired category 2-4 pressure ulcers increased in December. There have now been 146 cases reported in 2016/17 to date. This compares to 113 in the same period last year. A maximum trajectory for 2016/17 of 155 cases of category 2-4 hospital acquired pressure ulcers has been agreed via the Quality Committee.
✓ **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 pressure ulcers reported in December. In the year to date, 65 community acquired category 3 or category 4 pressure ulcers have been reported (including 2 category 4 cases). Of these 65 cases, 33 were deemed to be avoidable, 21 unavoidable and 11 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. The data includes community teams only.		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. In 2016/17 to date, 196 cases have been reported, compared to 113 in the same period in 2015/16. The observed increase in reported cases may be partly due to improvements in incident reporting during the period.

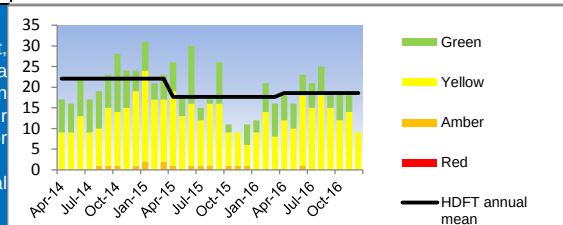
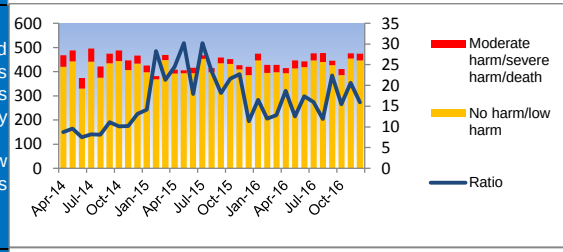
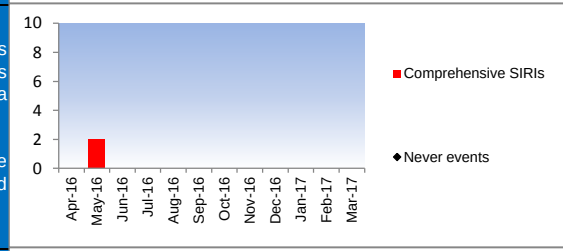
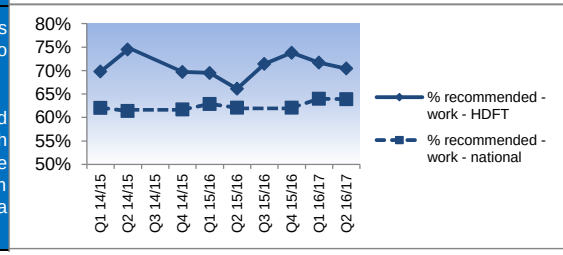
Quality - December 2016

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 December was 96.2%, 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 7.9 per 1,000 bed days in December, an increase on last month and above the HDFT 2015/16 average rate.
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 were no inpatient falls causing moderate harm, severe harm or death in December, a decrease on the previous month and below the average HDFT rate for 2015/16. There have been 9 inpatient falls causing moderate or severe harm in 2016/17 to date, all of which resulted in a fracture. This compares to 14 moderate or severe harm falls in the same period last year.
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 acquired 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 were 2 cases of hospital apportioned C. difficile reported in December, bringing the year to date total to 26 cases. 17 cases have now have root cause analysis (RCA) completed and discussed and agreed with HARD CCG. Of the 17 cases discussed and agreed, 5 have been determined to be due to a lapse in care and 12 were determined to not be due to a lapse in care. The remaining cases are due to be reviewed with HARD CCG on 17th January. No cases of hospital acquired MRSA have been reported in 2016/17 to date.

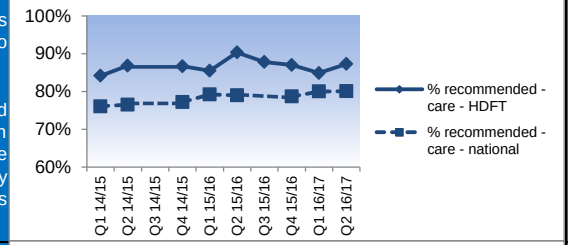
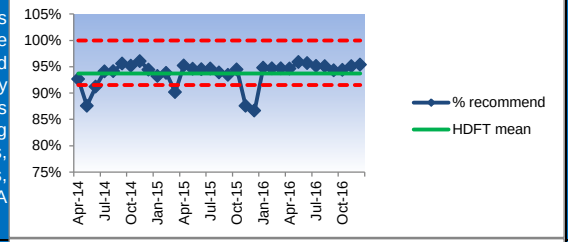
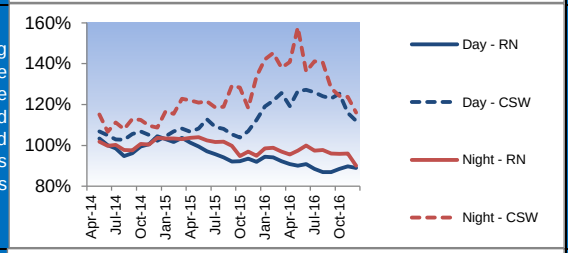
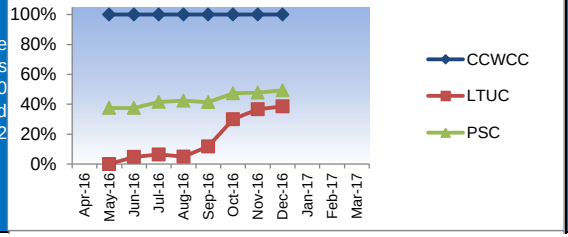
Quality - December 2016

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 276 avoidable admissions in November, an increase on the previous month. There is some seasonality in this metric so an increase during the winter months is expected. The figure is slightly lower than the level in the same period last year. Despite the increase seen in the overall numbers, the adult admissions (excluding CAT attendances) have remained fairly static in recent months.
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.*		For patients discharged from rehabilitation or reablement services in September, 69% were still in their own home at the end of December, a decrease on the previous month. A case note audit of a sample of patients is being carried out to understand any themes and actions required and the results will be reported by Long Term and Unscheduled Care Directorate.
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 increased to 104.51 in October but remains within expected levels. At specialty level, 1 specialty (Geriatric medicine) has a standardised mortality rate above expected levels. Following a recent notification letter from CQC regarding raised mortality in patients with acute cerebrovascluar disease (stroke) at HDFT, a clinical case note review of a sample of stroke patients is being led by the Medical Director.
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 92.67, compared to 92.36 last month. However this remains below the national average and below expected levels. At specialty level, 2 specialties (Geriatric Meidicine and Gastroenterology) have a standardised mortality rate above expected levels.

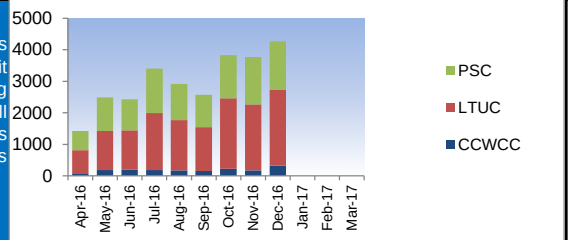
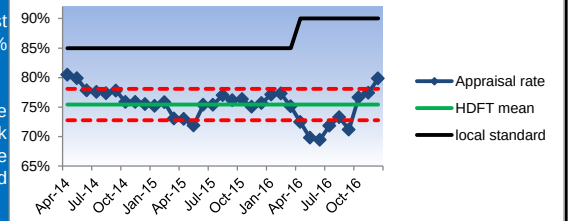
Quality - December 2016

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.		9 complaints were received in December compared to 18 last month, with none classified as amber or red. This is below the 2015/16 average.
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 Sep 15 to Mar 16) shows that Acute Trusts reported an average ratio of 34 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. Work is progressing to review the datix sytem to simplify the incident reporting process.
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 December.
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.		*There is no update of this data this month.* In Quarter 2, 70.4% of HDFT staff surveyed would recommend HDFT as a place to work, this remains above the most recently published national average of 64%. The Staff Friends and Family Test will next be carried out at HDFT during Quarter 4.

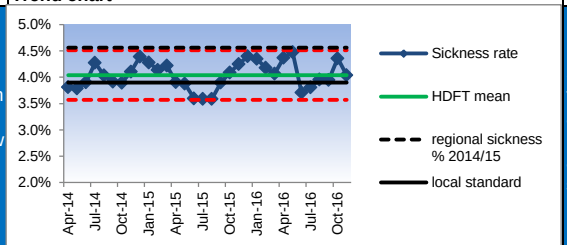
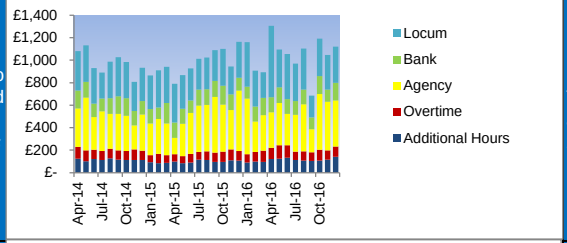
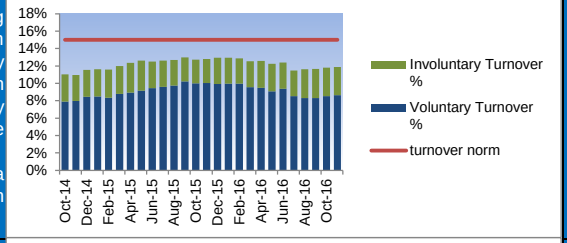
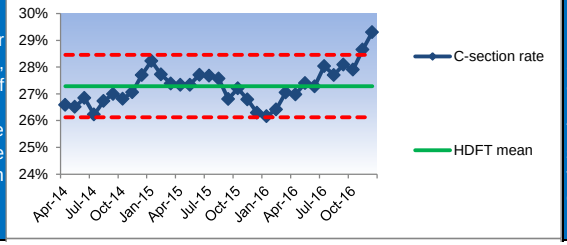
Quality - December 2016

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. .		*There is no update of this data this month.* In Quarter 2, 87.3% of HDFT staff surveyed would recommend HDFT as a place to receive care. This is an increase on Q1 and above the most recently published national average of 80%. The Staff Friends and Family Test will next be carried out at HDFT during Quarter 4.
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.		95.4% of patients surveyed in December would recommend our services, remaining in line with recent months and above the latest published national average.
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 102% in December. However, registered nurse staffing levels have reduced since last month. 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. A significant focus is being placed on Registerd Nurse recruitment and as a result, the Trust welcomed 24 newly qualified and 11 experienced Registered Nurses during September and October.
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, 49% of rosters were published on time during the period May to December 2016. The presentation of this data has been amended to show rosters based on roster start date, instead of roster end date, to provide more up to date information. All three Clinical Directorates are now showing improvements in recent when the data is presented this way. Publishing electronic rosters in a timely manner improves staff morale, increases bank fill rates and reduces bank/agency costs.

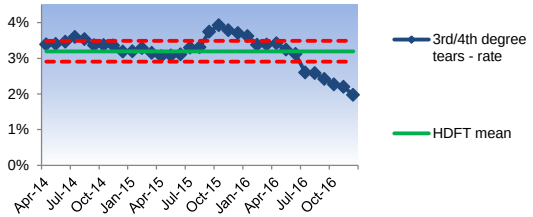
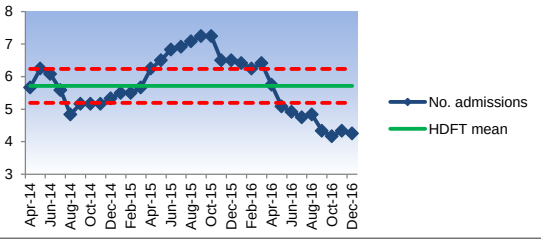
Quality - December 2016

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 30 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 chart shows the cumulative position. The number of unused hours increased significantly in the last few months, partly as a result of the merging of Byland and Jervaulx wards and subsequent un-merging. 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 December is 79.8%, a further increase on last month. A deadline of 31st December was set to achieve 90% appraisal completion. With the exception of the Childrens and County Wide Community Care Directorate, the Trust is not achieving this target of 90%. A discussion has been taken to SMT this month to consider additional actions.
Mandatory training rates 	The table shows the most recent training rates for all mandatory elements for substantive staff. The table excludes staff who TUPE transferred into the organisation on 1st April 2016. A high percentage is good.	**Competence Name** / **% Completed** Equality, Diversity and Human Rights - Level 1: 93 Fire Safety Awareness: 82 Infection Prevention & Control 1: 99 Infection Prevention & Control 2: 86 Information Governance: Introduction: 87 Information Governance: The Beginners Guide: 77 Prevent Basic Awareness (December 2015): 99 Safeguarding Children & Young People Level 1 - Introduction: 95	The data shown is for the end of December and excludes the staff who were TUPE transferred into the organisation on the 1st April 2016. The overall training rate for mandatory elements for substantive staff in this group is 91%. 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.
Mandatory training rates 	The table shows the most recent training rates for all mandatory elements for substantive staff. The table only includes staff who TUPE transferred into the organisation on 1st April 2016. A high percentage is good.	**Competence Name** / **% Completed** Equality, Diversity and Human Rights - Level 1: 70 Fire Safety Awareness: 84 Infection Prevention & Control 1: 100 Infection Prevention & Control 2: 55 Information Governance: Introduction: 53 Information Governance: The Beginners Guide: - Prevent Basic Awareness (December 2015): 75 Safeguarding Children & Young People Level 1 - Introduction: 97	The data shown is for the end of December and shows the statistics for the TUPE staff that transferred into the organisation on the 1st April 2016 from Middlesbrough, Durham and Darlington. The overall training rate for mandatory elements for substantive staff in this group is 74%. This is an increase of 5% since last month. The TUPE staff compliance figures will be reported separately until January 2017 at which point we plan to amalgamate the figures into one table of data. This allows the newly transferred staff time to establish systems and processes to access their mandatory training, complete data validation and increase their overall compliance to the level we have achieved across the Trust prior to their transfer.

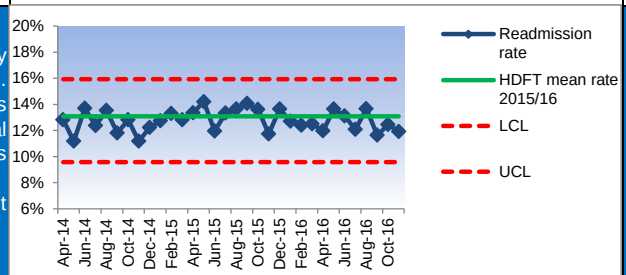
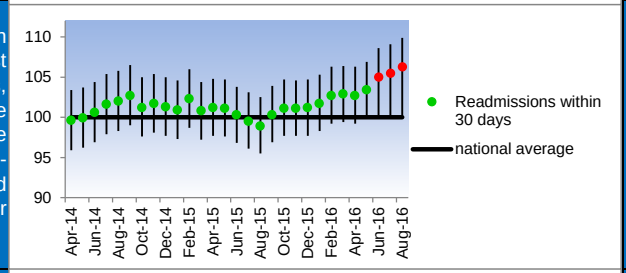
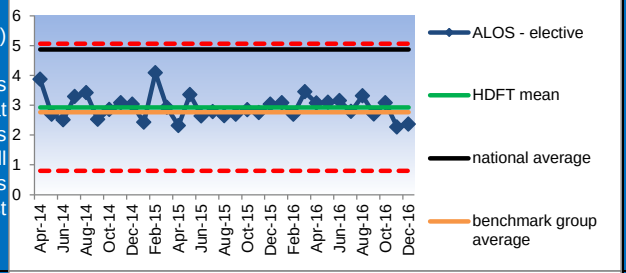
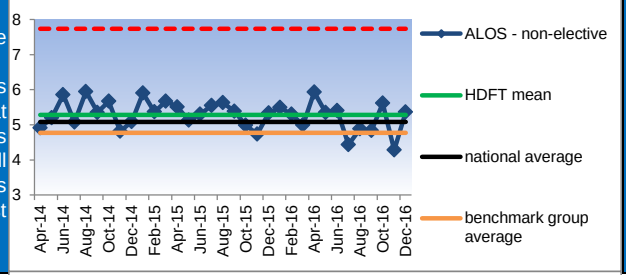
Quality - December 2016

Indicator name / data quality assessment	Description	Trend chart	Interpretation
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.		Sickness absence across the Trust showed a decrease during November to 4.0%. The Health & Wellbeing Group is relaunching its intranet site and promoting a number of activities aimed at raising awareness of both physical and emotional wellbeing. These include a survey of physical activity already undertaken by staff, and a Health and Wellbeing 'drop-in' session in Herriot's in January.
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 proportion of spend on temporary staff during November was 6.9%, an increase on last month but below the average level (7.6%) during 2015/16.
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.		Labour turnover remains static across the organisation.
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 December 2016 was 29.3% 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.

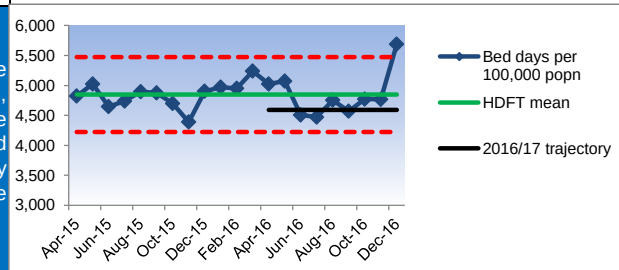
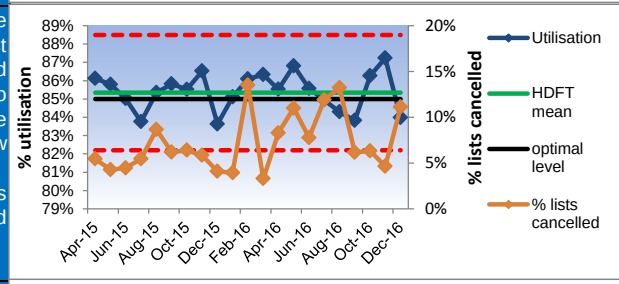
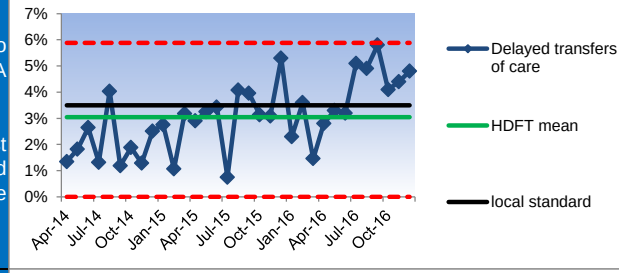
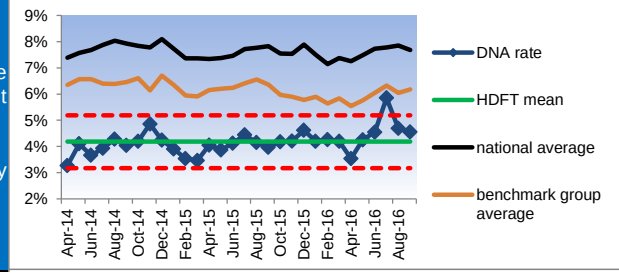
Quality - December 2016

Indicator name / data quality assessment	Description	Trend chart	Interpretation
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 2.0% of deliveries in the 12 month period ending December 2016, remaining well below previous months. The rolling 12 months rate is at its lowest point since the dashboard was created. This may reflect the significant amount of quality improvement work aimed at reducing the incidence of third degree tears.
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. We have amended the presentation of this indicator this month to show a 12 month rolling average position.		The chart shows the percentage of babies born at greater than 37 weeks gestation who were admitted to the Special Care Baby Unit (SCBU). The maternity team carry out a full review of all term admissions to SCBU. 4% of term babies were admitted to SCBU in December. This is line with the average over the last 12 months.

Finance and Efficiency - December 2016

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 October, when expressed as a percentage of all emergency admissions and remains below the average rate for 2015/16. HDFT and HARD CCG are undertaking an audit of readmissions in Quarter 3 to determine the proportion of readmissions 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.		*There is no update of this data this month as the data has not been updated yet within HED.* HDFT's standardised readmission rate has increased again this month - for the rolling 12 month period ending August 2016, the rate was 106.3, above the national average and above expected levels. At specialty level, Clinical Haematology, Paediatrics, Medical Oncology and Well Babies all have standardised emergency readmission rates above expected.
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 December was 2.4 days, an increase on the previous month but remaining below the benchmark group average. A focus on sustainably reducing this through the Planned Care Transformation programme is underway, which includes reducing the number of patients admitted the day before surgery.
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 December was 5.4 days, an increase on the previous month and now above both the benchmark group and national average. This increase in length of stay will be partly due to an increase in the number of delayed transfers of care seen in recent weeks.

Finance and Efficiency - December 2016

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 significantly in December. There is seasonality with this metric and an increase is expected during winter months. However this is higher than the level reported in December last year. This rise is reflective of the serious winter pressures experienced by the Trust during this period - there was an 11% increase in HARD CCG adult emergency admissions compared to December last year, combined with an increase in both the average length of stay and the number of delayed transfers of care.
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 84.0% in December. The number of cancelled sessions was11.1%, an increase on last month. Theatre cancellations increased in response to a number of challenges including ward staffing gaps, theatre staff sickness and a lack of beds including ITU. Overall December was a very challenging month operationally with daily risk assessments on the ability to continue with elective theatre lists.
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 remains high and were at 4.8% when the snapshot was taken in December, above the maximum threshold of 3.5% set out in the contract. 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 4.4% in August. This remains below that of both the benchmarked group of Trusts and the national average.

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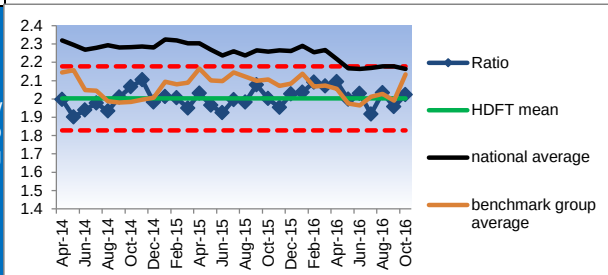
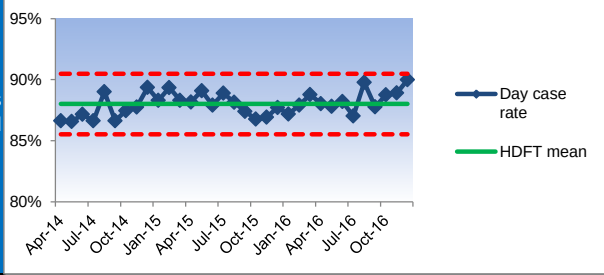
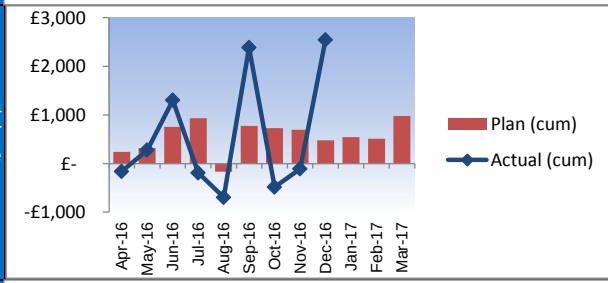
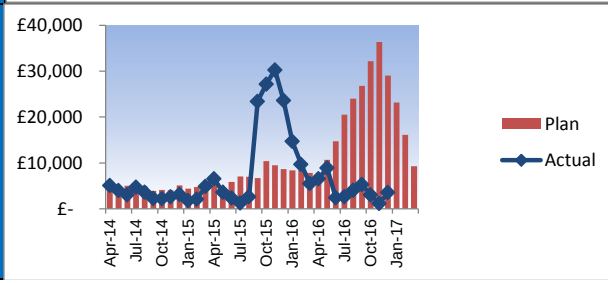
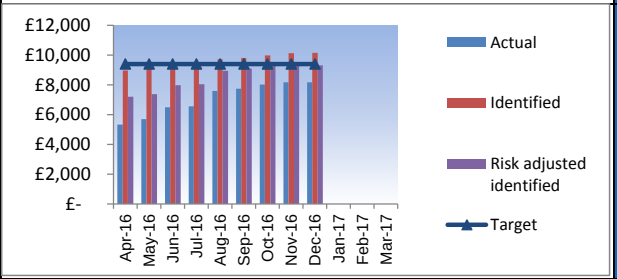
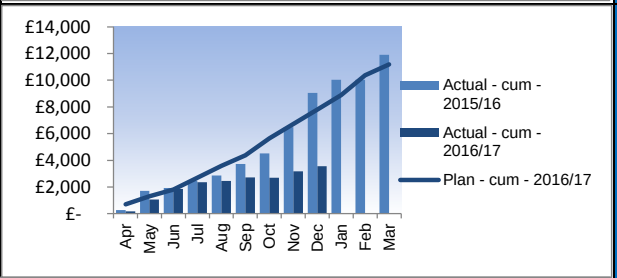
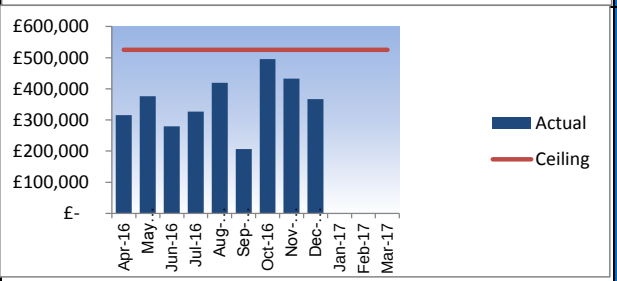
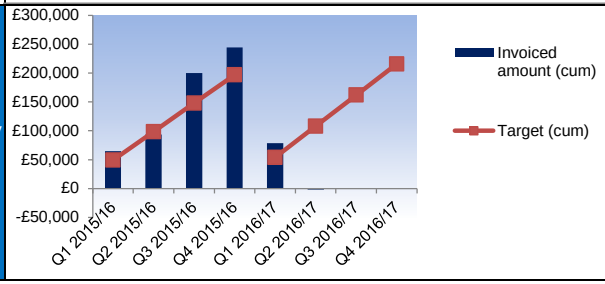
Indicator name / data quality assessment	Description	Trend chart	Interpretation
Outpatient new to follow up ratio ✓	The number of follow-up appointments per new appointment. A lower ratio is preferable. A high ratio could indicate that unnecessary follow ups are taking place.		Reducing the number of follow ups is a major part of HARD CCG's financial recovery plan. HDFT's new to follow up ratio increased in December but is still 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 90.0% in December, the highest level reported for some time.
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 £4,882k for the year to the end of December, £44k ahead of plan. This position is above the control total set for the Trust and therefore includes the full S&T funding available to the Trust. There are a number of risks in this position, as outlined further in the finance report.
Cash balance ✓	Monthly cash balance (£'000s)		The Trust reported a cash position of £3,589k at the end of December. This remains significantly behind the reprofiled plan. This is a significant area of focus for the finance team at present.

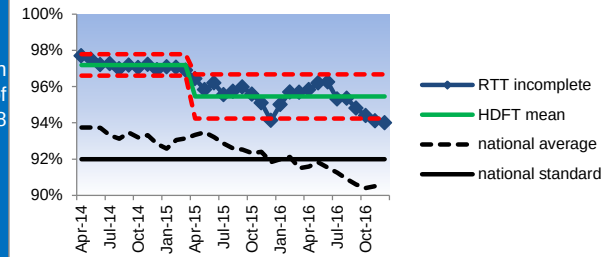
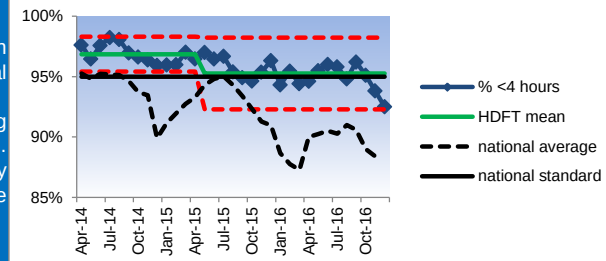
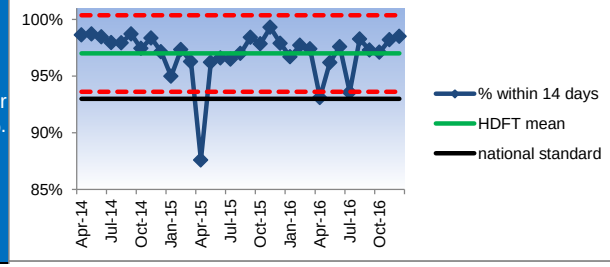
Finance and Efficiency - December 2016

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.	<table><tr><th>Element</th><th>Plan</th><th>Actual</th></tr><tr><td>Capital Service Cover</td><td>1</td><td>1</td></tr><tr><td>Liquidity</td><td>1</td><td>1</td></tr><tr><td>I&E Margin</td><td>1</td><td>1</td></tr><tr><td>I&E Variance From Plan</td><td></td><td>1</td></tr><tr><td>Agency</td><td>1</td><td>1</td></tr><tr><td>Financial Sustainability Risk Rating</td><td>1</td><td>1</td></tr></table>	The Trust reported a 1 for December.
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.		87% of CIP schemes have been actioned to date. Plans are in place for 108% of the efficiency requirement, the risk adjusted total reducing to 100%.
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.		Despite being below the agency ceiling, agency expenditure remains high at 2.9%.

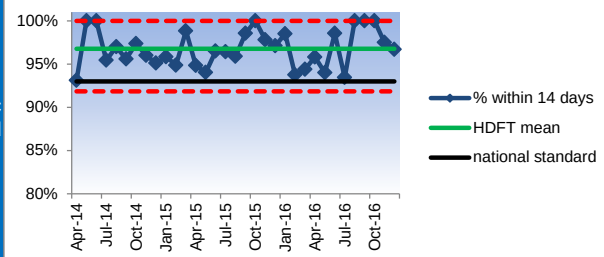
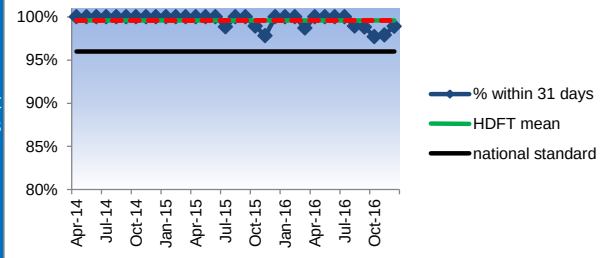
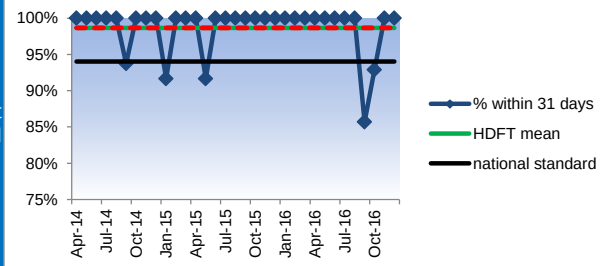
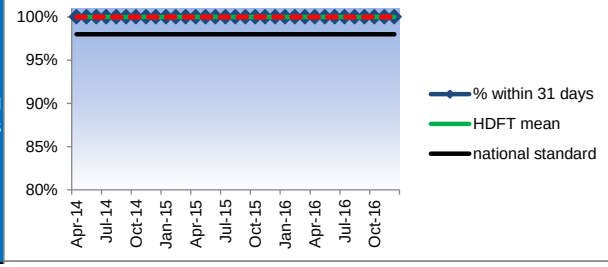
Finance and Efficiency - December 2016

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.

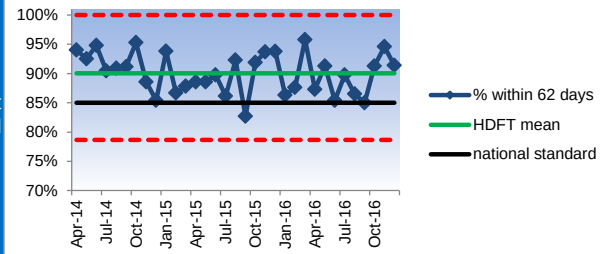
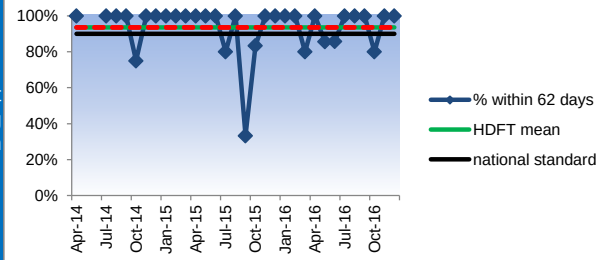
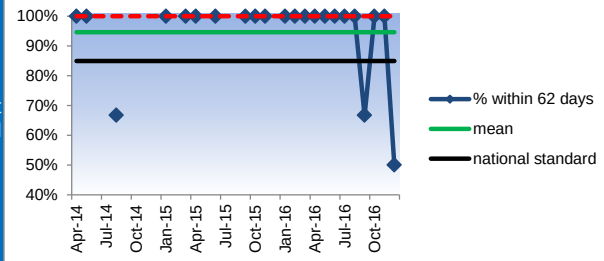
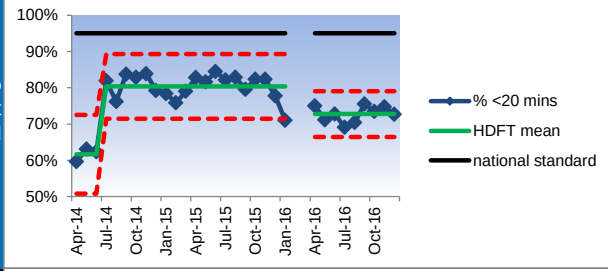
Operational Performance - December 2016

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.	**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 A&E 4-hour standard Cancer - 62 days Diagnostic waits	In December, HDFT was above the required level for 3 of the 4 key operational performance metrics. Performance against the A&E 4-hour standard was below the required 95% as detailed below.
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 December, above the required national standard of 92% but continuing the trend in deteriorating performance seen over recent months. At specialty level, Trauma & Orthopaedics and General Surgery were below the 92% standard again in December.
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 December 2016 was 92.5%, a decrease on last month and remaining below the required 95% standard. This includes data for the Emergency Department at Harrogate and Ripon MIU. Performance for Harrogate ED in December was 91.1%. This is the lowest performance reported by the Trust for some time. Despite this, HDFT remains one of the best performing Trusts in the country in relation to this standard.
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.

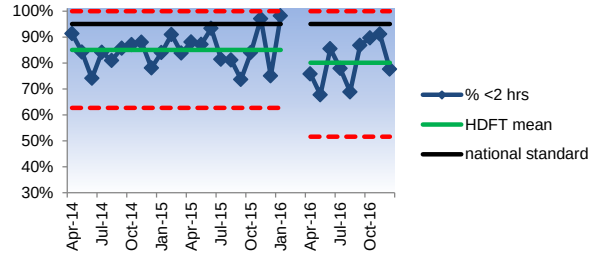
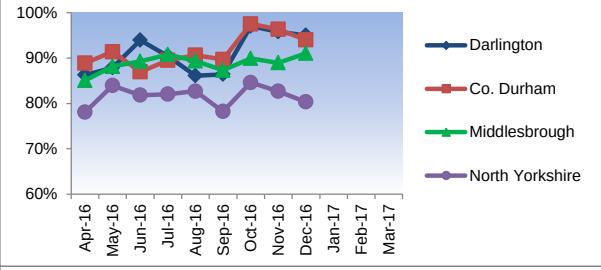
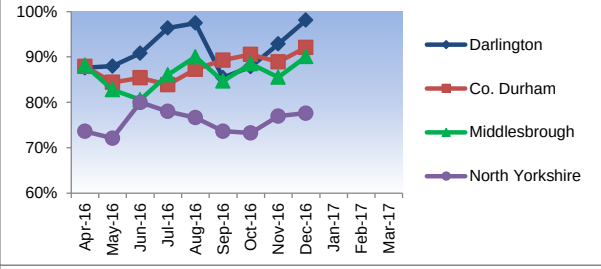
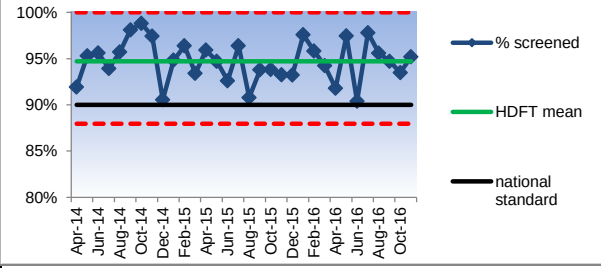
Operational Performance - December 2016

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.

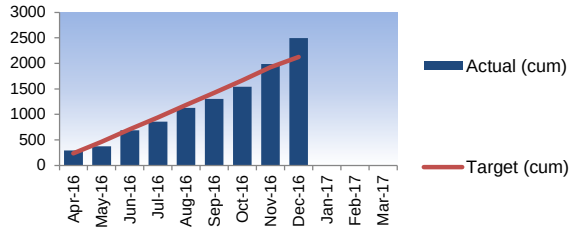
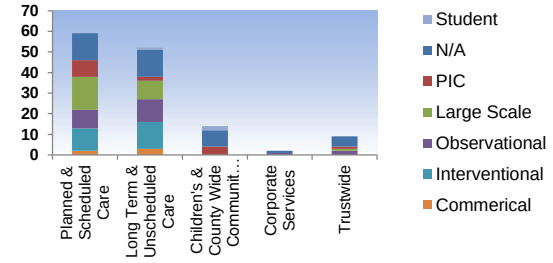
Operational Performance - December 2016

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.		Trust total delivery at expected levels. Of the 11 cancer sites treated at HDFT, 4 had performance below 85% in December - colorectal (1 breach), sarcoma (0.5 breach), upper gastrointestinal (0.5 breach) and urological (2 breaches). There were 2 patients who waited over 104 days for treatment in December - the main reasons for the delay was clinical complexity and patient initiated delay.
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.		Delivery at expected levels.
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.		During December, 1 patient breached the 62 day standard. This means that for Quarter 3 there have been 4 treatments and 1 breach giving a Quarter 3 performance of 75%. However this will not be reportable as it is below the de mininis level of 5 pathways per quarter.
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 and was at 73% in December. 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 - December 2016

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 at 80% in December. 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 December, 88% of babies were recorded on Systmone as having had a new birth visit within 14 days of birth. Darlington and Co. Durham teams have been working with the Information team during Quarter 3 to fully validate their data resulting in an improved, more accurate performance position for their localities.
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 December, 86% of children were recorded on Systmone as having had a 2.5 year review. Darlington and Co. Durham teams have been working with the Information team during Quarter 3 to fully validate their data resulting in an improved, more accurate performance position for their localities.
CQUIN - 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 - December 2016

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.		The year to date position on recruitment to research studies is now 17% above plan, an improvement on the position reported in previous months.
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.
Quality	Mandatory training rates - Darlington, Durham & Middlesbrough staff	**Amber** 	This indicator includes training data for TUPE staff that transferred into the organisation on 1st April 2016 from Middlesbrough, Durham and Darlington. There are some concerns about the quality and completeness of this information.
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: 25th January 2017	**Paper No: 7.0**

Title	Financial Position
Sponsoring Director	Mr Coulter, Director of Finance
Author(s)	Finance Department
Report Purpose	Review of the Trusts financial position

Key Issues for Board Focus:

1. The Trust reported a surplus of £4,882k for the year to the end of December, £44k ahead of plan. This position includes S&T funding as a result of meeting the control total set by NHS Improvement, as well as performance against the relevant operational standards.

2. Plans are in place for 108% of the £9.4m Cost Improvement target, reducing to 99% following risk adjustment. 87% of plans have been actioned to date.

3. The Trust cash balance at the end of December was £3,590k.

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	Submission of the Quarter 3 financial return and Use of Resource Metric to NHS Improvement

Action Required by the Board of Directors

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

The Board is asked to confirm and approve the financial return and associated Use of Resource metric submitted to NHS Improvement.

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December 2016 Financial Position

Financial Performance

- The Trust reported a surplus of £4,882k for the year to the end of December, £44k ahead of plan. This position includes S&T funding and is outlined below:

Description	YTD Plan	YTD Actual
Operating income	£161,467k	£160,550k
Operating expenditure	£154,247k	£153,812k
EBITDA	**£7,220k**	**£6,739k**
Non operating expenses	£5,832k	£5,307k
Net surplus	**£1,388k**	**£1,432k**
S&T funding	£3,450k	£3,450k
Trust financial position	**£4,838k**	**£4,882k**

- As outlined above the Trust has met the control total for Quarter 3. This performance, as well performance against improvement trajectories within acceptable tolerances, has resulted in the Trust receiving the full S&T funding for Quarter 3. Financial performance in December was reasonably positive as outlined on page 2.

- Despite this positive outcome, there are a number of underlying financial risks for the Trust. These include –

  - The EBITDA (an indicator of operational performance) is £481k behind plan

  - Month 9 reports included a number of technical accounting adjustments as a result of the month 9 accounts process. This included appropriate adjustments for stock, VAT and depreciation. There was also an adjustment in relation to work in progress, as a result of the operational pressures experienced towards the end of December.

  - The Trust has also accounted for the receipt of funding in relation to a number of developments including additional Dental income, WYAZ funding and funding in HR.

December 2016 Financial Position

- CIP delivery remains on track, with 99% of schemes (risk adjusted) in place and over £8.2m actioned out of our total plan of £9.4m.

- Despite an increase in the cash balance between November and December, cash remains behind plan. There are a number of actions in place to improve this position.

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 December is outlined below.

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

- Given the revised monthly submission timetable for financial information to NHSI, the financial returns will be submitted on 24th January. The Board is therefore asked to confirm and approve the financial return and associated Use of Resource metric that was submitted.

December 2016 Financial Position

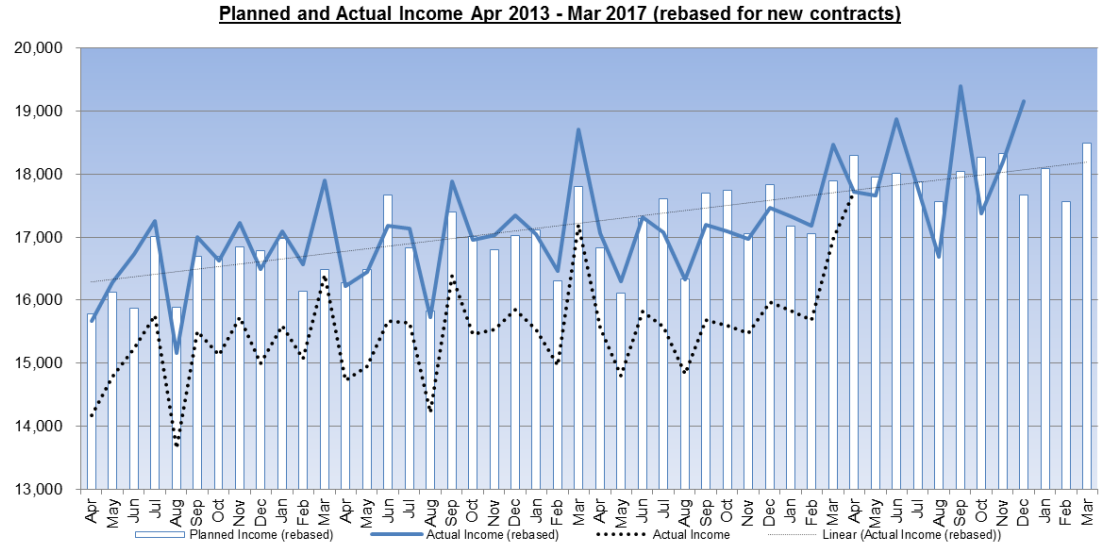
Summary Income & Expenditure 2016/17

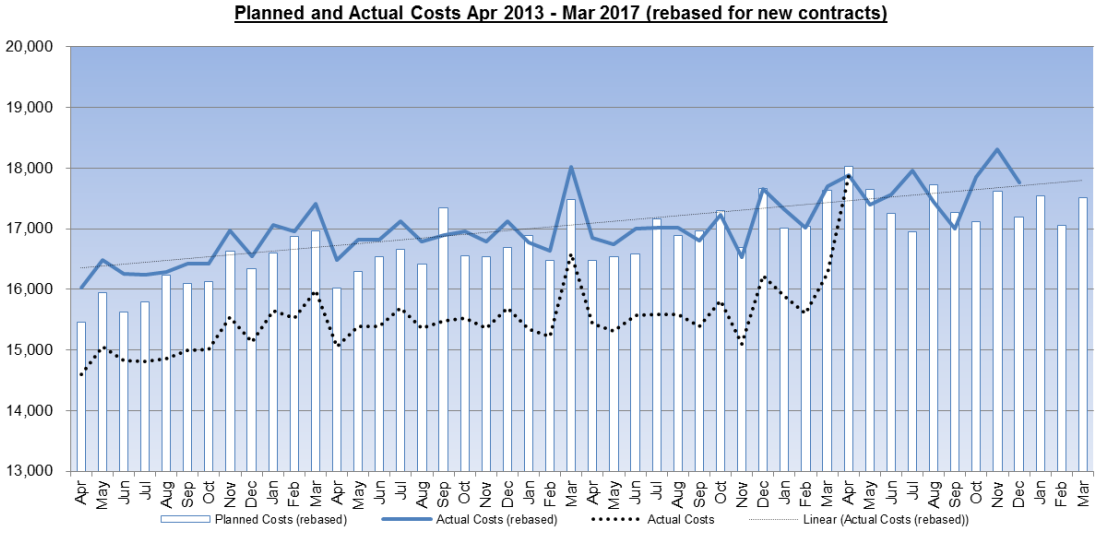
For the month ending 31st December 2016

	Budget		Actual	Cumulative	Change in	December
	Annual Budget £000	Proportion To Date £000	To Date £000	Variance £000	Variance £'000	Actuals £'000
INCOME						
NHS Clinical Income (Commissioners)						
NHS Clinical Income - Acute	142,759	106,717	105,786	(932)	889	12,630
NHS Clinical Income - Community	56,013	42,045	41,709	(336)	116	4,769
System Resilience & Better Care Funding	561	421	421	(0)	(0)	47
Non NHS Clinical Income					0	
Private Patient & Amenity Bed Income	1,922	1,453	1,041	(412)	31	154
Other Non-Protected Clinical Income (RTA)	523	392	370	(23)	(12)	32
Other Income					0	
Non Clinical Income	13,705	10,166	10,952	786	421	1,485
Hosted Services	498	273	272	(0)	(0)	43
TOTAL INCOME	**215,981**	**161,467**	**160,550**	**(916)**	**1,445**	**19,160**
EXPENSES						
Pay						
Pay Expenditure	(150,346)	(114,368)	(113,247)	1,121	25	(12,774)
Non Pay					0	
Drugs	(11,165)	(10,500)	(10,514)	(14)	(23)	(1,065)
Clinical Services & Supplies	(17,376)	(13,708)	(13,661)	47	(92)	(1,457)
Other Costs	(18,901)	(14,274)	(15,442)	(1,169)	(278)	(1,867)
					0	
					0	
Reserves : Pay	690	(9)	0	9	6	0
Pay savings targets	0	0	0	0	0	0
Other Reserves	(6,157)	(583)	0	583	(8)	0
High Cost Drugs	(1,364)	0	0	0	0	0
Non Pay savings targets	(169)	0	0	0	0	0
Other Finance Costs	(18)	(13)	(8)	6	1	0
Hosted Services	(1,201)	(791)	(939)	(148)	15	(90)
TOTAL COSTS	(206,005)	(154,247)	(153,812)	435	(353)	**(17,253)**
EBITDA	**9,976**	**7,220**	**6,739**	**(482)**	**1,092**	**1,907**
Profit / (Loss) on disposal of assets	0	0	0	0	0	0
Depreciation	(5,081)	(3,811)	(3,236)	575	141	(283)
Interest Payable	(90)	(68)	(169)	(101)	(28)	(36)
Interest Receivable	41	31	13	(17)	(2)	1
Dividend Payable	(2,646)	(1,985)	(2,099)	(115)	(13)	(233)
Net Surplus/(Deficit) before donations and impairmer	**2,200**	**1,388**	**1,248**	**(140)**	**1,190**	**1,357**
Donated Asset Income	0	0	183	183	38	38
Impairments re Donated assets	0	0	0	0	0	0
Impairments re PCT assets	0	0	0	0	0	0
Net Surplus/(Deficit)	**2,200**	**1,388**	**1,432**	**44**	**1,227**	**1,395**
Consolidation of Charitable Fund Accounts	0	0	0	0	0	0
Sustainability and Transformation Fund	4,600	3,450	3,450	0	767	1,150
Total and Consolidated Net Surplus/(Deficit)	**6,800**	**4,838**	**4,882**	**44**	**1,994**	**2,545**

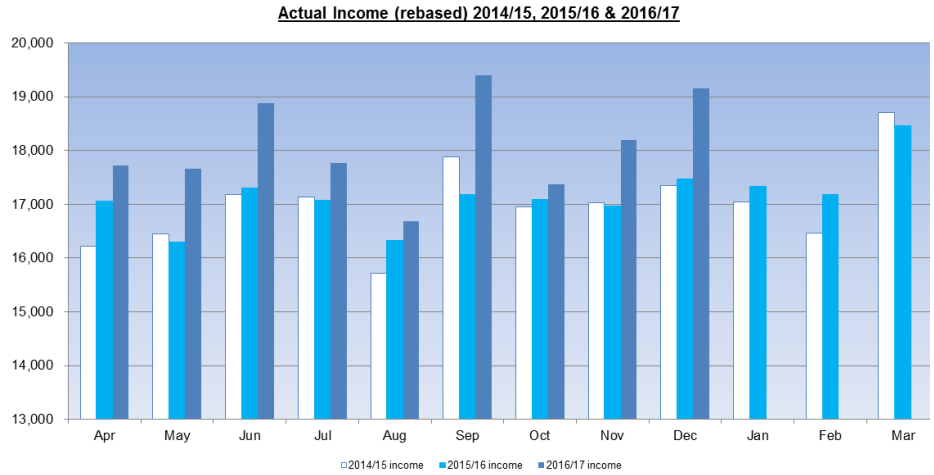
Negative sign under variance indicates an UNDER-recovery of forecast income, or an OVER-spending against budget

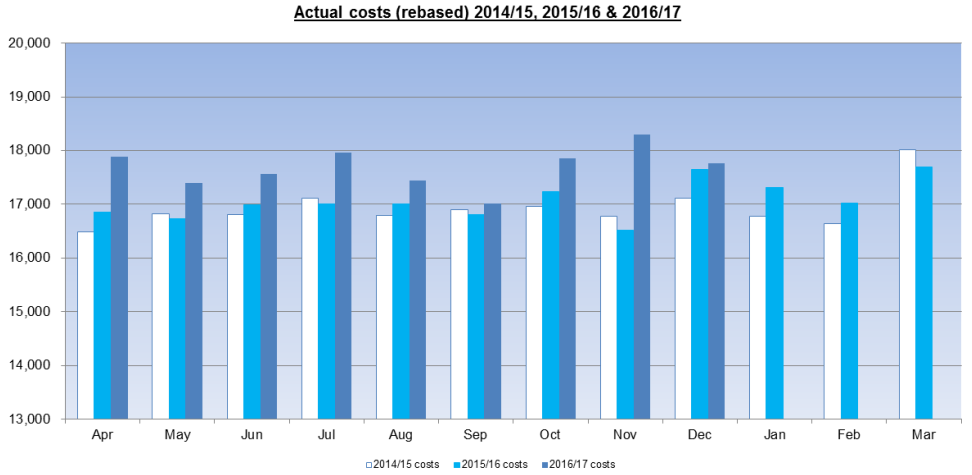
December 2016 Financial Position





December 2016 Financial Position



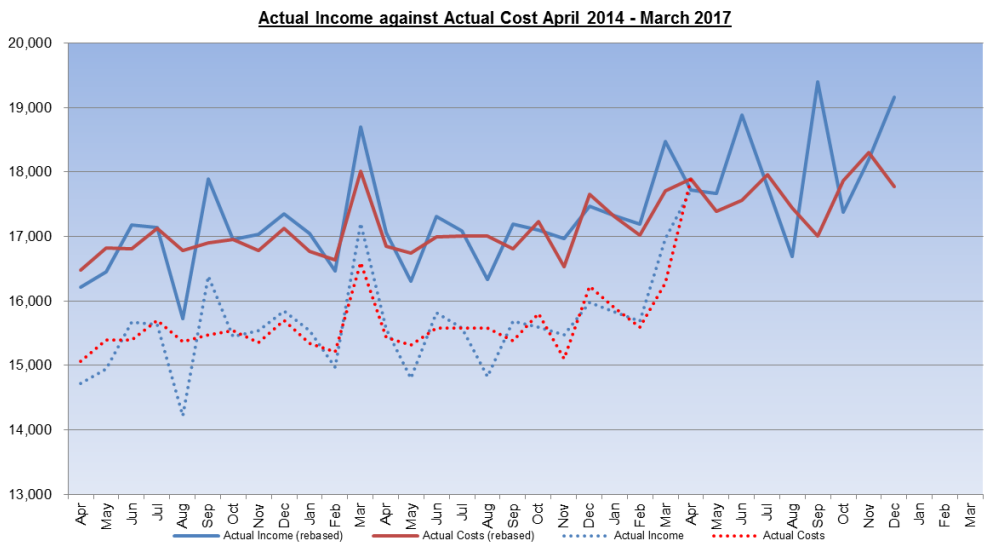


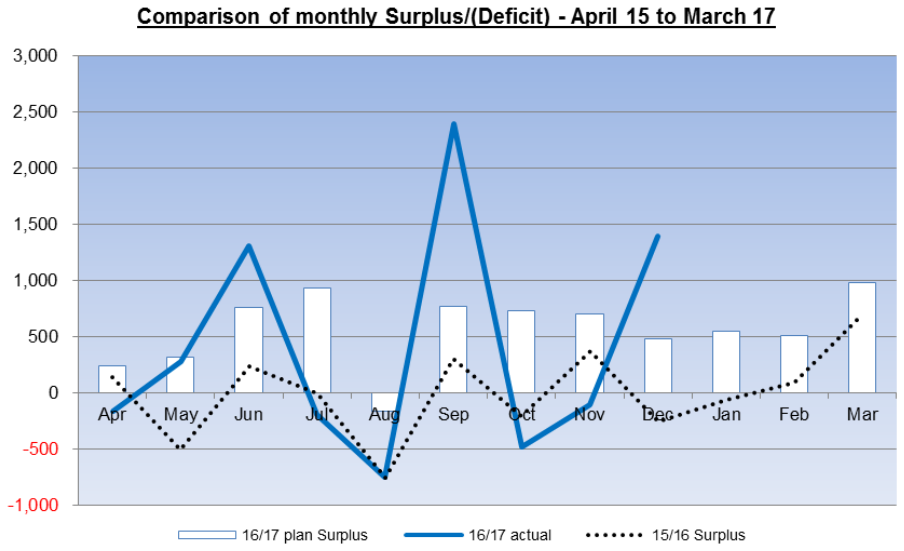
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2014/15 income plan	14,779	14,981	16,165	15,325	14,332	15,901	15,506	15,293	15,523	15,606	14,809	16,305
2014/15 income actual	14,717	14,945	15,674	15,637	14,221	16,388	15,451	15,533	15,845	15,539	14,967	17,201
2014/15 variance	**-62**	**-36**	**-491**	**312**	**-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	18,293	17,958	18,013	17,877	17,555	18,035	18,009	18,319	17,664	18,084	17,561	18,489
2016/17 income actual	17,725	17,665	18,876	17,771	16,693	19,398	17,376	18,197	19,160			
2016/17 variance	**-568**	**-293**	**863**	**-106**	**-861**	**1,363**	**-633**	**-122**	**1,496**			
2016/17 % variance	-3.1%	-1.6%	4.8%	-0.6%	-4.9%	7.6%	-3.5%	-0.7%	8.5%			

	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	18,021	17,640	17,258	16,941	17,721	17,262	17,278	17,620	17,184	17,539	17,052	17,509
2016/17 expenditure actual	17,887	17,392	17,567	17,961	17,444	17,007	17,859	18,304	17,766			
2016/17 variance	**-134**	**-248**	**309**	**1,020**	**-277**	**-255**	**581**	**684**	**582**			
2016/17 % variance	-0.7%	-1.4%	1.8%	6.0%	-1.6%	-1.5%	3.4%	3.9%	3.4%			

Note – the above plan relates to the annual plan submitted at the start of 2016/17 to NHSI.

December 2016 Financial Position



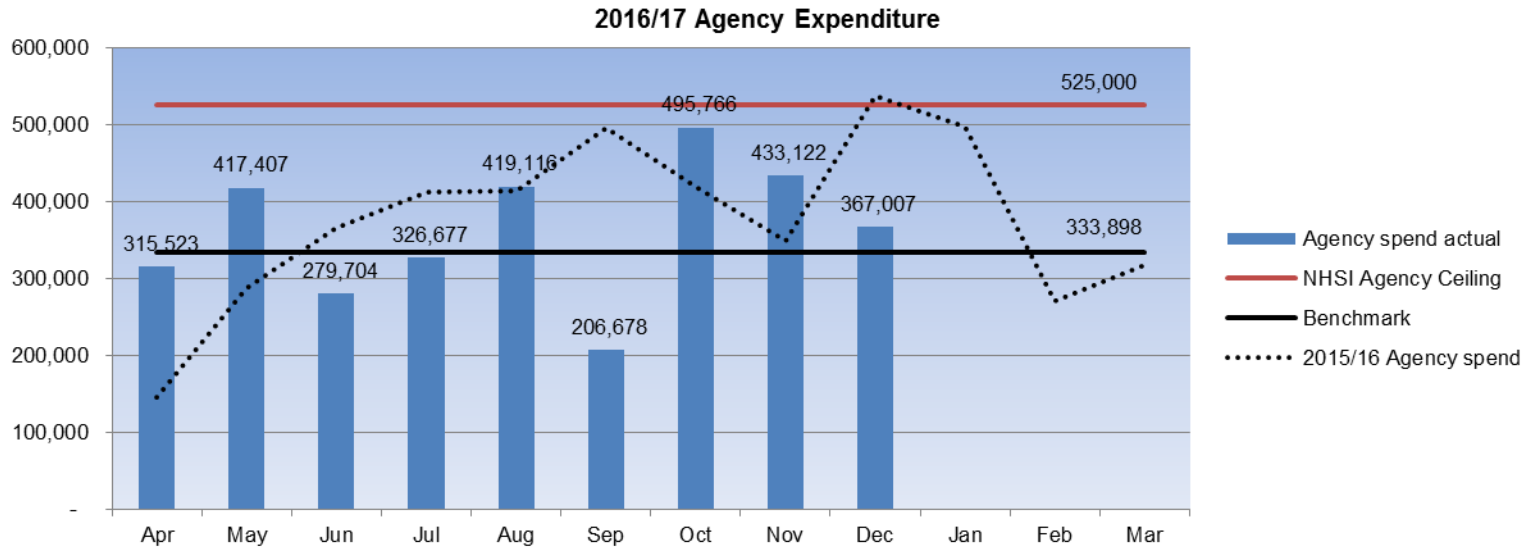


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2014/15 income	14,717	14,945	15,674	15,637	14,221	16,388	15,451	15,533	15,845	15,539	14,967	17,201
2015/16 income	15,564	14,802	15,810	15,578	14,826	15,689	15,595	15,467	15,968	15,828	15,686	16,967
2016/17 income	17,725	17,665	18,876	17,771	16,693	19,398	17,376	18,197	19,160			
2014/15 costs	15,058	15,394	15,387	15,695	15,362	15,476	15,533	15,358	15,695	15,346	15,214	16,591
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	17,887	17,392	17,567	17,961	17,444	17,007	17,859	18,304	17,766			
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	-751	2,391	-483	-107	1,394			

December 2016 Financial Position

Agency Expenditure

- Agency expenditure remains a key area of focus. The graph below outlines the Trust performance against the Agency ceiling. This expenditure ceiling was set by NHSI using information which included internal locum expenditure. The black line outlines a benchmark when internal locums are removed from the ceiling calculation.



2016/17 Efficiency Update

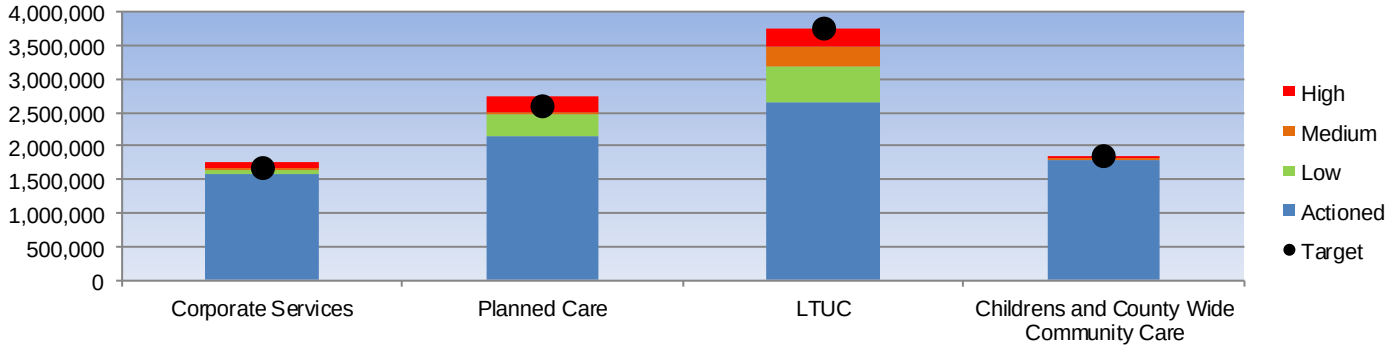
- As outlined below, £8.2m full year effect of cost improvement schemes have been actioned to date. This equates to 87% of the target.

- 26% of plans are currently non recurrent savings. If outstanding schemes are non recurrent this will increase to 39%. This is being reviewed as it will present a risk for 2017/18.

Summary	Target	Actioned	Low	Medium	High	Total	Total %age	Risk Adjust	Risk Adj %age
Trustw ide	9,400,000	8,172,000	891,781	412,430	674,875	10,151,086	108%	9,319,111	99%
	% age of target		9%	4%	7%				

- The table below outlines the directorate performance to date. These schemes continue to be assessed on a monthly basis, as well as looking to the 17/18 programme to ensure actions are being undertaken for schemes to commence in or before April.

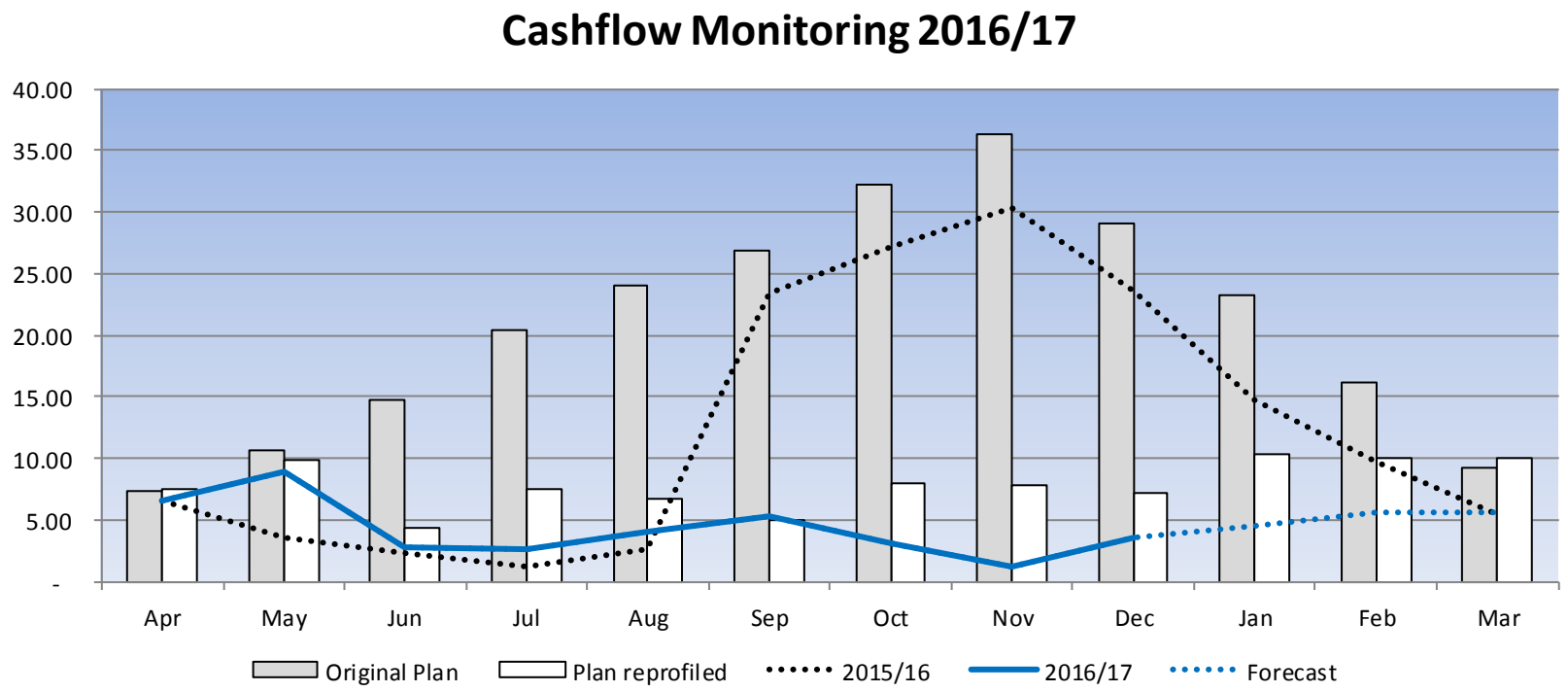
Summary	Target	Actioned	Low	Medium	High	Total	Total %age	Risk Adjust	Risk Adj %age
Corporate Services	1,675,100	1,572,800	55,800	52,000	90,000	1,770,600	106%	1,685,410	101%
Planned Care	2,620,400	2,155,872	303,431	33,267	262,900	2,755,470	105%	2,523,326	96%
LTUC	3,761,800	2,640,600	532,550	309,700	277,800	3,760,650	100%	3,449,843	92%
Childrens and County	1,859,900	1,802,728	0	17,463	44,175	1,864,366	100%	1,825,533	98%



Cash Management

The Trust reported a cash position of £3.59m at the end of December. This position is more positive than the previous forecast due to payments received which were expected in January. Cash remains a key financial risk for the Trust, with a number of actions being advanced against outstanding debts.

£'m	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16	6.56	3.60	2.38	1.25	2.63	23.42	27.18	30.27	23.59	14.71	9.70	5.53
2016/17	6.54	8.89	2.77	2.61	4.04	5.28	3.05	1.14	3.59			
Original Plan	7.34	10.67	14.74	20.48	23.98	26.81	32.15	36.33	29.02	23.19	16.11	9.27
Plan reprofiled	7.48	9.86	4.33	7.57	6.66	5.06	7.98	7.75	7.27	10.27	10.02	10.01



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Harrogate and District NHS
NHS Foundation Trust

Report to the Trust Board of Directors: 25th January 2017	**Paper No: 8.0**
Title	**Chief Operating Officer's Report**
Sponsoring Director	Mr R 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:

- The Trust has experienced significant winter pressures during December and January to date.
- The Trust is currently in the process of rolling out a new 'Moving on Policy'. This is one of a number of initiatives to support people's timely, effective discharge from our hospital.
- Planned and Surgical Care Directorate continue to focus on recovery plans for this year, working closely with clinicians to utilise available clinic and theatre space.

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.

CHIEF OPERATING OFFICER'S REPORT
Board of Directors' meeting 25th January 2017

1.0 WINTER PRESSURES

The first week of January was the busiest week ever experienced at HDFT. We hit maximum bed capacity and used every escalation space. In December 2016, there were 4,060 attendances in the ED department, and 986 of these resulted in an admission to hospital (24.3%). Compared to the same month last year, there was an 11% increase in ED attendances, and an 18% increase in the number of admissions to hospital from ED. Despite these pressures, HDFT is one of the best performing Trusts in the country which is testament to our team-working.

After the first week of January, Emergency Department attendances are back down to planned levels. However, building work starts in the department on Monday 16th January, and therefore this will impact on their capacity. Therefore we need to ensure exceptionally good flow out of the department for this period.

As of 12th January, our bed position has improved, with de-escalation of Swaledale ward, but other escalation areas are still in use.

Staffing gaps remain difficult to fill due to escalation areas being open on top of the current ward nursing vacancy rate. Community teams also remain under significant pressure. We have provided a list of duties to the CCG and have asked whether GP practices could action these in order to free up some capacity. We continue to request that delays affecting discharge are notified to Matrons to enable early escalation so that appropriate support and solutions can be found promptly.

2.0 WEST YORKSHIRE ACCELERATION ZONE

As part of the West Yorkshire Acceleration Zone, the Trust was given capital funding to support an increase in our Emergency Department capacity. The work will commence on Monday 16th January 2017 and continue until the first week in March 2017. This will result in some disruption in the department but there are plans in place to try and keep these to a minimum.

In order to support the ED works, the Orthopaedic department has moved some of its clinics to other locations so that the clinic space for ED can be maintained at the current level while works are being undertaken.

3.0 ACTIVITY AND 18 WEEK DELIVERY

Planned and Surgical Care Directorate management team continue to focus on recovery plans for this year, working closely with clinicians to utilise available clinic and theatre space. Challenges include medical staffing gaps and difficulty in recruiting particularly in the middle grade tier for General Surgery and Urology which in turn have led to financial pressures when filling via internal staff undertaking additional shifts or by locums. The team are also currently planning for the financial year 2017/18 to ensure that capacity is in place to meet the activity plans, and to address any shortfalls.

The Outpatient 10 month project progresses well with saving of up to £400K identified. Significant progress has also been made in supporting the move to electronic records in outpatients, promotion of outreach clinics and a review of the staffing model of all clinics. From a review of Ripon outpatients, capacity has been identified for further clinics which will in turn support in meeting activity plans.

Two specialities remain below the national constitutional standard for 18 week referral to treatment, General Surgery and Orthopaedics. The Directorate has developed a detailed action plan to return these specialities to the expected levels. These actions include the redistribution of Outpatient and Theatre capacity between different surgeons, changing the directory of services for some consultants to redistribute referrals to surgeons with lower waiting lists and the pooling of specified day case procedures between sub-speciality colleagues.

4.0 IMPROVING LENGTH OF STAY AND BED OCCUPANCY LEVELS

Moving On Policy

The Trust is currently in the process of rolling out a new 'Moving on Policy'. This is one of a number of initiatives to support people's timely, effective discharge from our hospital. The purpose of the policy is to ensure that choice is managed sensitively and consistently throughout the discharge planning process and that patients are provided with effective information and support to make a choice. It also provides a clear process for staff to follow when patients remain in hospital longer than is clinically required.

The intention of the policy is to reduce the number and length of delayed discharges, resulting in patients being successfully transferred to other services or support arrangements, where their needs for health/care support can be met. Ultimately it aims to improve outcomes for patients.

Every Hour Matters

The Trust will be running an "Every Hour Matters" initiative between 6th and 10th March 2017. This initiative is being supported by the wider Harrogate Health and Social Care System and involves a focus on improving flow through our hospital for the week. During this period we will cancel all non-essential meetings to free up time to focus on inpatient work. We will also be asking staff for their ideas on how they could work differently and giving them the support to try out different ideas. Throughout the initiative, we will have senior individuals from partner organisations working in the Trust to unblock those issues that we sometimes struggle to resolve and that would allow patients to be discharged from hospital in a timelier manner.

The purpose of this initiative is to support a reduction in bed numbers and test out some alternative ways to improve inpatient flow through our system which could then be used during times of high pressure or adopted into our everyday working practices.

5.0 CLINICAL LEADERSHIP TRAINING IN 0-5 SERVICES

Following negotiation with Public Health England, Children's Services have been successful in securing two pilots which will include training for 50 Health Visitors in clinical leadership and also testing against the revised "You're Welcome Standards" which is about improving access for young people to health services. Work is ongoing for the Celebration of Innovation event for Children's Services on the 22nd June 2017.

6.0 SHARED SINGLE POINT OF CONTACT – CHILDREN'S SERVICES INTEGRATION

The North Yorkshire 0-19 Healthy Child service will have the same contact number as North Yorkshire County Council (NYCC) with effect from 1st March 2017. This will improve access to services for the resident population of North Yorkshire and partner agencies as there will only be the one number to ring.

7.0 UNACCOMPANIED ASYLUM SEEKING CHILDREN

The Children's services team are starting to undertake initial health assessments for Unaccompanied Asylum Seeking Children in North Yorkshire and are becoming increasingly aware of the traumatic experiences this cohort of children and young people have dealt with. The management team are mindful of the impact of these stories and a debrief is offered to the practitioners. The 'Looked after Children' team are developing a training package to support practitioners working with these vulnerable children.

8.0 LOCAL GOVERNMENT ASSOCIATION NATIONAL AWARDS

NYCC has been nominated for a Local Government Association (LGA) Partnership Award for their MAST (Multi-Agency Screening Team). HDFT have been influential in the development of the service in terms of shared resources, governance, and information sharing processes and have been invited by NYCC along with the Police to deliver a presentation as part of the nomination process on the 27 January in London.

9.0 IMPROVING THEATRE STOCK CONTROLS

The Bluespier theatre stock control system is in the process of being ordered using STP capital funds. This will enable greater accuracy in the management of theatre stock control and will also support the transformational programme and the achievement of allocated CIP. Timescales for the roll out are being confirmed.

10.0 CCG HEALTH OPTIMISATION AND QUIPP PROGRAMME

Work continues with HARD CCG regarding the Health Optimisation Programme. HARD CCG has reported a 10% reduction in new referrals from GPs. This reduction has not been felt by HDFT this may in part be due to the back log in processing by the current Referral Support Service. Work also continues regarding reducing follow ups, with Dr Gough allocated as clinician lead and linking with clinical colleagues to understand further opportunities.

11.0 CARBON AND ENERGY FUND

During December, the system changeovers from steam to medium temperature hot water have been completed and all areas of the hospital are now operating using the new systems. Each element has been tested to prove its capacity and control arrangements, and the system is due to undergo a whole system 20 day proving period in January.

The removal of the equipment that has become redundant due to the new installation is now being undertaken with the whole project expected to complete in early February.

12.0 SERVICE ACTIVITY

Variances above or below 3% are as follows – at the end of December, new outpatient activity was 4.7% below plan, and elective admissions were 10.1% below plan.

For Leeds North CCG, new outpatient appointments were 17.3% above plan, follow-up outpatient activity was 4.7% above plan, non-elective admissions were 3.3% above plan, and ED attendances were 8.1% below plan

Report to the Trust Board of Directors: 25 January 2017	**Paper No: 8.1**

Title	Information Management and Technology Strategy 2016 – 2021
Sponsoring Director	Robert Harrison, Chief Operating Officer
Author(s)	Robert Harrison, Chief Operating Officer Paul Nicholas, Deputy Director of Performance and Informatics Richard Atkinson, Head of IMT Projects
Report Purpose	For approval.

Key Issues for Board Focus:

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	
Legal implications/ Regulatory Requirements	

Action Required by the Board of Directors To approve the new IM&T Strategy 2016-21

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Harrogate and District NHS
NHS Foundation Trust

Information Management and Technology Strategy 2017 – 2022

Author: **Robert Harrison, Chief Operating Officer**
Paul Nicholas, Deputy Director of Performance and Informatics
Richard Atkinson, Head of IMT Projects

Date: **January 2017**

Executive Summary

This document outlines the Information Management and Technology (IM&T) future strategic vision 2016 – 2021 for Harrogate and District NHS Foundation Trust. It replaces the previous IM&T Strategy 2014 – 2019.

The strategy provides a framework for IM&T developments within the Trust over the next five years, an update on the current state of the IM&T infrastructure and a consideration of the national IM&T agenda. The strategy is compatible with the NHS information strategy - “The Power of Information: putting us in control of the health and care information we need”.

The strategy describes the IM&T developments that support the Trust’s overall objectives and details the governance arrangements underpinning further investment in IM&T.

The Trust provides secondary care for Harrogate and District, North and West Leeds and community services across North Yorkshire, County Durham, Darlington and Middlesbrough, with staff working out of multiple Trust sites.

Increasing competition from other providers under the “Any Qualified Provider” process means that information and performance monitoring are critical for the future development of the Trust. The strategy details the developments required to help deliver this.

The key deliverable at the centre of the strategy is the implementation of an 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.

The national financial position in the NHS will continue to be challenging over the coming years and therefore, it is vital that the strategy focuses on ensuring the key requirements identified in the IM&T strategy progress in a timely manner.

The Strategy includes 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 involvement of staff in developing this strategy has been key to identifying the requirements for the service. This is also the start of the significant change management process which will be required to deliver the outcomes, as staff engagement will ensure success.

1. INTRODUCTION

The Trusts strategic aims are:

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

Overall, the overarching aim is to continue to deliver high quality care to our patients

The Trust has a clear strategy for the next three to five years which focuses on providing high quality, safe and sustainable services to its local population of Harrogate and North and West Leeds, as well as North Yorkshire and Durham, Darlington and Middlesbrough for the community services we provide.

The purpose of Information Management and Technology is to support the Trust's vision, strategy and business requirements through:

- ensuring that information and technology is used to support the quality and safety of care for patients;
- providing high quality, timely and meaningful information to support and enable the effective management and delivery of high quality clinical practice and corporate support;
- providing a robust fit for purpose network infrastructure that enables clinical and corporate services to execute their duties efficiently and effectively;
- providing procurement and system implementation support through effective and efficient programme and project management;

This paper defines the strategic direction for IM&T to support the Trust in achieving its objectives. Information and technology is a key enabler, increasingly underpinning everything that we do. Information and technology will be critical to supporting the delivery of service improvements, new developments and efficiency gains required over the next five years. Delivering the Trust business plan will rely on a modern and robust IT infrastructure and high quality relevant information systems.

2. CONTEXT AND BACKGROUND

The Trust provides secondary care for Harrogate and District, North and West Leeds and community services across North Yorkshire, County Durham, Darlington and Middlesbrough, with over 4000 staff working out of multiple Trust sites. These consist of a District General Hospital, Neurological Rehabilitation Centre, Community Hospital and numerous Health and Children's Centres across North Yorkshire, County Durham, Darlington and Middlesbrough.

Harrogate and District NHS Foundation Trust has a track record for innovation in technology, examples of this include:

- being an early adopter site for:
    - Choose and Book;
    - Electronic Prescribing and Medicines Administration (ePMA);
- working closely with Systems Providers to develop:
    - Results Reporting Systems;
    - Touchscreen technology;
- being a pilot site for Going Further Faster to deliver the 18-Weeks RTT standards;

2.1. Local Context

2.1.1. Current IM&T Landscape

Historically the Trust has progressed towards the delivery of a full electronic clinical record using an incremental approach, using the Clinical 5 requirements, (see list below), as a template. Keeping the focus on getting the basics right, the Trust has delivered two of the five requirements and are part way through delivering a further two.

The Trust has comprehensive patient and clinical systems in place across the organisation, using bi-directional data feeds from the Trust's Patient Administration System (PAS) to automatically populate patient demographic data in other clinical systems. This has a positive impact on the data quality, significantly reducing the potential for duplicate registrations. However, we do lack the ability to link clinical data and clinical systems at scale to enable transparent access to all clinical information.

- C5-1: Electronic Admissions, Discharge Transfer: Delivered
- C5-2: Universal Requesting and Results Reporting: Partial
- C5-3: Transparent Access to all Clinical Information: Partial
- C5-4: Scheduling – Clinics; Theatres; Tests; Beds: Delivered
- C5-5: E-Prescribing and Medicines Administration: Partial

The Trust ensures all clinical systems conform to national standards and uses iCS PAS as the core data source for hospital based services.

Community Services data is recorded using SystmOne, a shared EPR that records clinical contacts and activity data direct into patient records. This is then shared as appropriate with other services also providing care to the patient.

Data warehouse technology is used to develop and link patient data extracted from Trust clinical and administration systems. This enables us to develop system and reporting options that reflect real time, meaningful, high quality information accessed through web based applications. This will provide a firm foundation for the provision of high quality, timely and meaningful information. This will support and enable the effective management and delivery of high quality clinical practice and corporate reporting options across the Trust.

The Trust has adopted a *best of breed* approach when procuring and implementing clinical systems (as opposed to an *integrated* solution) and this has worked well, enabling the Trust to select the most appropriate solution for each application area. This has been the most fitting and cost effective strategy for a small District General Hospital to date, although there are downsides with this approach, such as:

1. A growing number of clinical systems not sharing clinical information with each other, lacking integration and exacerbating the duplication of clinical information;
2. An increasing number of systems placing an additional burden on IT and Information Services staff supporting them, e.g. maintenance, upgrades, testing, training;
3. Clinical staff needing to log on and off many IT systems which takes up valuable clinical time and needing to remember numerous usernames and passwords;
4. Clinical staff needing to access many different systems to view different types of patient information;
5. Additional cost in paying multiple suppliers to support the systems;
6. Clinical staff requiring training on multiple systems;
7. No “single view” of all the patients information;
8. Inability to share information across the community with other care providers;

2.1.2. Paper Environment

Clinicians and nurses still rely heavily on paper notes to record patient information. These are stored in multiple locations depending on whether they are hospital or speciality notes, and depending on the age of the notes. Most patient notes are stored in the main library, but some specialties have their own notes stored in their own departments.

When patients are admitted as inpatients, or have outpatient attendances, their notes are pulled from the location they are stored, prepped for clinics or wards and tracked to their locations. Additionally, when notes are required for other purposes such as for medical secretaries typing up letters or clinical coders using for coding purposes, these need to be requested, transported and tracked.

A significant amount of staff time is spent tracking and transporting paper notes within the Trust. This doesn’t just relate to staff working in Health Records, but staff from other locations as well. Patient notes are also stored off site and when these notes are required, they are pulled and transported to the Trust.

There are hundreds of different document templates in use across the Trust. Many of these duplicate the information being collected.

There are many issues associated with the use of paper records such as:

- Duplication of data and effort;
- Missing hospital notes;
- Paper and printing costs;
- Filing, storage and transport costs (Magnum and Local);
- Inability to share with more than one person at once;
- Constraints with sharing electronically (e.g. to GP’s);

- Time to transport patient notes to desired destination and be available to support patient care in a timely manner;
- Quality of data compromised;
- Time to complete;
- Risk of getting damaged, or misfiled;
- Limited security of patient information (i.e. left at the end of the patients bed or on trolleys);
- Time to find information within the hospital notes;
- Risk of using out of date document templates (compromising standardisation);

2.2. National Context

2.2.1. Five Year Forward View

The NHS "Five Year Forward View" (FYFV) describes the challenges the NHS faces and how the current NHS model is unsustainable. It describes how action is required to prevent illness such as obesity, smoking and alcohol, how patients need greater control of their own care, and how barriers need to be broken down between all care providers.

The Trust is one of a partnership of organisations that has been chosen as one of the "Integrated primary and acute care systems" Vanguard sites which will focus on joining up GP, hospital, community, social care and mental health services. This is one of the first steps towards delivering the FYFV and supporting improvement and integration of services. Each Vanguard site will take a lead on the development of new care models which will act as the blueprints for the NHS moving forward and the inspiration to the rest of the health and care system.

In order to support this, the effective, safe and secure sharing of information between all care providers and patients is critical. Currently there is limited sharing of information electronically between organisations, so the majority of information is shared verbally, on paper or not at all. There are clear risks with this, but in particular it means that care providers may not have the most up to date or accurate patient information to provide patients with the best and safest possible care.

2.2.2. Paper-free at the Point of Care – Preparing to Develop Local Digital Roadmaps

The FYFV identifies harnessing the information revolution as a key enabler to securing a sustainable NHS and made a commitment that, by 2020, all electronic health records would be fully interoperable so that patient records are paperless. This vision was supported by the establishment of the National Information Board and its ambition to transform the health and care digital landscape outlined in Personalised Health and Care 2020 – A Framework for Action.

In June 2016, along with Harrogate and Rural District CCG, North Yorkshire County Council and Tees, Esk and Wear Valley NHS Trust, we jointly developed a plan that establishes the 'footprint' of our local digital roadmap, detailing how we will achieve the ambition of being paper-free at the point of care by 2020.

For the Trust to deliver a true integrated digital care record and become paper-free, it needs to be in a position where vital patient related information can be accessed and clinical decision and support tools can be used in a joined up manner and in a single instance. This information needs to be available across sectors, services and providers, as well as accessible to the patient themselves.

2.2.3. Making IT Work: Harnessing the Power of Health Information Technology to Improve Care in England

In late 2015 the National Advisory Group on Health Information Technology in England was formed to advise the Department of Health and NHS England on its efforts to digitise the secondary care system. A report was produced by Bob Wachter titled “Making IT Work: Harnessing the Power of Health Information Technology to Improve Care in England”. The report describes ten overall findings and principles and ten implementation recommendations as follows:

Overall Findings & Principles

1. Digitise For The Correct Reasons;
2. It’s Better To Get Digitisation Right Than Do It Quickly;
3. “Return On Investment” From Digitisation Is Not Just Financial;
4. When It Comes To Centralisation, The NHS Should Learn, But Not Over Learn Lessons From NPFIT;
5. Interoperability Should Be Built In From The Start;
6. While Privacy Is Important, So Too IS Data Sharing;
7. Health IT Systems Must Embrace User Centred Design;
8. Going Live With A Health IT System Is The Beginning, Not The End;
9. A Successful Digital Strategy Must Be Multifaceted, And Requires Workforce Development;
10. Health IT Entails Both Technical And Adaptive Change;

Recommendations

1. Carry Out A Thoughtful Long Term National Engagement Strategy;
2. Appoint And Give Appropriate Authority To A National CCIO;
3. Develop A Workforce Of Trained Clinician-Informaticists At The Trust And Give Them Appropriate Resources And Authority;
4. Strengthen And Grow The CCIO Field, Others Trained In Clinical Care And Informatics, And Health IT Professionals More Generally;
5. Allocate The New National Funding To Help Trusts Go Digital And Achieve Maximum Benefit From Digitisation;
6. While Some Trusts May Need Time To Prepare To Go Digital, All Trust Should Be Largely Digitised by 2023;
7. Link National Funding To A Viable Local Implementation/Improvement Plan;
8. Organise Local/Regional Learning Networks To Support Implementation And Improvement;
9. Ensure Interoperability As A Core Characteristic Of The NHS Digital Ecosystem – To Promote Clinical Care, Innovation And Research;
10. A Robust Independent Evaluation Of The Programme Should Be Supported And Acted Upon;

Whilst at this stage it is unclear which of these findings, principles and recommendations NHS England will adopt, they do provide the Trust with some guidance to delivering its IT Strategy. Some of these will be picked up at a National level but others will need to be picked up at a local level. Reassuringly, many of these are already part of the Trust's Strategy.

In particular, the Trust has appointed a clinical IM&T lead, with some of their time protected to fulfil this role. This role will lead on the EPR deployment over the coming years and chairs the recently formed EPR Board.

3. DEVELOPING THE STRATEGY

Traditional paper-based recording and storage systems do not support the Trust in an efficient and effective manner. Paper records are sometimes lost, difficult to read, incomplete and inaccessible when they are needed. Current paper-based systems cannot support the increasing demand and more complex organisation of care. As we are constantly adapting and changing to support the ever changing needs of our patients and commissioners, the services that we offer require modern clinical systems and processes in place to meet them.

In October 2015, The Trusts Executive Team and the senior team from IM&T discussed the need to have an electronic patient record that supports the Trust becoming a paperless organisation and allowing the sharing of information not just to Trust staff but to the wider health community. They discussed how the Trust not only needed a solution that would provide an effective and efficient way of recording and viewing patient information, but would also use patient data more effectively so as to reduce duplication, re-use data where possible and also provide Clinicians with the decision support tools to improve patients care and safety. They reviewed the constraints and risks associated with the current best of breed EPR solution and considered whether to continue down this path, or to change its strategy to an integrated EPR solution.

The Trust Executive team agreed that the integrated EPR solution would be the best option to deliver its future objectives and address some of the existing problems with the current strategy. They agreed that the integrated EPR solution should:

- Enable the replacement and reduction of the existing systems over time (as opposed to a replace all, big bang approach), initially scoping 3-5 years as the EPR system functionality is mature enough - i.e. not take big backwards steps in functionality but take it when it is similar or better than what we already have;
- Enable the filling of existing gaps - i.e. where we don't currently have IT systems in place such as clinical noting, self-check-in kiosks, task management;
- Accommodate the development of new functionality that doesn't exist in the EPR solution and in particular, enable the Trust to be part of the future development of the solution so that it meets our specific needs and allowing the Trust to shape the products development in a flexible, timely and easy way;

- Provide enhanced clinical functionality, which will help to reduce and ultimately remove the large number of paper based systems the Trust currently uses;
- Provide a complete view of the patient record (clinical portal) that receives data feeds from existing internal systems as an interim until the EPR can replace them, and other external systems such as SystmOne and EMIS;
- Be affordable and offer value for money given the financial constraints on the Trust and the NHS as a whole;
- Be intuitive and easy for clinical staff to use so that utilisation is high and the impact of training is kept to a minimum;
- Enable the removal or reduction of duplication of data and effort and re-use data that is already recorded somewhere in the system rather than replicate;
- Provide real time and accurate information to the right people, at the right time in the right place both within the Trust and also to other care providing organisations in the wider community;
- Make working processes more effective, more efficient and safer for patients;
- Enable the transition from old systems and old ways of working to be as seamless and risk free as possible;
- Provide an enabler for patients to see and update their own records electronically.

4. KEY PRIORITIES

4.1. Phase 1 introduction of an EPR

Detailed below are the three priority modules for the establishment of an EPR at Harrogate and District NHS Foundation Trust. Once these are in place and evaluated the development would seek to incorporate further modules which either digitise paper processes or integrate existing systems as described in 4.5 The EPR Roadmap.

4.2. Clinical Portal

The clinical portal will receive patient information from other clinical IT systems (via HL7 interfaces) and present them as a single patient record which will be viewable from anywhere within the Trusts secure network from an electronic computer device. This would be underpinned by integration software that will use the NHS Number as the primary identifier. This could be made available to non-Trust staff such as GP's, Social Care staff and Mental Health staff and potentially they could add to the patient record.

The following benefits and outcomes are anticipated to be delivered:

- The number of clinical IT systems that staff would need to log into separately would reduce and in turn save time to return to patient care;
- Reduce the need to remember lots of different usernames and passwords;
- The Trust does not need to invest in a separate single sign on system;

- Patient information would be visible to staff who currently can't see it, as they may not have access to the existing clinical systems, or even if they do, may not know that the information is there without checking every system individually;
- Multiple clinical staff would be able to view and review the whole patient record from different locations at the same time, enabling tele-conferencing. This could support MDT meetings as an example;
- Staff would become less reliant upon paper notes;
- Reduce the amount of pulling, prepping and filing of paper notes and would enable their eventual removal;
- Reduce clinical risk and improve care provided for patients at the Trust and other care providing organisations;

4.3. Clinical Noting & Documentation

This will enable the recording, viewing and sharing of clinical and non-clinical patient information that has traditionally been held in paper notes, assessments and charts. This is a key component of an electronic patient record and the patient's information workflow. The following benefits and outcomes are anticipated to be delivered:

- Improved patient experience;
- Removal of inefficient paper processes;
- Standardisation and reduction in locally defined forms;
- Provision of better, safer patient care by ensuring that all patient information is available when needed, enabling improved and speedier decision making and treatment;
- Improved clinical decision making at the point of care to support best practice and reduce operational and clinical risk through the immediate availability of patient information;
- Improved legibility, quality, completeness and more up to date patient information to support better decision making including the ability to make data capture mandatory;
- Improved electronic sharing of information to support the patient pathway across geographical and organisational boundaries;
- Improved security of patient information;
- Improved efficiency and effectiveness of the Trusts clinical and administrative staff working practices through the reduction in duplication and the availability of patient information when and where it is needed;
- Ability for multiple clinical staff to view and discuss the whole patient record from different locations at the same time, enabling tele-conferencing. This could support MDT meetings as an example;

4.4. Self-Check In

This aims to provide self-check in kiosks initially to the main reception desk but potentially to other outpatient reception desks including Radiology and Therapy Services.

Instead of the patient going to the reception desk to confirm their details and find out which waiting area to go to, they will enter some basic details about themselves into

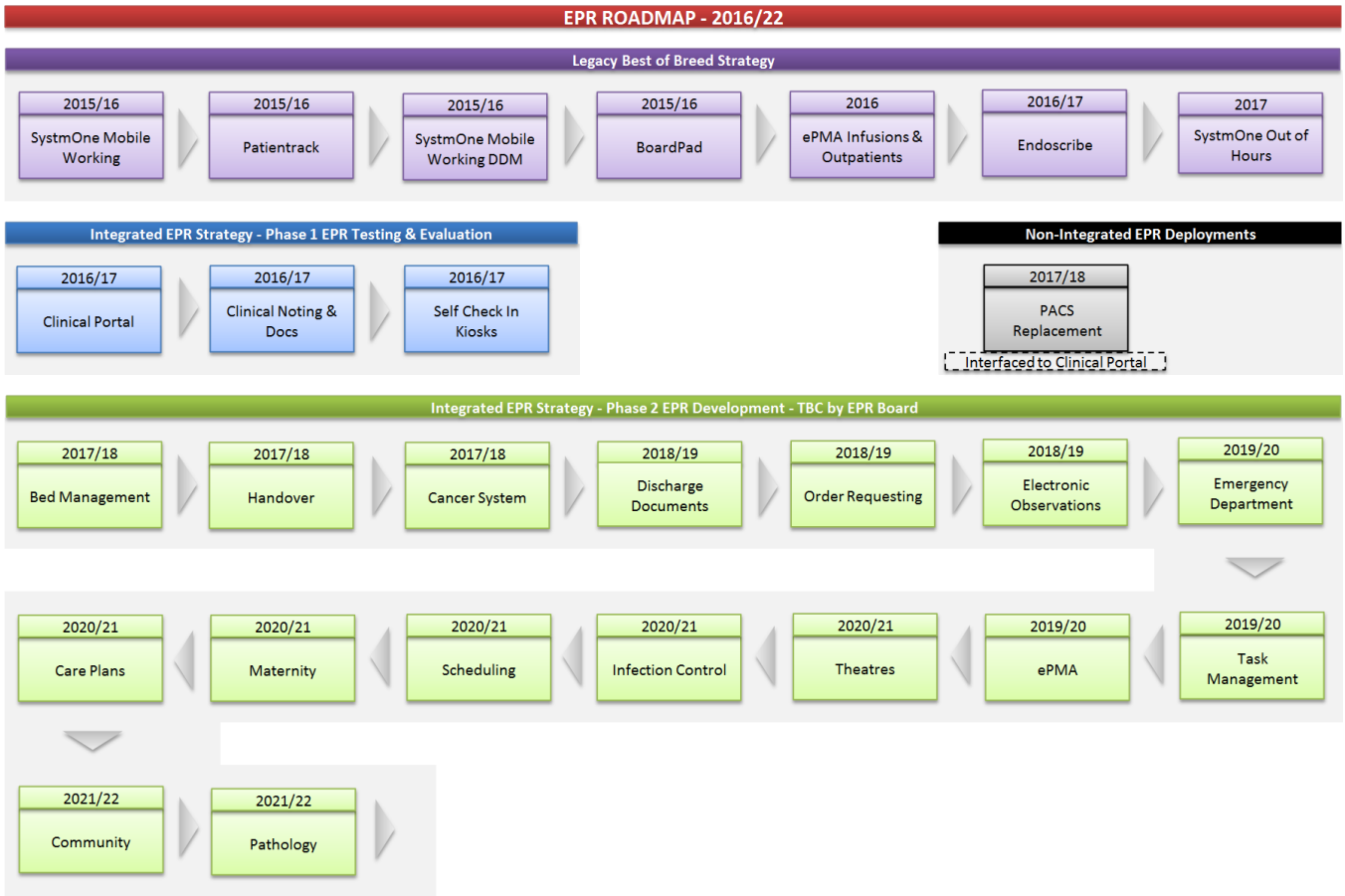
a touch screen “kiosk”. This kiosk will then direct them to the right waiting area and also (if required) ask them to confirm some of their details as a way of improving upon the data quality of patient records.

There are significant business transformation opportunities for the Trust by using technology to provide an automated self-service check-in and patient calling system, such as:

- Resource being used more effectively;
- Improved existing processes;
- Improved patient experience;
- Greater quality of care for patients;
- Improved data quality;

4.5. The EPR Roadmap

The Trust’s EPR roadmap is shown in three sections: Best of breed - pre EPR; Phase 1 EPR testing; Phase 2 EPR development. If successful the deployment of further capabilities over at least the next five years will enhance the functionality of the electronic patient record. As priorities change during this period, the roadmap may change to reflect this. The diagram below illustrates the roadmap for the next five years.



4.6. Picture Archiving and Communication System (PACS) Replacement

The national contract for Picture Archiving and Communication System (PACS) and data storage is coming to an end. The Trust is part of the West Yorkshire Acute Trusts (WYAT) group who are procuring the replacement PACS on a collaborative basis in 2017/18 when the current contracts come to an end.

4.7. Infrastructure

The Trust has built up a communications network and data storage infrastructure that supports digital imaging across the corporate network, mobile working via Wi-Fi on the district general hospital site and community premises across North Yorkshire, County Durham, Darlington and Middlesbrough. This is being extended across all sites with additional infrastructure as we continue to roll out mobile working in the community.

Further extended use of mobile working across the hospital site will need to continue in parallel to community service mobile working implementation and rollout. Close working with the Clinical Directorates regarding change management will be critical to ensure this is combined with change in working practice to deliver benefits.

Continued upgrading of the Trust's storage and continued maintenance and improvements to the network across the organisation is also required on an on-going basis over the lifetime of this strategy. This will ensure the infrastructure continues to remain fit for purpose as the demand placed upon it increases.

In 2018/19 the Trust will replace its current servers as they will be nearing end of life. The following year in 2019/20, the storage will also be replaced for the same reason.

The number of desktop PCs, laptops and smartphones / tablet devices in use across the organisation is now circa 5,000. To service, replace and licence this number of devices is a significant challenge and therefore the strategy for Cloud Computing and Desktop Virtualisation will be explored and combined with the technical assessment on service improvement, security and cost.

The many different types of computer devices will continue to be reviewed to ensure the Trust has the right equipment for staff to perform their jobs effectively. Clinical staff will play a key role in the selection process to ensure any devices procured are fit for purpose and support rather than hinder the clinical process.

IT will be an enabler to support Trust provision of services over a wide geographical area, including Trust access to mobile working infrastructure and platforms such as Webex communications and teleconferencing.

The on-going maintenance, replacement and continued development of the communications infrastructure and hardware will continue throughout the lifecycle of the strategy as the Trust continues to use IT to support innovative ways of working.

4.8. Information strategy with extended coverage of the data warehouse

Providing high quality, timely and meaningful information will support the effective management and delivery of high quality clinical and corporate practice.

Data warehouse technology supports retrieval from a single repository for clinical and corporate data, enabling web based reporting for directorates to access and produce structured reports as and when required. This will allow all levels of the organisation to proactively monitor and analyse performance reporting to support operational service delivery.

Data extracts from clinical and administrative systems are routinely loaded into the data warehouse; these are then linked to enable a consistent view of service delivery including comprehensive modelling against planned activity. Recent developments include:

- Prescribing reports by ward or prescription, with access available to all clinicians and pharmacists;
- Infection control reporting supporting the Saving Lives Audit;
- Workforce development reporting automating the tracking and automated emailing of appropriate staff;
- Non Elective Flow dashboard supporting patient flow through the Emergency Department
- Upgrade of servers to SQL 2010 for the data warehouse and are currently migrating systems across to the new server;

This has shown the proof of concept and potential benefits from the automation of routine tasks and quick easy access for clinicians to clinical reporting.

Over time, where possible, an increased level of appropriate clinical and corporate systems data will be housed in the data warehouse and then made available to teams through a user friendly reporting interface.

4.9. National Local Service Provider (LSP) Contracts

There are now only two LSP contracts remaining. The N3 network will be replaced with the Health and Social Care Network in 2017/18 and as described above, the PACS system will be replaced in 2017/18. All other LSP contracts have been replaced with local contracts.

4.10. Adherence to Standards, Governance and Processes

As the organisation and our services become significantly more dependent on IM&T for the day to day running and patient care, the assurance of adherence to standards, governance and process becomes fundamental to the strategy. These will ensure that the organisation adheres to inter-operability standards, technical standards and data standards.

There are three groups within the Trust that play a key role in ensuring that all systems and processes are and remain fit for purpose in relation to the development of the EPR. These are the IT Steering Group; Data and Information Governance Steering Group; Health Records Committee. The latter of these remains responsible no matter what media is used for ensuring clinical records are maintained to the appropriate standards. A new EPR Board will be set up to oversee the implementation of the Integrated EPR system.

We are working with our Local Digital Roadmap partners to ensure robust data sharing agreements are in place to support the delivery of an integrated digital care record where vital patient related information can be accessed across sectors, services and providers through a clinical portal.

The threat of software virus attacks on NHS IT systems and networks continue to be a risk and recent increased activity and complexity of malware has resulted in a focused review of IT security arrangements in place and current practice. This area of work will continue to be prioritised and monitored closely. Appendix A details the Trust governance structure with the three groups highlighted.

4.11. Capacity and Capability

IM&T is increasing in importance for the Trust with patient care being increasingly dependent on having network and IT facilities that are both robust and available 24/7. Appendix C details the organisational structure for IM&T.

5. FINANCIAL ASSESSMENT

The delivery of this strategy will require significant investment over the forthcoming years. National funding is available through a number of Technology Funds for which organisations are able to bid. The Trust has previously been successful in bidding for funds to support the rapid acceleration of ePMA and also Real time observation and escalation projects. We will continue to submit bids to support the implementation of the strategy as and when further funds become available,

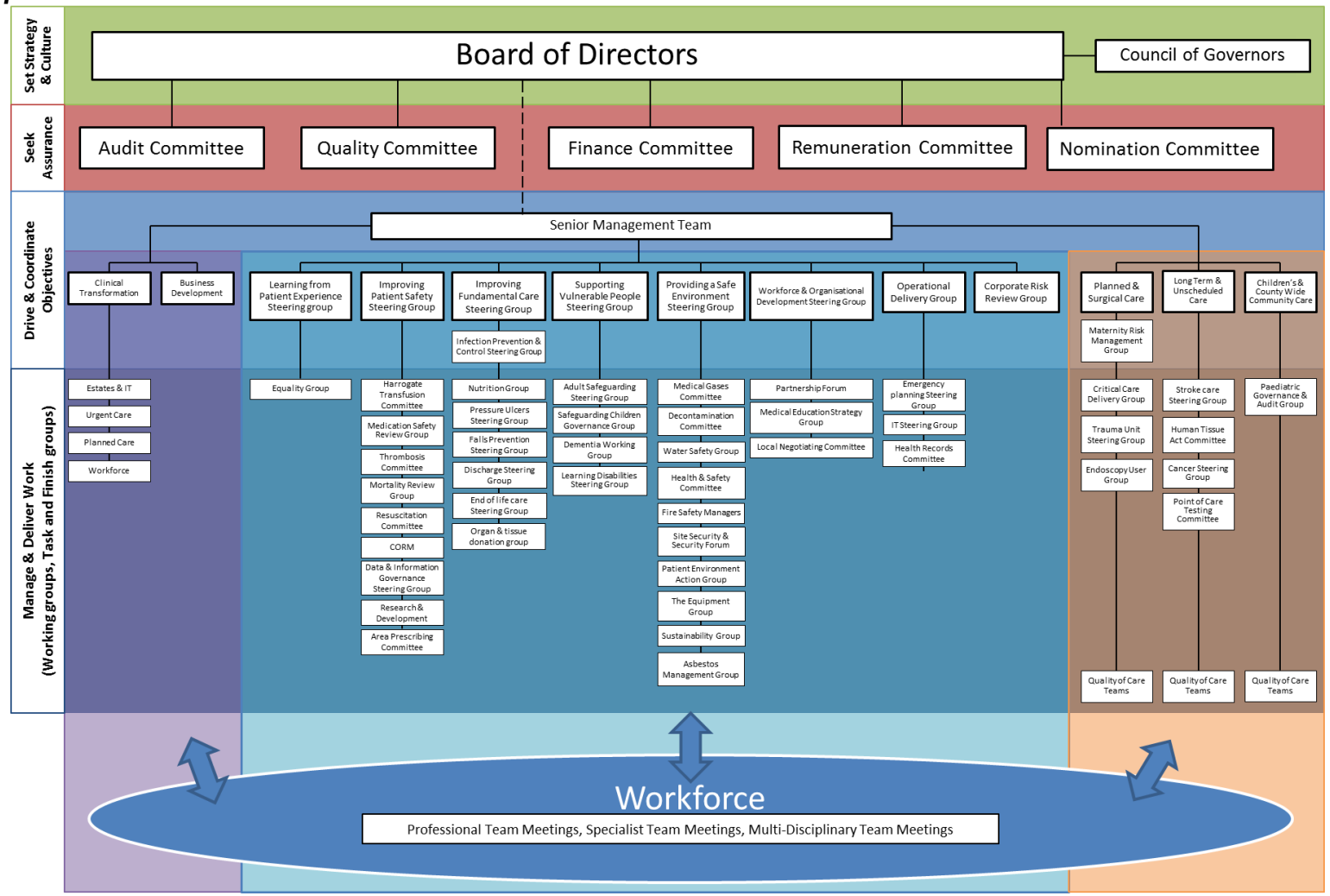
The change management approach to this work will be critical in ensuring that the Trust maximises the benefits in relation to efficiency and effectiveness of teams across the Trust. These benefits will be identified within each detailed business case for each stage of the delivery of this strategy.

Possible funding streams over the next few years could include:

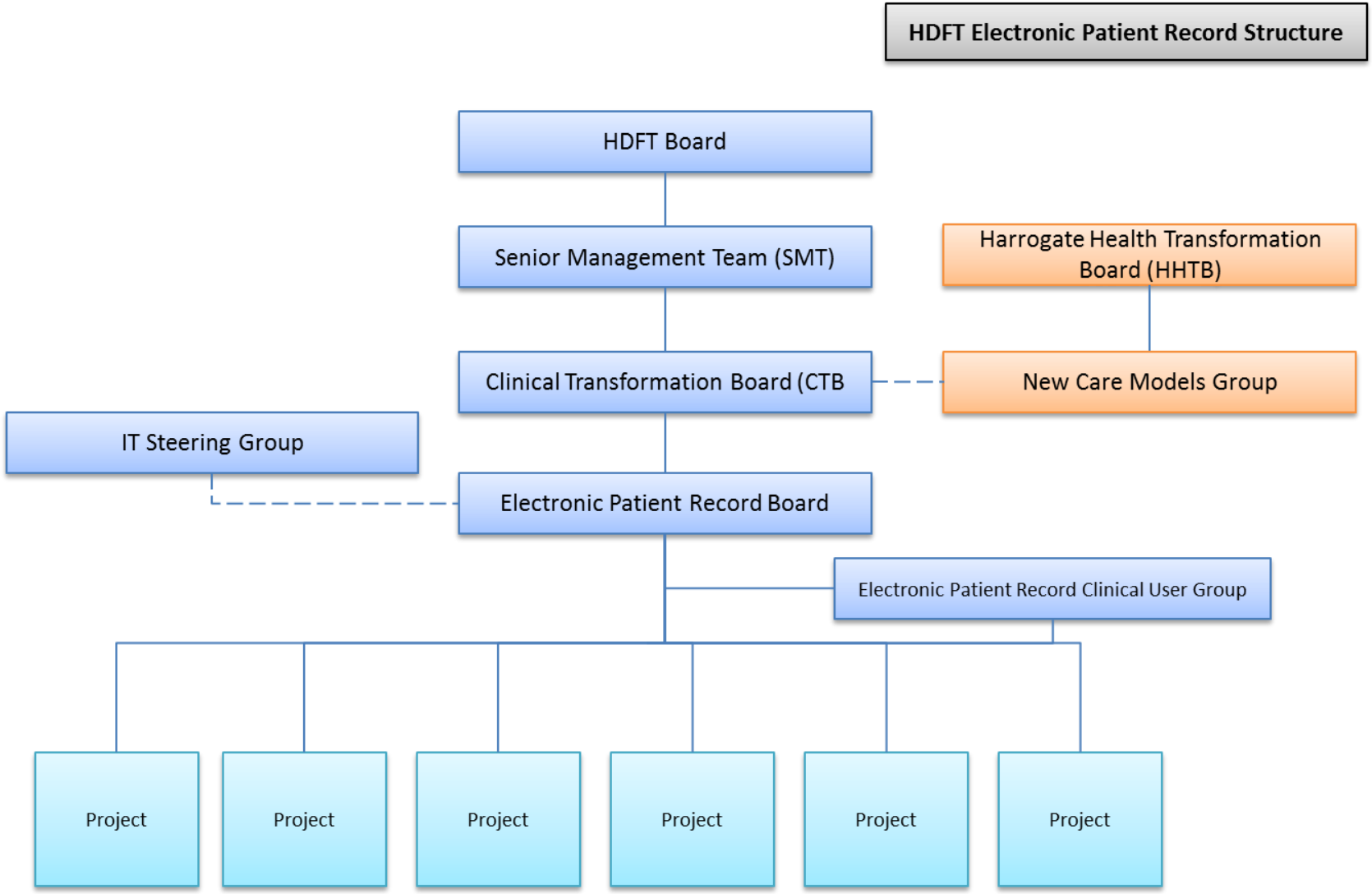
1. Local funding secured through the development of local business cases;
2. National Information Board (NIB);
3. Estates & Technology Transformation Fund (ETTF);
4. Sustainability & Transformation Plan (STP);
5. Local Digital Roadmap (LDR) technology funds (as described in the Making IT Work: Harnessing the Power of Health Information Technology to Improve Care in England Report);

6. APPENDICES

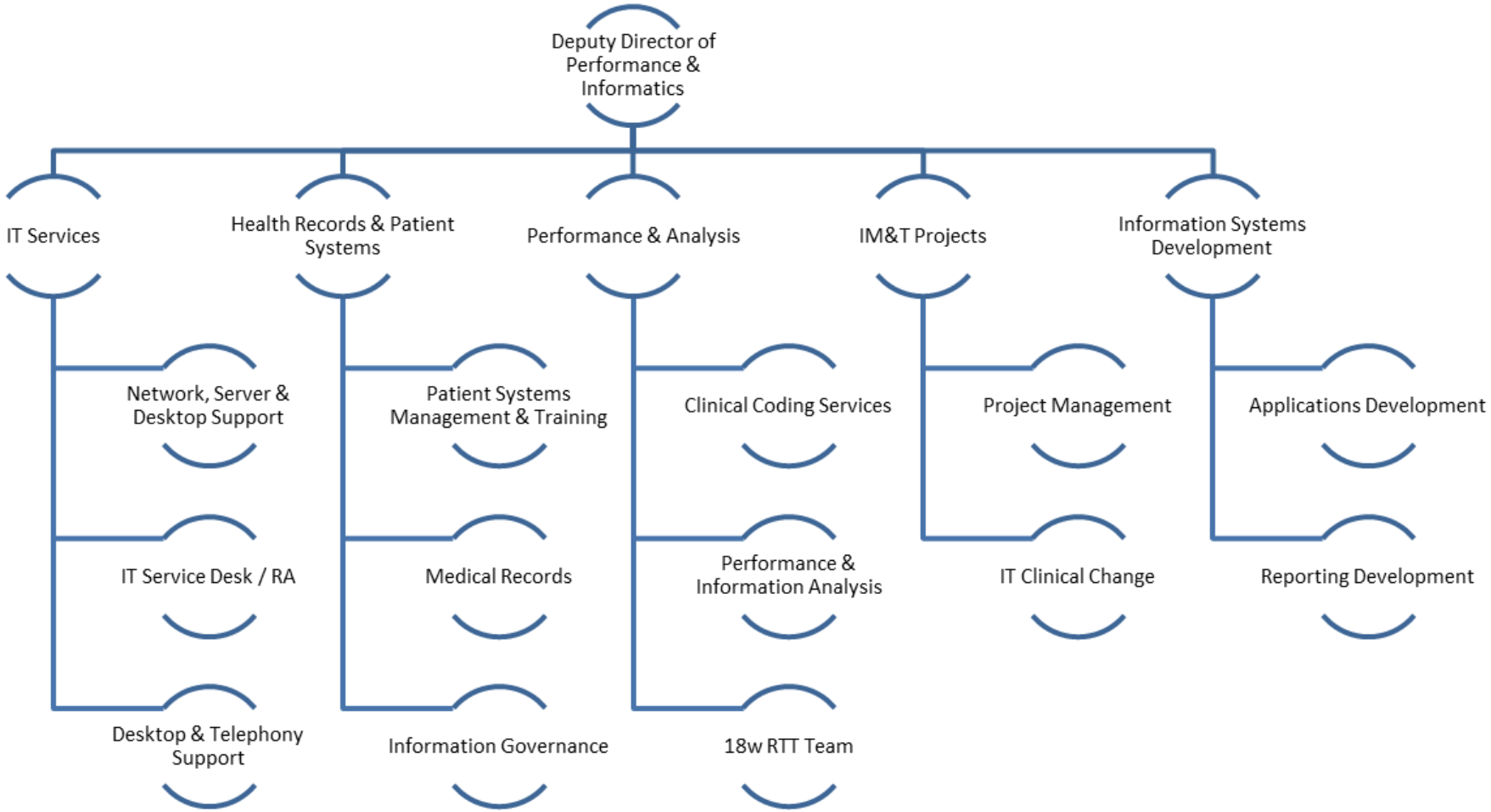
6.1. *Appendix A – Governance Structure*



6.2. *Appendix B– EPR Structure*



6.3. *Appendix C – IM&T Organisation Structure*



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Report to the Trust Board of Directors: 25 January 2017	Paper No: 9.0
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: Key Issues for Board Focus: The Board are asked to:

- **Note** the results of Director Inspection Visits and the red rating for Farndale and Littondale Wards.
- **Note** the decrease in the number of complaints received by the Trust in December 2016.
- **Understand** the steps being undertaken to maintain safe staffing levels including robust registered nurse recruitment and to receive an update on CATT, AMU, Byland and Jervaulx
- **Note** two of our service areas have undergone CLAS inspections
- **Receive** a briefing regarding the national LeDeR programme
- **Approve** the EDS2 Summary Report for publication

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 assurance regarding Trust participation in a national programme to improve care for people with learning disabilities and working with partners to improve access to care and treatment for people with protected characteristics
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
The Board of Directors are asked to receive and note the content of the report and approve the EDS2 summary report for publication.

Unannounced Directors' Inspections 2016-2017

Date	Ward/Dept.	Risk Rating	Critical Issues	Review Date	Outcome	Critical Issues
14/04/16	Mortuary	Green				
26/04/16	Endoscopy	Green				
06/05/16	Day Surgery Unit *(follow up visit)*	Green				
12/05/16	Acute Medical Unit	Red	Lack of cannula VIP scores.	09/09/2016 Successful audit now compliant	Green	
06/06/16	Medical Day Unit	Amber	Largely relating to the non-compliant chairs in the treatment room and waiting room.	**Update Sept** Treatment room chairs now replaced. Waiting room chairs remain non-compliant.	Amber	
16/06/16	Pannal *(follow up visit)*	Red	Further review to be undertaken (Lack of cannula VIP scores)	Remains red following re-visit failed again.	Red	
24/06/16	Harlow	Red	Lack of cannula VIP scores	JF IPC re-audited Sept Harlow now compliant	Green	
14/07/16	Whitby Dental Clinic	Green				
29/07/16	Ice Store, Knaresborough	Red				
16/08/16	Dental Clinic Settle HC	Green				
230/8/16	Lascelles	Red		02/11/16	Green	
31/10/16	Operating Theatres	Green				
10/11/16	Farndale	Red	Controlled drug check book had gaps			
21/11/16	Monkgate Dental Clinic	Green				
02/12/16	Littondale Ward	Red	Controlled drug check			

1. **Patient Safety Visits**

Since the last report to Board, the following visits have taken place:

Date	Area
27/09/16	**Sewing Room**
27/09/16	**Woodlands Ward**
13/10/16	**Kingswood Dental**
25/10/16	**Stanley Education Centre, County Durham**
25/11/16	**Wensleydale Ward**
06/12/16	**CATT**

2. Complaints Update

The number of complaints received this month is nine.

Of the nine complaints received in December 2016, all have been graded Yellow.

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	23	21	25	18	19	18	9				
2015/16	26	18	30	15	17	26	11	9	12	12	21	16	**213**

3. Nurse Recruitment

The nurse recruitment campaign continues to be successful in that the number of registered nurses being recruited is exceeding the number of registered nurses leaving.

A recruitment evening was held on 8th December 2016, conditional offers of employment were made to three Registered Nurses and a number of students qualifying in September 2017. The number of conditional offers made to students currently totals 27.

4. Actual versus Planned Nurse Staffing - Inpatient areas

The table below summarises the average fill rate on each ward during **December 2016.** 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 December was 7.20 care hours per patient per day. NHS England will be publishing this data for every Trust but we don't know yet how our data will compare to that of other Trusts.

Dec-2016	**Day**		**Night**		**Care hours per patient day (CHPPD)**		
Ward name	**Average fill rate – reg nurses/ midwives**	**Average fill rate - care staff**	**Average fill rate – reg nurses / midwives**	**Average fill rate - care staff**	**Registered nurses/ midwives**	**Care Support Workers**	**Overall**
AMU	89.8%	102.7%	97.6%	123.7%	4.40	2.60	7.00
Byland	70.4%	105.4%	71.0%	75.8%	2.50	2.50	5.00
CATT	98.9%	138.7%	100.4%	135.5%	4.50	2.80	7.30
Farndale	93.4%	119.4%	100.0%	132.3%	3.00	3.70	6.70
Granby	87.8%	120.8%	114.5%	103.3%	3.20	3.20	6.40
Harlow	100.0%	95.2%	100.0%	-	6.00	1.70	7.70
ITU/HDU	92.2%	-	96.8%	-	21.40	2.40	23.80
Jervaulx	76.6%	117.7%	83.9%	93.5%	2.90	3.00	5.80
Lascelles	91.9%	104.5%	100.0%	100.0%	4.50	4.30	8.80
Littondale	91.2%	115.5%	86.0%	112.9%	3.30	2.10	5.40
Maternity wards	92.5%	61.5%	97.5%	80.2%	8.60	1.80	10.40
Nidderdale	98.8%	95.9%	93.2%	122.2%	3.60	2.70	6.20
Oakdale	94.1%	108.1%	92.7%	125.8%	4.20	2.80	7.00
Special Care Baby Unit	92.2%	96.2%	104.8%	-	10.70	2.40	13.10
Trinity	77.3%	125.0%	98.4%	83.9%	3.10	2.90	6.00
Wensleydale	83.5%	136.3%	100.0%	100.0%	3.10	2.60	5.70
Woodlands	81.7%	98.4%	92.5%	93.5%	8.80	2.90	11.70
Trust total	**88.8%**	**112.4%**	**95.2%**	**103.8%**	**4.40**	**2.70**	**7.20**

ED staffing	91%	78%	108%	90%			

Further information to support the December 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.

On Granby ward the increase in care staff hours above plan was to support the opening of additional escalation beds.

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

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 RN gaps in December were due to staff sickness and the care staff gaps were due to 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 additional support. In December this is reflected on the wards; AMU, CATT, Farndale, Oakdale and Littondale.

On Wensleydale although the daytime RN hours were less than planned in December, the occupancy levels varied in this area throughout the month which enabled staff to assist in other areas.

On Trinity ward the daytime RN hours were less than planned due to RN vacancies. The ward is actively recruiting.

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

The staffing complement for the children's ward, Woodlands, is designed to reflect varying levels of occupancy. Although the day and night time RN and care staff hours are less than 100% in December, 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. These figures also reflect increased investment in the Woodlands RN establishment and we are currently recruiting to this.

What this means

The actual versus planned staffing information is an indication of where the vacancies and gaps are and therefore the areas at increased risk to patient safety. The highest areas of risk due to nurse staffing levels continue to be on the acute floor, CATT and AMU and the frail elderly floor, Byland and Jervaulx. Beds on Farndale and Nidderdale have also been temporarily reduced for short periods due to staffing levels.

Throughout December and continuing into January there has been intensive operational pressures and the requirement to support additional escalation areas on Granby, CATT, Wensleydale and Swaledale. I have visited all areas and it is apparent staff are feeling the pressure and appear tired. Senior nursing staff have discussed their concern that this period of increase in activity and use of escalation beds has lasted for a longer period than last year and are worried about sustainability. All staff are worried about providing safe care and maintaining the quality of care they give.

I believe we continue to provide safe and effective care to patients, however we have seen an increase in the number of falls in December from an average of 52 per month to 82 and a small increase in the number of Category 2 pressure ulcers. It should be noted, however, the falls were all in the category of no or low harm, there were no falls with fractures and the number of Category 3 pressure ulcers did not rise above average. The number of complaints received in December was nine compared to 18 in November 2016

and 12 in December 2015. I intend to conduct an analysis of the falls in December and will continue to monitor staffing levels and the metrics related to patient harm.

5. Children's Services Inspections

We received a second CLAS (Combined Looked After and Safeguarding) Children Inspection in the City of York during December 2016 which involved the HDFT Specialist Looked after Nursing Children Team. The service has made some immediate changes to process after the initial feedback and the report is due out in the next 4 weeks.

We are still waiting for the Durham CLAS inspection report. Upon receipt of these reports relevant elements will be brought to the Board of Directors as appropriate

6. Learning Disabilities Mortality Review (LeDeR) Programme (Briefing Note)

What is LeDeR?

The national LeDeR Programme has been established following the Confidential Enquiry into the Premature Deaths of People with Learning Disabilities (CIPOLD). All NHS regions have been asked to establish the LeDeR process locally to undertake the reviews. LeDeR also complements the NHS Operational Planning and Contracting Guidance for 2017/19 which contains 2 'must-dos' for people with learning disabilities:

- "Improve access to healthcare for people with a learning disability so that by 2020, 75% of people on a GP register are receiving an annual health check.
- Reduce premature mortality by improving access to health services, education and training of staff, and by making reasonable adjustments for people with a learning disability and/or autism."

LeDeR involves:

- Reviewing the deaths of all people aged 4 to 74 (inclusive).
- Identify the potentially avoidable contributory factors related to deaths of people with learning disabilities.
- Identify variation in practice.
- Identify best practice.
- Develop action plans to make any necessary changes to health and social care service delivery for people with learning disabilities.

A national database has been developed and anonymised reports will be submitted. This will allow, for the first time, a national picture of the care and treatment that people with learning disabilities receive.

What LeDeR is not:

The LeDeR Programme is not:

- A formal investigation.
- A complaints process.
- An avenue to apportion blame.

Some of the deaths will be subject to statutory review processes such as CDOP, Serious Care Reviews and Safeguarding Boards. In these cases LeDeR will not duplicate, overtake or dominate. Statutory review processes will always take precedence. Instead, Reviewers are asked to:

- Link into these processes
- Follow their timescales
- Offer their expertise and knowledge on learning disabilities
- Capture the outcomes

- Submit the anonymised outcomes to the central LeDeR team.

The LeDeR Programme will only establish an independent multi-agency review if the death requires further investigation and is not incorporated into a statutory review process. LeDeR requires that all deaths of people with learning disabilities who are either from a BME community or aged between 18 and 24 be subject to a multi-agency review.

However, if the death is of someone from a BME community or were aged between 18 and 24 and is subject to a statutory review then again, this statutory process will take precedence.

LeDeR does not only look at clinical outcomes. It is important to capture the extent of personalised services, including the use of reasonable adjustments, choice and control and the well-being of people with learning disabilities. Good practice examples will be written up and shared nationally.

What is happening locally?

NHS England's Learning Disability Project Team is leading the work locally in Yorkshire and Humber. Progress to date includes:

- A Steering Group of health and care professionals has been established to direct the work and monitor outcomes of reviews. The group also includes self-advocates.
- The process has been refined to allow for more flexibility and person-centred practice.
- 40 Reviewers have been recruited and trained and will be supported by the Local Area Contact.
- A detailed Reviewer Support Pack has been developed to ensure Reviewers have all the relevant information needed.
- Monthly meetings for the Reviewers have been established to develop a learning and peer support network.
- Accessible materials are being developed to promote what LeDeR is and is not.

Partnership working with Speakup Self Advocacy is underway to include the rights and requirements of people with learning disabilities in the programme. 6 events are being planned to promote the work to people, families and the wider third sector.

Hull CCG have developed best practice in writing LeDeR into its provider contracts, recruiting 8 Reviewers and linking LeDeR into its well-being programme for people with learning disabilities.

What is the ask?

All health and care services are asked to support the LeDeR Programme, report deaths and share information with the Reviewers. Data sharing of confidential information is allowed via a Section 251 Agreement, which has been approved nationally. This is a pilot programme with an expectation that LeDeR will become 'business as usual' by 2018. In Yorkshire and the Humber the plan is to launch with a low key profile and build. This will allow for the process to be refined and for organisational capacity to be determined, with continuous support provided by the project team
The Trust has a process in place to notify the programme.

7. Equality Delivery System (EDS2) Assessment January 2017

The Board is asked to note and support the approach taken to meet the requirements of EDS2, and to approve the summary report for publication. The Summary Report is attached to the Chief Nurse Report at Appendix A..

The main purpose of EDS2 is to help NHS organisations, in discussion with local partners including local people, review and improve their performance for people with characteristics protected by the Equality Act 2010. Organisations are required to assess their performance in relation to the 4 goals and 18 outcomes, and the 9 groups whose characteristics are protected by the Equality Act, and consider whether people from those protected groups fare as well as people overall. The grading to be used is:

In January 2016 we reported the initial work undertaken to review EDS2 to the Board including our first assessment and our equality objectives linked to each of the goals. These are:

Better health outcomes

- To ensure that our services provide effective and safe treatment and care that is sensitive to people's personal and cultural needs as well as appropriate to their clinical condition.

Improved patient access and experience

- To seek effective feedback about the experiences of people with protected characteristics who use our services in order to improve access and experience, and improve staff awareness and communications about equality.

A representative and supported workforce

- To utilise the workforce equality group to deliver action plans focused on improving the availability of workforce equality information to assess our progress towards ensuring we have a representative and supported workforce.

Inclusive leadership

- To ensure that Trust leaders have the right information and skills to promote equality within and beyond the organisation and to support their staff to work in a fair, diverse and inclusive environment.

During 2016 we have established our Equality and Diversity Group and the two stakeholder sub-groups, and a work plan to drive progress towards meeting the objectives.

We participated in a regional workshop organised by NHS Employers and we expect the recommendations from workshops to be considered at a national level and hope that there will be some future review and alignment of EDS2 to other initiatives such as the Workforce Race Equality Standard and the Disability Equality Standard.

We have assessed progress and evidence in a number of services and reviewed our grading for each of the outcomes, and feel we have some confidence in the improved position that we can report. We have used evidence such as local and national patient and staff survey data, interpreter service data, complaints processes and data, incident reporting data and management, workforce data, patient stories and case studies, our 2016 CQC inspection report and feedback from our stakeholders.

We held a meeting for our stakeholders on 16 January 2017 and presented our approach to EDS2, a sample of evidence in the form of case studies from several services and received positive feedback and support for the approach taken and the self-assessment we presented.

Published EDS2 summary 2015/16

Better health outcomes		Improved patient access and experience		A represented and supported workforce		Inclusive leadership	
1.1	Developing	2.1	Developing	3.1	Achieving	4.1	Developing
1.2	Developing	2.2	Developing	3.2	Achieving	4.2	Undeveloped
1.3	Developing	2.3	Developing	3.3	Developing	4.3	Developing
1.4	Developing	2.4	Developing	3.4	Developing		
1.5	Developing			3.5	Developing		
				3.6	Achieving		

Self-assessment 2016/17

Better health outcomes		Improved patient access and experience		A represented and supported workforce		Inclusive leadership	
1.1	Achieving	2.1	Achieving	3.1	Achieving	4.1	Achieving
1.2	Achieving	2.2	Achieving	3.2	Achieving	4.2	Undeveloped
1.3	Achieving	2.3	Achieving	3.3	Achieving	4.3	Developing
1.4	Developing	2.4	Achieving	3.4	Developing		
1.5	Achieving			3.5	Achieving		
				3.6	Developing		

We will seek to further embed our equality objectives and will incorporate feedback from the stakeholder meeting in our on-going work plan.

Jill Foster
Chief Nurse
January 2017

Equality Delivery System for the NHS

EDS2 Summary Report

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

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

NHS organisation name:

Harrogate and District NHS Foundation Trust

Organisation's Board lead for EDS2:

Jill Foster, Chief Nurse

Organisation's EDS2 lead (name/email):

Dr Sylvia Wood, Deputy Director of Governance (sylvia.wood@hdft.nhs.uk)

Level of stakeholder involvement in EDS2 grading and subsequent actions:

Stakeholders invited to event to share progress with equality objectives and to discuss and agree EDS2 grading include:
Healthwatch
HaRD CCG
HDFT Stakeholder Equality Group - includes Patient Voice Group and Public Governor representatives
HDFT Workforce Equality Group
Harrogate and Ripon CVS
Harrogate Borough Council
North Yorkshire Equality and Diversity Strategic Partnership

Organisation's Equality Objectives (including duration period):

These are our objectives for 2016-2018
Better health outcomes:
To ensure that our services provide effective and safe treatment and care that is sensitive to people's personal and cultural needs as well as appropriate to their clinical condition.
Improved patient access and experience:
To seek effective feedback about the experiences of people with protected characteristics who use our services in order to improve access and experience,

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

We have reviewed services, workforce data and other evidence for our latest EDS2 self-assessment. We have evidence of good results from the A&E, Inpatient and Maternity National patient experience surveys, the National Staff survey and other local audits, and there is some useful evidence about the protected groups. We have reflected mainly on the 0-19 service, Specialist Children's service, Community Dental service, Maternity, Learning Disabilities and Business Planning, as relevant examples of services, but with examples from other services where relevant. We feel we have confidence to indicate improvement with several outcomes this year.

Publication Gateway Reference Number: 03247

Date of EDS2 grading	January	2017	Date of next EDS2 grading	January	2018

Goal	Outcome	Grade and reasons for rating	Outcome links to an Equality Objective
Better health outcomes	1.1	**Services are commissioned, procured, designed and delivered to meet the health needs of local communities** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: ✓ Age; ✓ Disability; ☐ Gender reassignment; ✓ Marriage and civil partnership; ✓ Pregnancy and maternity; ✓ Race; ✓ Religion or belief; ✓ Sex; ☐ Sexual orientation Evidence drawn upon for rating: Healthy Child Programme and Specialist Children's Services - offered to all children and young people regardless of disability. Now have parent, governor and lay membership as part of a service development group. Improved access to telephone interpreter service. Relocated therapy and paediatric clinics to provide better environment. Review and evaluate our work to ensure our service meets the needs of children, young people and	✓
	1.2	**Individual people's health needs are assessed and met in appropriate and effective ways** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: ✓ Age; ✓ Disability; ☐ Gender reassignment; ✓ Marriage and civil partnership; ✓ Pregnancy and maternity; ✓ Race; ✓ Religion or belief; ✓ Sex; ☐ Sexual orientation Evidence drawn upon for rating: Healthcare is designed around individual risk assessments and screening e.g. VTE, sepsis, dementia, maternity etc in order that care is planned to meet specific needs. Work undertaken to implement the Accessible Information Standard, and improve access to facilities for people with hearing impairment and visual impairment, and people with learning disabilities. Started work to improve care for trans-gender people.	✓
	1.3	**Transitions from one service to another, for people on care pathways, are made smoothly with everyone well-informed** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: ✓ Age; ✓ Disability; ✓ Gender reassignment; ✓ Marriage and civil partnership; ✓ Pregnancy and maternity; ✓ Race; ✓ Religion or belief; ✓ Sex; ✓ Sexual orientation Evidence drawn upon for rating: Specialist Children's Services have transition pathways to support children with special educational needs and/or disabilities who are transitioning from pre-school to school and have ongoing health needs. We ensure that families in the Military are seen within five working days of us becoming aware of the transfer in. There is an effective process for transitioning care between	✓

Goal	Outcome	Grade and reasons for rating	Outcome links to an Equality Objective
Better health outcomes, continued	1.4	**When people use NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse** **Grade:** Undeveloped / Developing / Achieving / Excelling **Which protected characteristics fare well:** ✓ Age; ✓ Disability; ✓ Gender reassignment; ✓ Marriage and civil partnership; ✓ Pregnancy and maternity; ✓ Race; ✓ Religion or belief; ✓ Sex; ✓ Sexual orientation **Evidence drawn upon for rating:** Healthcare is designed around individual risk assessments and screening e.g. VTE, sepsis, dementia, maternity etc in order that care is planned to meet specific needs and to reduce risks. Incidents and errors are reported using Datix and learning from incidents prioritised. Participation in clinical audits focuses on evaluating practice against standards. Significant progress with staff awareness and training for MCA.	✓
	1.5	**Screening, vaccination and other health promotion services reach and benefit all local communities** **Grade:** Undeveloped / Developing / Achieving / Excelling **Which protected characteristics fare well:** ✓ Age; ✓ Disability; ✓ Gender reassignment; ✓ Marriage and civil partnership; ✓ Pregnancy and maternity; ✓ Race; ✓ Religion or belief; ✓ Sex; ✓ Sexual orientation **Evidence drawn upon for rating:** Community dental service provide targeted programme of oral health promotion to encourage vulnerable individuals, groups and communities to maintain and improve their oral health. The service now commissioned to train a range of Health professionals and key workers to give oral health advice to "at risk" high need groups. Screening programmes for bowel cancer and 0-19 service have taken steps to ensure effective access to screening and	✓
Improved patient access and experience	2.1	**People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds** **Grade:** Undeveloped / Developing / Achieving / Excelling **Which protected characteristics fare well:** ✓ Age; ✓ Disability; ✓ Gender reassignment; ✓ Marriage and civil partnership; ✓ Pregnancy and maternity; ✓ Race; ✓ Religion or belief; ✓ Sex; ✓ Sexual orientation **Evidence drawn upon for rating:** People, carers and communities are able to readily access health care services via their GP and onward referral to secondary care provider (HDFT) and are not denied access on unreasonable grounds to services. Services are offered to all relevant people - decisions based on individual need Work to ensure members of the Armed Forces are not disadvantaged by moving.	✓

Goal	Outcome	Grade and reasons for rating	Outcome links to an Equality Objective
Improved patient access and experience	2.2	**People are informed and supported to be as involved as they wish to be in decisions about their care** **Grade:** Undeveloped / Developing / Achieving / Excelling **Which protected characteristics fare well:** ✓ Age; ✓ Disability; ✓ Gender reassignment; ✓ Marriage and civil partnership; ✓ Pregnancy and maternity; ✓ Race; ✓ Religion or belief; ✓ Sex; ✓ Sexual orientation **Evidence drawn upon for rating:** Trust performed significantly better than average for several relevant questions within the National A&E Survey 2014, National Maternity Survey 2015, National Inpatient Survey 2015, no significant difference for others. No questions for which we were significantly worse than average. Acute Liaison Nurse provides 1:1 support to people with LD to encourage understanding and involvement in decision making.	✓
	2.3	**People report positive experiences of the NHS** **Grade:** Undeveloped / Developing / Achieving / Excelling **Which protected characteristics fare well:** ✓ Age; ✓ Disability; ☐ Gender reassignment; ☐ Marriage and civil partnership; ✓ Pregnancy and maternity; ✓ Race; ✓ Religion or belief; ✓ Sex; ✓ Sexual orientation **Evidence drawn upon for rating:** Disaggregated evidence is available for National A&E Survey 2014, National Maternity Survey 2015 and National Inpatient Survey 2015. Equality monitoring questions in use within local patient surveys since December 2015. Whilst difficult to drawn any clear conclusions about the experiences of people within protected groups compared to the general population, no evidence to suggest they do not fare well. Patient satisfaction at HDFT is generally high	✓
	2.4	**People's complaints about services are handled respectfully and efficiently** **Grade:** Undeveloped / Developing / Achieving / Excelling **Which protected characteristics fare well:** ✓ Age; ✓ Disability; ✓ Gender reassignment; ✓ Marriage and civil partnership; ✓ Pregnancy and maternity; ✓ Race; ✓ Religion or belief; ✓ Sex; ✓ Sexual orientation **Evidence drawn upon for rating:** Information leaflet "Making Experiences Count" is available in all areas and the information is accessible from the Trust website. The leaflet highlights how to access the information in other formats or languages, and both the leaflet and website highlight the PET team contact details including minicom contact number to assist people to report a complaint. 100% of complaints are acknowledged within 3 days as stated in	✓

Goal	Outcome	Grade and reasons for rating	Outcome links to an Equality Objective
A representative and supported workforce	3.1	**Fair NHS recruitment and selection processes lead to a more representative workforce at all levels** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: Age; Disability; Gender reassignment; Marriage and civil partnership; Pregnancy and maternity; Race; Religion or belief; Sex; Sexual orientation Evidence drawn upon for rating	☐
	3.2	**The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: Age; Disability; Gender reassignment; Marriage and civil partnership; Pregnancy and maternity; Race; Religion or belief; Sex; Sexual orientation Evidence drawn upon for rating	☐
	3.3	**Training and development opportunities are taken up and positively evaluated by all staff** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: Age; Disability; Gender reassignment; Marriage and civil partnership; Pregnancy and maternity; Race; Religion or belief; Sex; Sexual orientation Evidence drawn upon for rating	☐

Goal	Outcome	Grade and reasons for rating	Outcome links to an Equality Objective
A representative and supported workforce	3.4	**When at work, staff are free from abuse, harassment, bullying and violence from any source** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: Age; Disability; Gender reassignment; Marriage and civil partnership; Pregnancy and maternity; Race; Religion or belief; Sex; Sexual orientation Evidence drawn upon for rating	☐
	3.5	**Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: Age; Disability; Gender reassignment; Marriage and civil partnership; Pregnancy and maternity; Race; Religion or belief; Sex; Sexual orientation Evidence drawn upon for rating	☐
	3.6	**Staff report positive experiences of their membership of the workforce** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: Age; Disability; Gender reassignment; Marriage and civil partnership; Pregnancy and maternity; Race; Religion or belief; Sex; Sexual orientation Evidence drawn upon for rating	☐

Goal	Outcome	Grade and reasons for rating	Outcome links to an Equality Objective
Inclusive leadership	4.1	**Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: Age; Disability; Gender reassignment; Marriage and civil partnership; Pregnancy and maternity; Race; Religion or belief; Sex; Sexual orientation Evidence drawn upon for rating: In addition to evidence from previous assessment: Made arrangements to enable young people with protected characteristics to do work experience placements. Introduced a Youth Forum to give young people the chance to discuss relevant issues, engage with decision makers and contribute to improving the lives of young people within their communities.	✓
	4.2	**Papers that come before the Board and other major Committees identify equality-related impacts including risks, and say how these risks are to be managed** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: Age; Disability; Gender reassignment; Marriage and civil partnership; Pregnancy and maternity; Race; Religion or belief; Sex; Sexual orientation Evidence drawn upon for rating: Work undertaken to develop an impact assessment process for cost improvement programmes (CIPs) and other service developments. It is to be included in business planning documentation. We will consider what would be useful to include on papers that come before Board in relation to impact assessments and risks Business plans coming to Board will include this in future but it is	✓
	4.3	**Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: Age; Disability; Gender reassignment; Marriage and civil partnership; Pregnancy and maternity; Race; Religion or belief; Sex; Sexual orientation Evidence drawn upon for rating:	✓

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Harrogate and District NHS
NHS Foundation Trust

Report to the Trust Board of Directors: 25 January 2017	Paper No: 9.1
Title	Patient Safety Visit Annual Report
Sponsoring Director	Jill Foster, Chief Nurse
Author(s)	Michael England, Governance & Emergency Planning Officer and Sylvia Wood, Deputy Director of Governance
Report Purpose	To provide information and assurance regarding the Patient Safety Visit programme

Key Issues for Board Focus: To note findings

Related Trust Objectives	
1. To deliver high quality care	Yes – report provides assurance that safety remains the highest priority in the Trust
2. To work with partners to deliver integrated care	No
3. To ensure clinical and financial sustainability	No

Risk and Assurance	Risks associated with the content of the report are reflected in the Board Assurance Framework via: 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	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 consider the assurance provided by the content of the report.

Patient Safety Visits: Annual Report January 2016 – December 2016

Background

Patient Safety Visits were introduced at HDFT in 2009. Since then 146 patient safety visits have taken place to wards and departments across the Trust. This includes all inpatient wards, 23 community areas, and 29 departments.

This report summarises the patient safety visits undertaken since the last annual report to Board of Directors in January 2016. It provides examples of issues raised and resolved since previous visits and includes detail from the patient safety visit database of issues identified as high priority to provide assurance of action taken. It contains the reviewed and updated standard operating procedure for patient safety visits for ratification.

It should be noted that in November 2016 the Board asked for a review of the format and value of patient safety visits, as Non-Executive Directors were concerned that several were cancelled at short notice. This is addressed below.

1. Patient Safety Visits 2016

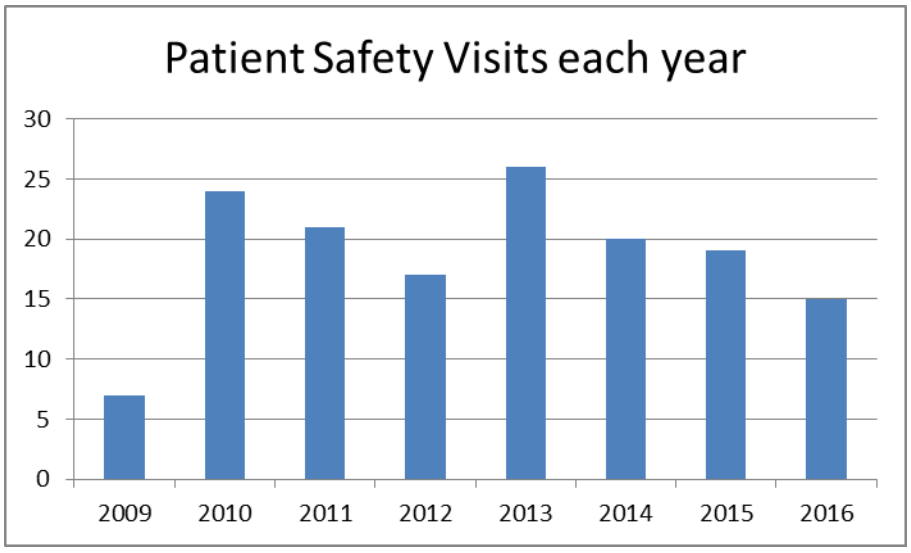
At the beginning of 2016, the Clinical Directorates and Corporate Services were asked to identify services to prioritise for a visit.

At the same time potential dates for visits were identified in Executive and Non-Executive Director's diaries. As always, more dates were identified in diaries than we expected to need in order to have some spare options as some dates are not convenient for the areas to visit. The Governance Officer contacts the lead for each service and attempts to match an available date for a visit, with days and times that are convenient for the service.

Since January 2016, when patient safety visits were last reported to the Board of Directors, there have been visits to 15 services; five of these have been new visits and ten re-visits. The log of all visits undertaken is at Appendix 1.

It is worth noting that as a result of preparation for the CQC inspection there were lots of senior management led visits to wards and departments, and no patient safety visits were arranged between January and March 2016.

During the visit when staff raise operational issues as a concern, they are encouraged to use existing departmental and directorate structures and processes. Where issues cannot be easily remedied, such as those that may require large capital expenditure it is important that these are progressed via other established structures and processes e.g. business planning and risk registers. There are a small number of concerns raised that are appropriate to follow up as a matter of some urgency outside these established methods. These are identified at the time by the Executive lead for the visit and recorded on the patient safety visit action log as high priority. During 2016, reports have been received at Senior Management Team and key findings from patient safety visits have been highlighted and discussed.



Year	Number of Visits
2009	7
2010	24
2011	21
2012	17
2013	26
2014	20
2015	19
2016	15

The services that have been visited for the first time during the period are:

- The Equipment Library
- Scarborough Wheelchair Service
- Orthopaedic Outpatients
- Sewing Room
- Stanley Education Centre

The services that have had a re-visit during the period are:

- CATT
- Kingswood Dental Practice
- Wensleydale Ward
- Maternity Services
- Lascelles
- ITU/HDU
- Radiology
- Ripon Community Hospital
- Woodlands Ward
- Jervaulx/Byland Ward

Visits that were not arranged or undertaken

The following services were identified as locations for a patient safety visit, but a visit was either not arranged or not undertaken in the period:

Farndale Ward

Due to last minute staff absences on the ward (including Ward Manager and Sister) a patient safety visit was cancelled at short notice on 6th May. This was discussed at the time with the Matron responsible for the area and ITU/HDU was identified as an alternative location for the patient safety visit. A visit to Farndale Ward will be rearranged in 2017.

AMU

The day before the arranged patient safety visit to AMU on 8th November it became clear that the Ward Manager would be absent and the ward team were not aware of the planned visit. Staffing levels meant this could not proceed and an alternative location could not be offered. However the Matron suggested that a patient safety visit to CATT would be more beneficial and a visit was arranged and undertaken on 6th December.

Antenatal Clinic

A visit has been arranged for 6th January 2017.

GP OOH
There continue to be issues with arranging a suitable visiting time out of hours.

Community Children's Services
Service managers suggested patient safety visits to the new Community Children's Services in Middlesbrough, Darlington and County Durham once they had been incorporated into the Trust. A visit took place to the County Durham Community Children's Service at Stanley Education Centre on 25th October 2016 and visits to the remaining services will be arranged in due course.

Regarding the concern raised about patient safety visits being cancelled at short notice, it can be seen below that this is not a consistent issue and has been significantly better during 2016. The concern raised by the Non-Executive Directors probably relates to the dates identified for patient safety visits that are not utilised being perceived as cancelled visits.

	2015	2016
Potential dates identified	29	23
Dates not utilised and therefore removed from diaries	6	7
Patient safety visits arranged and confirmed	23	16
Number of arranged visits cancelled	4	1
Number of visits undertaken	19	15

2. Patient Safety Visiting Team

An Executive Director usually leads a patient safety visit with the Deputy Director of Governance and a Non-Executive Director. Members of the Council of Governors are also invited to take part in patient safety visits.

Non-Executive Director		Executive director		Governors	
Sandra Dodson	2	Ros Tolcher	2	Claire Cressey	2
Ian Ward	3	David Scullion	2	Beth Finch	2
Sue Proctor	2	Jonathan Coulter	5	Bernard Bateman	1
Lesley Webster	2	Jill Foster	3	Joyce Purkis	1
Chris Thompson	2	Phillip Marshall	2	Jane Hedley	1
Maureen Taylor	2	Rob Harrison	1	Daniel Scott	1
Neil Mclean	2				
Total	15		15		8

3. Information for the visiting team

Prior to a number of visits in 2016 the Governance Officer produced a summary sheet for the visiting team to provide an overview of patient safety information including staffing levels, staff turnover, recent incidents and complaints, any SIRIs, and patient experience feedback. It was hoped that these summaries would promote focused lines of enquiry and discussions during the visit. However this involved a considerable amount of time to produce and was often not used. It was felt to add limited value to the outcome of of the patient safety visit and was therefore discontinued.

4. The value of patient safety visits

Patient safety visits have a unique purpose and value in encouraging a positive safety culture. They encourage staff to raise any concerns in a forum which is supportive, building good communication and establishing local solutions to minimise risk whenever possible.

Sometimes when wards and services are very busy, staff are only able to participate for a short time, but in general the informal feedback that we receive from staff who attend patient safety visits is that they value the opportunity to meet senior leaders and raise concerns with them.

The most useful visits are those where staff are clear about the purpose of the visit and have had an opportunity to think about issues they might want to highlight. It is disappointing that despite the effort that goes into the arrangements, staff are sometimes unprepared and not expecting the visit when we contact them to confirm in the days before the visit.

5. Sample of issues raised at patient safety visits

A small sample of issues recorded from patient safety visits during 2016 has been included to illustrate some of the findings.

5.1. Good practice

Team Working

A number of areas reported good team working. These include Radiology, Lascelles, Scarborough Wheelchair and Podiatry Services, Linen/Sewing Room and Wensleydale Ward. Anecdotally, in a number of areas experiencing high operational pressures, nursing staff said that it was working with their colleagues that meant they continued to turn up to work.

Patient Focused Innovation Projects

These include SITUP (Supporting Intensive Treatment Unit Patients) clinics for patients discharged from ITU; Wanderguard devices trialled on Lascelles; Reminiscence Sessions on Jervaulx and Byland for elderly patients; Acclimatisation Programme for patients visiting Kingswood Dental Service.

5.2. Themes and ongoing issues

Staffing

A number of areas reported issues relating to staffing pressures including: national shortage of radiographers for MRI; low morale amongst teams such as ITU who are often redeployed to cover staffing gaps in other areas; pressures on the nurse-in-charge responsible for junior nursing staff and having to fill nursing gaps themselves in order to deliver safe care to patients; concerns regarding nurse to patient ratios on night shifts particularly due to an increase in acuity of patients in Byland Ward; transferring patients in ‘bulk’ rather than staggering the flow during de/escalation puts teams under unnecessary pressure; the impact of an increased turnover of staff is felt in other supporting services such as the Linen/Sewing Room; difficulties in releasing staff in order that they can undertake mandatory and essential skills training; student nurses and new starters who are supposed to be super-numerary are often relied on as part of the ward establishment; teams feeling that they are struggling to deliver fundamental aspects of care due to staff shortages.

Environment and equipment issues
A number of areas continued to report issues associated with equipment maintenance and within an unsuitable environment. Issues were reported in Lascelles, Ripon Community Hospital, Orthopaedic Outpatients, Jervaulx & Byland Ward, Woodlands Ward and CATT ward. Issues include: delays in maintenance and repair from time of reporting; shortage of equipment; unsuitable and ageing environments; under-utilised space that is no longer fit for purpose. It is hoped that following the reconfiguration of the estates workforce during 2016/17 that this will address a number of these recurrent issues.

Patientrack
There were some recurrent themes regarding Patientrack including the reliability and timely repair of equipment, connectivity issues and usability. A number of areas including Jervaulx and Wensleydale wards had specifically reported difficulties using the fluid balance module, opting to use paper based charts instead. However it was also recognised that Patientrack had made the recording of routine observations easier.

5.3. Issues noted as resolved since previous visit

Medical Cover at Lascelles
The team reported that since the development of a proper protocol for medical cover, the issues relating to getting an appropriate on call medical response to acute requests for review of a patient had been resolved.

Fluid and food thickening on Jervaulx/Byland
Following a patient safety alert relating to the risk associated with thickening powder both wards had undertaken risk assessments and had addressed the risk using different approaches.

Volunteers
Jervaulx ward had gained volunteers to assist with patient feeding at lunch time. To encourage young volunteers to continue supporting the ward for a longer period the clinicians were providing incentives such as being offered the opportunity to observe care of the elderly ward rounds.

Maternity Unit
Carpet replaced with flooring during refurbishment. Staff reported more monitoring equipment available now and CTG monitors were appropriately labelled. Admin support was much improved with a full time ward clerk. The team were being proactive about replacing staff with eight recently recruited midwives at the time of the visit.

5.4. High priority issues

Following a patient safety visit there is usually a quick debrief between members of the visiting team in order to identify any high priority actions. Over the past year, whilst there have been a number of actions that have been followed up promptly, there have been a limited number of actions considered “high priority”.

Mental Health facilities on Woodlands Ward
Whilst work was underway to create a “ligature free” side room, Dr Tolcher felt that it would be appropriate for a full mental health review of the ward based on the foreseeable needs of young people admitted. Following feedback from the directorate and department it is understood that this action has been incorporated into the CQC action plan which is being overseen by the Operational Director for Children’s & County Wide Community Care.

6. Future Planning

The Standard Operating Procedure has been reviewed and updated and approved at Senior Management Team on 18 January 2017. Essentially we are proposing that the process continues without significant changes.

The Clinical Directorates have been asked to identify 4 - 5 sites/wards/departments each for visits in 2017 with a particular focus on those services that might not have been visited before or they feel might benefit from a visit. Corporate services have also been asked to consider any areas that may benefit from a patient safety visit. Visits may also be requested during the year and this will be accommodated if possible.

We will suggest that dates identified in Executive and Non-Executive diaries are held for "potential patient safety visits" until confirmed. We would like to highlight that we aim to identify more dates than required, to facilitate arranging a visit that will be convenient to a service and expect not to use all of these. We will endeavour to release unused dates with as much notice as possible.

We will continue to ask ward and service managers to communicate effectively within the local team in order that staff are aware of a planned patient safety visit and its purpose, and can participate.

7. Summary

Patient safety visits continue to provide valuable opportunities to:

a. Increase the awareness of safety issues among all staff.
b. Make safety a priority for senior leaders by spending dedicated time promoting a safety culture.
c. Educate staff about patient safety concepts such as incident reporting.
d. Obtain and act on information that identifies areas for improvement.
e. Build communication and relationships with frontline staff to work together to deliver safe care.

Appendix 1: Patient safety visits undertaken by location and date

Site	Visit 1	Visit 2	Visit 3	Visit 4	Visit 5
Jervaulx	11/01/2010	12/08/2011	11/09/2013	11/03/2015	13/07/2016
Byland	16/11/2009	08/06/2011	23/10/2013	11/03/2015	13/07/2016
Woodlands/SCBU	11/03/2010	29/11/2011	08/11/2013	08/04/2015	27/09/2016
Ripon Community Hospital	30/06/2011	21/03/2013	28/08/2013	09/05/2014	14/06/2016
Endoscopy	18/11/2010	05/03/2013	24/10/2013	23/04/2015	
ED	25/10/2010	17/11/2011	30/10/2013	13/08/2015	
Main Theatre	07/05/2010	03/07/2012	12/09/2013	03/09/2015	
Fountains/Bolton/AMU/CAT	15/04/2010	02/11/2011	04/10/2013	09/09/2015	
Littondale	03/11/2009	02/06/2011	16/10/2013	07/10/2015	
Nidderdale	01/02/2010	13/10/2011	10/10/2013	01/12/2015	
Radiology	20/05/2010	25/07/2011	12/03/2014	13/04/2016	
Critical care (ITU/HDU)	12/11/2009	27/06/2011	11/06/2014	06/05/2016	
Lascelles	01/03/2009	07/07/2011	11/10/2013	12/05/2016	
Maternity (Pannal)	09/03/2010	01/05/2012	03/10/2013	02/08/2016	
Wensleydale	08/02/2010	05/07/2011	14/08/2013	25/11/2016	
Oakdale	05/03/2010	04/10/2012	21/08/2013		
Granby	07/12/2009	21/11/2011	18/09/2013		
Harlow	25/01/2010	11/05/2012	11/02/2014		
Outpatients	06/08/2010	22/11/2012	26/09/2014		
Pharmacy	09/12/2010	25/10/2012	19/11/2014		
PAAU	24/09/2010	10/08/2012	31/03/2015		
Therapy Services	14/06/2010	13/07/2012	05/05/2015		
Day Theatre	03/06/2010	01/08/2011	25/09/2015		
Phlebotomy	28/09/2009	12/03/2013	13/11/2015		
Haematology/Transfusion	23/08/2010	06/10/2011			
CSSD	30/09/2010	31/10/2011			
Swaledale	21/12/2009	14/11/2011			
Hotel Services	16/12/2010	14/09/2012			
Elmwood	19/07/2010	14/11/2012			
Biochemistry	29/11/2010	21/01/2013			
Heart Centre	20/10/2011	23/01/2013			
Pathology	10/12/2010	30/01/2013			
Critical Care Outreach	07/12/2010	13/02/2013			
Site Co-ordinators	28/11/2011	07/03/2013			
Selby MIU	02/08/2012	05/09/2013			
Scarborough Podiatry	04/09/2012	01/04/2015			
Ripon RRT	31/07/2012	05/11/2015			
Kingswood Dental Surgery	14/05/2014	27/09/2016			
Askham Grange	08/12/2011				
Northallerton Prison	12/12/2011				
Monkgate Dentistry	03/05/2012				
SALT – Northallerton	07/08/2012				
Iles lane VWT	06/09/2012				

Knaresborough Health Visiting	09/11/2012				
Boroughbridge VWT	29/01/2013				
Farndale	23/08/2013				
HDH Catering Services	06/03/2014				
Hornbeam – Harrogate Community Nursing Team	03/04/2014				
Ripon Community Nursing Team	29/04/2014				
Selby/York GPOOH	29/05/2014				
Selby HV Team	10/07/2014				
Scarborough – Children's Services and Sexual Health	25/07/2014				
Blood Sciences Lab	13/08/2014				
SROMC	11/09/2014				
Portering Services	05/11/2014				
General Office	28/11/2014				
Selby/York Podiatry	03/12/2014				
Easingwold – Specialist Children's Service	18/12/2014				
York Wheelchair Services	30/04/2015				
Domestic Services	07/05/2015				
Ophthalmology	09/06/2015				
Medical Day Unit	24/11/2015				
Skipton Podiatry	17/12/2015				
The Equipment Library	08/06/2016				
Scarborough Wheelchair Service	28/06/2016				
Orthopaedic Outpatient's	01/07/2016				
Sewing Room	27/09/2016				
Stanley Education Centre	25/10/2016				
AMU	08/11/2016				
CATT	06/12/2016				
Key	Visits undertaken since last report to Board (Jan 2016)				
	Visits arranged but cancelled				
	Visits not arranged				

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Report to the Trust Board of Directors: 25 January 2017	**Paper No: 10.0**
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:

- **CQC case note review on cerebrovascular mortality**
- **Changes to Summary plan for Emergency Care and Treatment**
- **Clarification of priority clinical standards for seven day services**

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.

Report by the Medical Director - January 2017

1. Mortality

The HSMR (Nov 15-Oct 16) increased from 101.67 to 104.51. There was a slight increase in SHMI from 92.36 to 92.67. The former remains within expected levels and the latter below expected levels. I intend to meet with the team in Information Services in order to explore possible explanations for the recent change in indices.

The Trust has recently received a letter from the CQC regarding mortality rates for patients with cerebrovascular disease. The letter is in response to an earlier communication from Dr Foster to the Trust in September 2016 (copied to the CQC) indicating a higher than average mortality rate between the period of July 2015 to June 2016. A number of potential reasons for this were documented in the communication. Having considered the information received, the CQC has asked the Trust for further more detailed information, mainly in the form of a case note review. The original deadline for this piece of work was considered unrealistic and I have secured an extension upon agreement with the CQC. The case note review has started and I will be responding to the CQC before the agreed deadline. I will feedback to the Board the outcome of this process.

I am planning to attend the national Learning from Death annual conference in London on March 9th. This aims to discuss the recommendations of the CQC report into learning from deaths published in December 2016. These recommendations were accepted by the Secretary of State and compel Trusts to collect and publish information on deaths with evidence of learning and improvement. I expect some guidance will be forthcoming on the day to support Trusts in this work.

A national LeDeR (Learning Disabilities Mortality Review) l programme has been established following the confidential enquiry into deaths of people with learning disabilities (CIPOLD report). All inpatient deaths will be subject to independent review in order to identify variation in practice, and potential avoidable factors. Good practice will also be highlighted and shared. I have arranged a meeting with the regional LeDeR team to come into the Trust to discuss implementation and the process for notification of death.

The Programme is not a formal investigation, complaints process or an opportunity to apportion blame.

2. Organ Donation

I have attached a summary report as appendix A for the period April-September 2016 which will be made available in the reading room. The numbers of patients considered suitable are not surprisingly very small for a hospital of this size, though there is evidence of encouraging practice in some areas.

3. Recommended Summary Plan for Emergency Care and Treatment (ReSPECT)

The proposed new national document that attempts to combine both DNACPR instructions and ceilings of care for individual patients has been circulated. Regional implementation of this form (potentially in early 2017) is to be discussed at the next regional meeting on 19th January. The Trust is represented by Nicki West, Resuscitation Officer and chair of the Resuscitation

Committee. This project is a considerable change from the historical model of the dedicated DNACPR form and will require careful and considered implementation.

4. Guardian of Safe Working Hours quarterly report

The first report from Dr Gray since implementation of the new junior doctor contract is provided separately for the Board to consider under item 10.1.

5. Seven day services in hospitals: clarification of priority clinical standards

The four priority standards are:

- Standard 2: Time to first Consultant review
- Standard 5: Access to diagnostic tests
- Standard 6: Access to Consultant directed interventions
- Standard 8: Ongoing Consultant review twice daily (HDU), daily for others

The purpose of the document is to feedback to Acute Trusts who requested clarification on certain aspects of the standards. Helpful clarifications include time of clock starting, definition of "consultant", choice of diagnostic tests and principles for ongoing Consultant directed review. Duties and expectations of the on-call Consultant in relation to timing of admitted patients has also been clarified.

6. Annual Survey of Doctors in Training

The Trust has received the results of the GMC's annual survey of doctors in training and the Director of Medical Education has briefed the Senior Management Team on some of the specific issues which arise in it. The Registrar of the GMC has specifically urged Trust Boards to review the results and consider what steps can be taken to improve the experiences of doctors who are delivering training, and of those being trained. I will update the Board next month.

Dr David Scullion, Medical Director
January 2017

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Harrogate and District NHS
NHS Foundation Trust

Report to the Trust Board of Directors: 25 January 2017	**Paper No: 10.1**
Title	**First 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 establishment and appointment into the role of Guardian of Safe Working Hours
2. The Trust is currently carrying 15.7% of gaps in the Doctor in Training workforce
3. The first meetings of the Junior Doctors Forum have taken place

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.

Q3 2016-17 QUARTERLY REPORT ON SAFE WORKING HOURS: DOCTORS AND DENTISTS IN TRAINING

January 2017

Executive summary

The new NHS Junior Doctors' contract ('2016 TCS') creates the role of Guardian of Safe Working Hours to prevent unsafe working and poor educational experience in medical and dental training posts. The 2016 TCS prescribes quarterly and annual reports to the Boards of NHS provider units.

This is the first 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.

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 presently in the introductory phase with only 21 doctors in the FY1 grade transferred into the new 2016 TCS contract since its start in December 2016.

Twenty-one exception reports have been received to date from trainees and dealt with. These have all concerned over-runs of working hours owing to the busy state of the wards and to individual patient matters.

No systematic problem has yet been identified. No service reviews have yet been necessary. No complaints on educational standards have been received. No fine has yet been levied.

The Guardian has attended the introductory national meeting and has held the first trainee doctors' forum jointly with the Deputy Director of Medical Education.

Introduction

This is the first quarterly report of the Guardian of Safe Working Hours which presents the Trust's statistics in the form recommended in the national template. The report is to be subsumed in the Report of the Medical Director.

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 the introductory phase with only 21 doctors in the FY1 grade transferred into the new 2016 TCS contract since its start in December 2016. Eleven more Doctors in Training in various grades and specialties transfer to the 2016 TCS on 1st February 2017. The rest of the Doctors in Training will progressively transfer to the 2016 contract on changing jobs over the next two to three years.

An informative slidepack on the future regulation of junior doctors' safe working and the role of the Guardian of Safe Working Hours has been prepared by NHS Employers. This has been placed in the Reading Room.

High level data

Number of doctors / dentists in training (total):	121
Number of doctors / dentists in training on 2016 TCS (total):	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 W&OD team]
Amount of job-planned time for educational supervisors:	0.5 PAs per trainee

a) Exception reports (with regard to working hours)

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 always be reports awaiting attention by individual clinical supervisors. Presently, in this introductory phase the Trust has only the F1 doctors on the 2016 TCS. These data will progressively expand in scope over the months and years.

This is not a full quarter owing to the irregular start-up of the system. Initial exception reports cover the period 1st December 2016 - 16th January 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	19	18	1
Gen Surgery	0	5	2	3
Total	0	24	20	4

Exception reports by grade				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
F1	0	21	18	3
F2	0	0	0	0
CT1-2 / ST1-2	0	0	0	0
Total	0	21	18	3
Exception reports (response time)				
	Addressed within 48 hours	Addressed within 7 days	Addressed in longer than 7 days	Still open
F1	0	17	3	4
F2	0	0	0	0
CT1-2 / ST1-2	0	0	0	0
ST3-8	0	0	0	0
Total	0	17	3	4

b) Work schedule reviews

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

c) Vacancies

Please see Appendix 1.

Of 121 junior doctor training posts, the Trust currently (as at 17/01/17) has 19 vacancies (15.7%) in 13 specialties. Six posts are expected to be filled within a few weeks.

d) Fines

The Guardian under the 2016 TCS has the contractual power to penalize Departments / Directorates for failure to ensure safe working hours. Fines are public money levied on Clinical Directorates to the detriment of their budget. The moneys may be put to respectable uses for the benefit of Doctors in Training and their education.

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 introductory national meeting for Guardians on 26 July 2016 in London.

The Guardian – jointly with the Deputy Director of Medical Education – has held the first regular forum for Doctors in Training in the Doctors' Mess on 28 November 2016. The work of the Guardian in relation to safe working hours was introduced. No substantial issue was raised. The next forum meeting is on 23 January 2017.

The Guardian will attend the next national event for guardians in London on 14 March 2017.

The Guardian will attend regional Guardian meetings for information and support. The first meeting is on 30 January 2017.

These are early days in the introduction of the 2016 TCS for Doctors in Training in this Trust.

The Trust has only 21 doctors on 2016 TCS presently and 32 from 1 February 2017. Further doctors will progressively transfer to 2016 TC as they move through the system and change jobs.

The Trust has established the exception reporting system on the DRS software application. This is accessible to all junior doctors. Doctors have used the system already to make a small number of exception reports.

Each Doctor in Training has an appointed educational supervisor who serves for their training period. These may be Consultants or GP trainers and may be remote from this Trust. Each Doctor moves from job to job and is under the daily supervision of their clinical supervisor who in this Trust will usually be a clinical consultant. Clinical supervisors have had additional duties dropped upon their heads by the 2016 TCS to which they are becoming accustomed. Importantly, clinical supervisors are required to respond in the first instance to exception reports. Clinical supervisors are learning how to respond to these as they occur.

There are sporadic reports of a 'clock-watching' attitude in trainee doctors. Trainees are encouraged by the TCS to work their contracted hours accurately. There will be tensions from time to time between punctual finish times and patient needs arising late in a shift. Most doctors spoken with admit to expecting to start a little early and to finish a little late. Professionalism requires a degree of flexibility.

Issues arising

1. The Guardian is appointed and trained.
2. The exception reporting system is established on DRS.
3. Exception reports are being received and processed.
4. Initial exception reports are of over-running working time owing to clinical pressures and individual patient requirements.
5. No systematic issue is identified as yet.
6. There are gaps in rotas (15.7%) owing to failed recruitment. Six posts are expected to be filled shortly. Rota gaps are a worsening issue throughout medical specialties especially in the North of England.
7. Contacts with the body of trainees and their representatives are developing through formal and informal means.

Actions taken to resolve issues

1. Exception reports are being received and processed.
2. Recruitment activity continues.
3. No specific action has been necessary at this stage.

Summary

The systems required by the 2016 TCS are established in the Trust. The 2016 TCS apply to 32 doctors in training only, from February 2017. More will follow progressively.

Working hours are showing some sporadic over-runs resulting from clinical pressures on the wards. No systematic problem has been established but these are early days. No dangerous working hours have been detected.

Consultants as clinical supervisors are learning to respond to exception reports within the time required.

There are gaps in rotas owing to non-recruitment. This is a worsening problem in almost all specialties across the NHS with a gradient worsening northward up the country. Locum provision is as always precarious. Gaps and no locum cover will inevitably impact upon working hours over time.

Key quality assurance statement for the board

The Board is advised that overall working hours of Doctors in Training across the organisation are satisfactory and that there are presently no specific concerns in Departments or Directorates.

Rota gaps and recruitment are a developing problem throughout the NHS.

Questions for consideration

1. The Board is asked to receive the report and to consider the assurances provided by the Guardian.
2. There are presently no issues outlined in the report which are not being (or cannot be) addressed.
3. The Guardian at present 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.
4. The Board is invited to consider the format of this report. Is it appropriate for the Board's requirements?

Appendices

Appendix 1: Current gaps in rotations

Dr Carl Gray
Guardian of Safe Working Hours
January 2017

Directorate	Department	Grade Establishment	Additional establishment	Deanery or Trust	January
LTUC	Cardiology	ST3+	N	Deanery	GAP
LTUC	Chemical Pathology	ST3+	N	Deanery	GAP
LTUC	Elderly Medicine	ST3+	N	Deanery	GAP
LTUC	Elderly Medicine	ST3+	N	Deanery	GAP
LTUC	Elderly Medicine	CT1/ 2	N	Deanery	GAP
LTUC	Emergency Medicine	ST3+	N	Deanery	GAP
LTUC	Emergency Medicine	ST3+	N	Deanery	GAP
LTUC	Haematology/Oncology	FY2	N	Deanery	GAP
LTUC	Respiratory	CT1/ 2	N	Deanery	GAP
PSC	Anaesthetics	ST2 (ACCS)	N	Deanery	Gap
PSC	Anaesthetics	ST3+	N	Deanery	GAP
PSC	Dermatology	CRF	Y	Trust	GAP
PSC	General Surgery	ST3+	N	Deanery	Gap
PSC	General Surgery	FY2	N	Deanery	Gap
PSC	Obs and Gynae	ST3+	N	Deanery	Gap
PSC	Orthopaedics	CT1/ 2	N	Deanery	GAP
PSC	Rheumatology	ST3+	N	Deanery	GAP
CCWCC	Paediatrics	GP STS	N	Deanery	Gap
CCWCC	Paediatrics	ST3+	N	Deanery	Gap

Comments
Advertising unsuccessful.
Department usually carries a gap.
Clinical Lead approving JD and advert. Then we will advertise on NHS Jobs. Has been out to advert previously.
Clinical Lead approving JD and advert. Then we will advertise on NHS Jobs. Has been out to advert previously.
Recruiting MTI.
Department usually carries a gap.
Department usually carries a gap.
Currently re-advertising on NHS Jobs.
Advertising unsuccessful.
Awaiting to hear from department on whether they wish to advertise on NHS Jobs.
Gap due to be filled by new starter on 01 February 2017.
Shortlisting to department was unsuccessful. Re-advertising to be postponed until further notice from departı
Awaiting to hear from department on whether they wish to advertise on NHS Jobs.
Gap due to be filled through internal rotation in April 2017.
Gap due to maternity leave. Advertising unssucessful.
Gap due to be filled by new starter on 01 February 2017.
Interviews held in January. Offer letter sent to doctor - awaiting to receive signed confirmaiton of offer accept
Live advert on NHS Jobs.
Gap due to be filled by new starter on 01 February 2017.

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Report to the Trust Board of Directors: 25 January 2017	Paper No: **11.0**

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. **Workforce and Organisational Development Strategy –** quarterly update
2. **The Clinical Leads Transition to Leadership Programme –** the Trust has secured 15 places on this course, delivered by the Inspiring Leaders Network
3. **Investors in People –** the Trust is working towards Bronze level through reassessment in March 2017

Related Trust Objectives	
1. To deliver high quality care	Through the pro-active management and development of the workforce, including recruitment, retention and staff engagement.
2. To work with partners to deliver integrated care	Working with external organisations, including NYCC, Health Education England 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.

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 invited to **note** and comment on the update on matters specific to Workforce, Training and Education, Service Improvement and Innovation and Organisational Development.

The Board is invited to **consider** whether there is a continuing need for a discrete quarterly report on the Workforce and Organisational Development Strategy.

a) Workforce and Organisational Development Strategy 2015-2020 – Excellent Workforce, Excellent Care

The Workforce and Organisational Development Strategy was approved at the Senior Management Team meeting on Wednesday 18 November 2015. A copy was placed in the reading room for Board members' information. The progress against the strategy is in the main, as recommended as part of the Well-Led Review, being monitored through the Clinical Transformation Board and an up-date was provided to the Board in May 2016.

Developing the Best Behaviours:

The values-based appraisal toolkit, is now embedded in the Trust, with a review taking place to identify whether documentation can be streamlined following feedback from staff across the Trust. In addition to this, the recent appraisal audit findings and actions are being incorporated into the review to ensure that these are being taken forward as appropriate. The next part of the development work is the roll-out of values-based recruitment, which is likely to commence in summer 2017/18.

The Developing the Best Behaviours project is to be closed as a Clinical Transformation Board (CTB) Project and embedding of the project is to continue within business as usual. The appropriate project closure documentation is in the process of being completed and will be placed in the reading room.

Learning and Organisational Development:

The Leadership Development Strategy has been approved by the Senior Management Team. The approval of the Leadership Development Strategy did not include funding for all of the preferred programmes. This has impacted on the ability of the Trust to access pathway programmes for each level of regional leadership programmes run by the NHS Leadership Academy. The development of talent management processes requires additional full-time resource at Band 7. This was originally included in the Leadership Development Strategy approved by SMT but has not yet been delivered. The Pathway to Management Training continues to be rolled out, with good levels of attendance and evaluation and this has been mandated for all managers.

The Shadow Board programme, which was a pilot programme run by Inspiring Leaders Network, which 13 participants attended, drawn from our Succession Plan, has now been completed. Mentoring arrangements have been put in place, supported by the Non-Executive Directors. This pilot programme was funded by Health Education England Yorkshire & the Humber (HEE Y&H) Leadership Academy.

Work continues with New Care Models and the use of the Calderdale Framework across 33 teams for the assessment of competencies and design of new roles and the appointment of a Clinical Skills Trainer. The Advanced Clinical Practitioners are nearing successful completion of their training programme and planning is underway to commence recruitment of a second cohort.

A new preceptorship programme has been developed and launched, with positive feedback. Ring-fencing of preceptorship training time as 'protected' has been secured to ensure staff are freed up to attend.

Significant work has been undertaken to support the implementation of the Apprenticeship Levy in May 2017. The plan is to commence with apprenticeships for Health Care Assistants.

Care Certificate training is in place for all new starter Health Care Assistants (HCA). Existing HCA workforce are undertaking Care Certificate training although the timescales for completion may need extension. Investors in People re-accreditation is scheduled for March 2017.

Fourteen participants have undertaken an ILM Coaching & Mentoring programme, and are currently working towards completing their qualification, with work time allocated to support achievement of ILM level 5. The aim is to complete the work by 31 July 2017. The launch of our Coaching Strategy is contingent on having a cohort of qualified internal coaches. A draft coaching strategy has been developed and is to be considered in January.

Three individuals have been supported to undertake the national NHS Leadership Academy Nye Bevan programme - which is a flagship programme preparing delegates for Board-level working.

Fifteen places have been secured on the Clinical Leads Transition to Leadership Programme pilot, which commences in March 2017 (see also **c)** below).

The Leadership and Management Development Project has been closed as a work stream on the Clinical Transformation Board (CTB), and embedding of the Project is to continue within business as usual. The appropriate project closure documentation has been completed.

Health and Wellbeing:

The Sheffield Hallam Wellness pilot has been extended for 6 months until May 2017 to support the robust evaluation of this intervention. Unfortunately we have still not had the uptake in Nursing that we had hoped for in order to support the evaluation of the pilot. Mentally Healthy Workplace training is being rolled out alongside Mental Health First Aid Champions and Schwartz Rounds. We are in the process of developing a business case to implement a Rapid Access MSK service for staff to further enhance the health and wellbeing offer to staff and drive down sickness absence for this reason. It is envisaged that approval for this work will be sought from the Trust in March 2017.

This work stream remains live on the CTB agenda.

Workforce Redesign and Reward:

The Oceans Blue pilot continues with interventions taking place. Following a data cleansing exercise £125,000 was identified as shifts/hours that could be reclaimed from staff in the inpatient ward areas due to inefficient rostering practice. This data was signed off by the Ward Managers of each in-patient ward. An agreement was reached by the Director Team to recover this time before the end of March 2017. In addition to this, plans have been enacted to automatically correct incorrect ‘shift in lieu’ errors as well as incorrectly allocated overtime shifts, which has generated a further saving of £111,800.

Monthly monitoring against Job Planning progress continues with monthly meetings of the Job Planning Steering Group now taking place, with a particular focus on SAS job plan completion rates. Job planning training sessions are being organised during January and February 2017. Schedule 15 (Pay Progression) has been rolled out for career grade doctors, to support appraisal completion and Statutory and Mandatory Training compliance. New guidance is also to be issued to consultant medical staff for the payment of Category A and Category B on call payments, which recognise the frequency and complexity of work undertaken during those sessions.

This work stream remains live on the CTB agenda.

Advisory Group on Temporary Workforce

This executive-level group has been established to identify and monitor strategies to facilitate the reduction of the use and cost of external agencies to provide temporary workforce cover for medical and nursing staff. It will meet monthly and report to the Senior Management Team as appropriate.

A new work stream is to be incorporated into the CTB projects, following the approval of the Clinical Workforce Strategy in November 2016.

Equality and Diversity:

The Trust has published the Workforce Race Equality Scheme information on the intranet as well as a self-assessment against the workforce standards set out in the national Equality Delivery Scheme. An action plan has been developed in support of any areas where the Trust assesses the need for improvement or changes to be made. Progress is being reported into the Equality Group and the Workforce and Organisational Development Steering Group.

b) NHS Jobs employer feedback score

Following the closure of a vacancy, NHS Jobs invites each applicant to rate the Trust on the following criteria:

Advertisement
Information
Communication
Overall score

Each question is scored out of five (five being the highest (best) score that can be achieved) and comments can be left concerning the applicant's overall opinion of the service they have received. Trust scores are collated over a continuous 90-day period and compared with the NHS national average score.

The table below shows HDFT's score and its comparison with the national NHS average.

	0-90 days ago		91 to 180 days ago		181 to 270 days ago		270 – 360 days ago	
Question	**HDFT score**	**NHS Average**	**HDFT score**	**NHS Average**	**HDFT score**	**NHS Average**	**HDFT score**	**NHS Average**
Advert	4.23	3.65	3.81	3.67	4.23	3.68	3.57	3.58
Information	4.23	3.63	3.87	3.64	4.18	3.67	3.60	3.59
Communication	4.00	2.58	3.37	2.59	3.66	2.60	2.92	2.63
Overall	3.91	2.92	3.68	2.93	3.83	2.95	3.06	2.95

The information shows that HDFT consistently scores well above the national average in all categories and has significantly improved its service throughout the rolling 360-day scoring period.

A positive influence on the figures above is the detail provided during the HR Pathway to Management training course. Particular attention is given to the advert content, job descriptions and interviewing. The comments left by applicants are on the whole positive towards the excellent service and information they have received throughout their application and for some successful applicants, the pre-employment check process.

c) Clinical Leads Transition to Leadership Programme

The Trust has secured 15 funded places from HEE (Y&H) to pilot the Clinical Leads Transition Programme at HDFT.

Dr Natalie Lyth will be working with Shirley Silvester on the implementation plan, and we are liaising with our delivery partners to ensure that the content reflects the reality and challenges of being a Clinical Lead.

The delivery faculty are from Inspiring Leaders Network, an organisation which is working across the health sector to support leadership development, with the backing of HEE (Y&H). They recently worked with the Trust on our successful Shadow Board Programme.

Each Clinical Directorate is being offered five places on the Clinical Leads Transition to Leadership Programme, and has been asked to discuss as a Directorate Management Team, and with prospective delegates, who they feel would benefit the most from attending. It is suitable for both those currently working as Clinical Leads and for future Clinical Leads to support them in the delivery of this role at HDFT, and in their own personal development. The programme will be held in Harrogate over a five-month period between 22 March and 19 July 2017. Directorates have been invited to forward names to the Learning and Development team by 31 January 2017 at the latest.

d) Appraisals

DIRECTORATE	Assignments Appraised	Number of Assignments	% Appraised	% in July 2016
CHILDRENS AND COUNTY WIDE	487	543	89.69%	54.83%
CORPORATE SERVICES	483	562	85.94%	60.41%
LONG TERM AND UNSCHEDULED CARE	851	1057	80.51%	63.76%
PLANNED AND SURGICAL CARE	489	732	66.80%	61.26%
TOTAL	2,310	2,894	79.82%	60.07%

CHILDRENS AND COUNTY WIDE inc TUPE	856	949	90.20%	Not available

As reported previously, with the exception of the Children's and County Wide Directorate, the Trust is not achieving its appraisal target of 90% of appraisals completed within a 12-month period. A deadline of 31 December 2016 was set to achieve this. The data above shows that at the end of December the Trust achieved 79.82%, which, despite recent significant improvement - remains over 10% adrift.

The Trust now needs to consider options available to improve the appraisal completion across the Trust; some considerations have been more widespread eg roll out of team appraisals, as well as the implementation of an appraisal period ie they are completed within the first six months of the financial year.

The outcome that needs to be achieved is that all staff are appraised within a 12-month period. There was discussion at the most recent SMT around the approach that should be taken to improve compliance rates in 2017/18. Directorates have been challenged to bring forward plans to deliver 90% appraisal compliance. These could include a recommendation to move to a mandatory period, at the beginning of the financial year, during which all appraisals need to be completed.

e) Sickness Absence

Sickness absence across the Trust showed a decrease during November to 4.11% from October's adjusted 4.29% figure. This represents a noticeable decrease and is in line with the level seen in November 2015. There remain concerns in relation to the accuracy and timeliness of absence reporting, with significant levels of adjustments taking place in both Long Term & Unscheduled Care and the Children's and County Wide Community Care Directorates.

All directorates have shown reductions in sickness absence, with the exception of Planned & Surgical Care, where there has been a slight increase.

Stress, anxiety and depression-related absence remains the leading cause of sickness in terms of days lost throughout the organisation; there has, however, been a noticeable decrease in the number of days lost during November compared with the previous month. Ongoing emotional wellbeing support continues to be a focus for the organisation with Mental Health First Aid, Mentally Healthy Workplace and Schwartz Round activity all ongoing through into the New Year.

The number of days lost due to colds and flu has remained stable between October and November, but there has been a noticeable decrease in absences due to gastrointestinal problems. MSK and back issues as the cause have also seen a fall in absence levels during this period.

There has been a further increase in the number of staff reported as being on long-term sickness absence, although return to work plans have been put in place for a number of staff.

The Health & Wellbeing Group is relaunching its intranet site and promoting a number of activities aimed at raising awareness of both physical and emotional wellbeing. These include a survey of physical activity already undertaken by staff, and a Health and Wellbeing 'drop-in' session in Herriot's on 11 January, to support improved communication of information to staff and promote continued uptake of the Trust's Wellness programme – all of which will help to create a heathier workforce throughout 2017. The session was very successful, with a significant number of enquiries about opportunities, at least 25 staff signing up to discounted gym memberships and others booking appointments for the Wellness programme. Subsequently information (and fresh fruit) was distributed round the wards for those staff who had not been able to visit Herriot's.

f) Job Planning

The latest job planning figures for Consultants and Specialty Doctor and Associate Specialist grades as at 31 December 2016 are shown in the table below. Overall progress in completed Job Plans month on month is shown as a RAG rating. Progress is being made on a number of those Job Plans shown as out of date or not recorded and some have been received in early January. It is hoped to provide more detail on Job Plans in progress in future reports.

JANUARY 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	8	8	100.00%	0	0.00%	0	0.00%	0		
LT & UC	51	47	92.16%	4	7.84%	0	0.00%	0		
P & SC	61	31	50.82%	28	45.90%	2	3.28%	0		
Total	**120**	**86**	**71.67%**	**32**	**26.67%**	**2**	**1.67%**	0		

JANUARY 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	3	50.00%	3	50.00%	0	0.00%	0		
LT & UC	9	7	77.78%	1	11.11%	1	11.11%	0		
P & SC	34	13	35.30%	3	8.82%	18	52.94%	0		
Total	**49**	**23**	**46.94%**	**7**	**14.29%**	**19**	**38.78%**	0		

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

The Job Planning Working Group met on 10 January and discussed different approaches to be taken to reduce the number of outstanding Job Plans, particularly in the Planned and Surgical Care directorate. The draft Job Planning Policy was discussed further at the LNC meeting on 12 January, following some detailed points being raised by the BMA representative. Scheduling of the training sessions has consequently been delayed, although it will take place in the Spring, ready for the new round of annual job planning. Following the comments received on the proposed survey of Category A and B supplements and the survey, questions were re-worked and Clinical Leads were invited to respond by 16 January. Once analysed, the responses will be considered by the Job Planning Consistency Panel.

g) West Yorkshire and Harrogate Excellence Centre

The inaugural meeting of the West Yorkshire and Harrogate Excellence Centre employer's forum to support development of apprenticeships across the STP has now taken place. The Trust is now signed up to be an Employer Associate with the National Skills Academy for Health. The purpose of the Forum is to ensure that employers can achieve maximum return on levy payments and commission common education programmes at both scale and pace. Internally we are currently working on the apprenticeship levy payments to identify the availability of suitable programmes and how much of the levy we can utilise.

The next employer's forum meeting is planned for late February.

h) Global Health Exchange Scheme – funding of Immigration Skills Charge

The Chief Operating Officer for the Global Health Exchange scheme, Jonathan Brown, has confirmed that Health Education England is not in a position to authorise payment of the Immigration Skills Charge for applicants joining the Global Health Exchange scheme after 1 April 2017.

The Immigration Skills Charge has therefore been included as a cost pressure for the Trust, as it will be for all NHS organisations which recruit staff on Tier 2 visas from outside the European Economic Area.

The Trust continues to progress the appointment of up to 23 nurses from India through this scheme. Thirteen have now started their English language training course in preparation.

j) Flu

This year's campaign has seen a significant drop in the uptake to date in comparison with previous years. There will be a debriefing session for the Steering Group in early February with a view to further discussion and review of how the campaign can be placed for the coming 2017/18 season

Staff Group	Number of HCWs	Number Vaccinated	% Vaccinated
All Doctors	320	141	44.1%
Registered Nurses	1,287	513	39.9%
Qualified Support Staff	471	181	38.4%
Unqualified Support Staff	789	320	40.6%
TOTAL	**2,867**	**1,155**	**40.3%**

Please note the figures exclude bank staff, GP OOH and those on long term absence as at 1 December (for example long term sick, career break, maternity leave). As at this point in time in previous years, the uptake has been **57.5%** in 2014/15 and **53.3%** in 2015/16.

k) Investors in People

HDFT is committed to retaining Investors in People (IiP) status and in order to maintain IiP accreditation, the Trust is required to undergo re-assessment by 31 March 2017. Having maintained the standard since 2011, the Trust is now working towards Bronze level.

As part of the process, a sample of 106 staff (2%) and 24 managers has been selected at random and each will be invited to undertake a short interview or attend a focus group on 2 or 3 March or between 13 and 17 March, conducted by an External IiP Assessor. The Learning and Development Department is in the process of contacting line managers and selected staff to arrange one to one or group meetings. To enable us to achieve accreditation at Bronze level, managers must ensure that the selected staff are released to attend.

Interviews with the Executive Group and External Assessor will take place from 27 February to 1 March.

Further information regarding the process will be forwarded to staff, and posters placed in wards and departments, over the next two weeks. Directorates will be updated with progress on the assessment.

Phillip Marshall
Director of Workforce and Organisational Development

January 2017

Harrogate and District NHS
NHS Foundation Trust

Report to the Trust Board of Directors: 25 January 2017	**Paper No: 12.0**

Title	Lord Carter Hospital Pharmacy and Medicines Optimisation - Transformation Plan (HPTP)
Sponsoring Director	Andrew Alldred, Director of Pharmacy / Clinical Director Long Term & Unscheduled Care
Author(s)	Andrew Alldred & Sara Moore
Report Purpose	For Board approval prior to submission to NHS Improvement.

Key Issues for Board Focus:

- To note the transformation plan & the actions recommended.
- To comment prior to NHS Improvement submission.
- To note benchmarks and comparisons.

Related Trust Objectives	
1. To deliver high quality care	The plan supports the development of high quality medicines optimisation.
2. To work with partners to deliver integrated care	To ensure delivery the plan, requires cooperation of WYAATs, Y&H, STP collaboration as detailed.
3. To ensure clinical and financial sustainability	The plan details operational productivity, efficiency and medicines savings.

Risk and Assurance	
Legal implications/ Regulatory Requirements	Requires submission to NHS Improvement as part of Carter requirements.

Action Required by the Board of Directors

To note, comment and approve prior to NHS Improvement submission by end of January 2017.

1. Executive Summary

This paper describes the Harrogate and District NHS Foundation Trust (HDFT) Hospital Pharmacy Transformation Plan in line with the Lord Carter recommendations for Hospital Pharmacies and Medicines Optimisation provision. This programme is supported by our current Medicines Management and Optimisation Strategy 2016-2018 *(Appendix 3).*

Harrogate is part of the West Yorkshire and Harrogate STP footprint and collaborates across this area as well as a wider Y&H geographical area. HDFT is also a PACS (Primary and Acute Services Collaborative) Vanguard, currently modelling new joint health and social care provision across the district.

Using the model hospital benchmarks and indicators *(Appendix 2)* and the NHS Improvement Hospital Pharmacy Assessment and Action Planning Tool *(Appendix 1)* we have identified current and planned performance and the key issues and actions for HDFT in relation to Medicines Optimisation provision.

HDFT benchmarks favourably across the majority of the model hospital indicators as described below, including having 78% of pharmacist activity providing frontline clinical patient care (against a national target of 80%).

The key elements of the HDFT HPTP are focused around:

i. Increasing the number of pharmacist prescribers
ii. Improving medicines stock holding, e-trading and supply chain opportunities
iii. Further roll out of e prescribing (complex infusions and outpatients)
iv. Building on the already high performing front line core clinical service provision (for pharmacists and non-pharmacist staff) supporting medicines optimisation for our patients.
v. Continuing and further developing collaboration of key pharmacy infrastructure services in order to maximise productivity and efficiency.

2. Carter Metrics and Model Hospital Benchmarks

HDFT as an Organisation has engaged with the Lord Carter Procurement and Efficiency Programme through its development phases and with the subsequent national launch. The Trust has incorporated the findings into its annual planning processes as agreed at the Board of Directors.

The Hospital Pharmacy Transformation Programme is an important element for HDFT. We have used the Carter Metrics and Model Hospital Benchmarks (appendix 2), in conjunction with the Carter recommendations pertaining to Hospital Pharmacy, alongside the existing HDFT Medicines Management and Optimisation Strategy and Quality Priorities to inform our HPTP.

Each section detailed below describes our

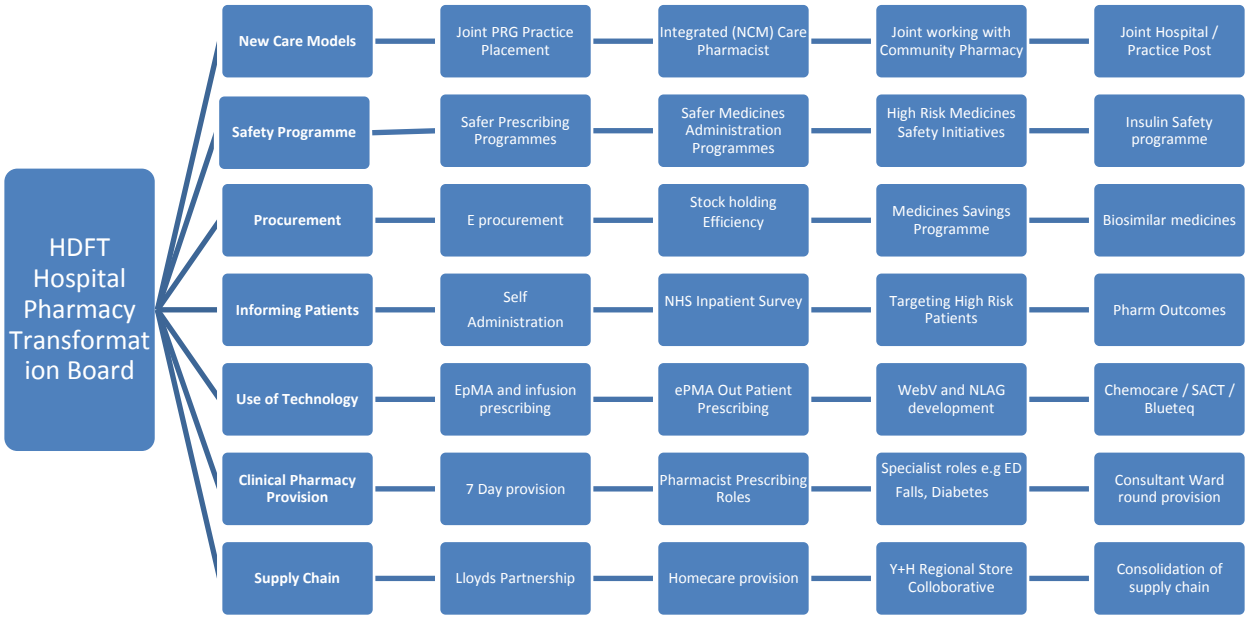
- Current position against each recommendation / benchmark;
- Planned position and timeline;
- Progress update.

a) HPTP planning and governance in place (Recommendation 3a)

The HPTP has been developed in consultation with service users and stakeholders, building on previous medicine optimisation strategies, the Carter metrics/benchmarks and the action planning template. The draft plan was approved at the Directorate Board on 18th October 2016.

HDFT is committed to having board level oversight of the programme. The Trust Senior Management Team (SMT) has given final sign off to the draft HPTP on 19th October prior to submission. This final plan will be submitted to the Board of Directors, in line with requirements, in January 2017.

A Hospital Pharmacy Transformation Board is in the process of being set up and a summary of the overall programme of work is described below:



HPTP Planning and Governance (Recommendation 3a)			
Carter Recommendation & Model Hospital Benchmark	**Current Position / Performance**	**Planned Position / Performance**	**Progress**
HPTP Planning and Governance (3a)	• Executive Sponsor agreed as Medical Director. • Trust Carter programme in place. • HDFT Medicines Management strategy and quality priorities in place consistent with Carter Programme. • HPTP Transformation plan in place • Yorkshire and Humber Collaboration in place for Clinical Pharmacy, E+T, QA, MI, and Procurement. Strong Chief Pharmacist Network.	HDFT HPTP Board implemented.	Draft plan developed – Directorate Board approval 18/10/16; SMT approval 19/10/16. BOD approval January 2017.

b) Review of Clinical Pharmacy and Direct Medicines Optimisation (Recommendation 3b)

The delivery of high quality, safe and effective medicines management is integral to the services provided by the Pharmacy Department at HDFT. Approximately 1.8million doses are administered on our wards annually. HDFT recognises the important role that medicines play in delivering care and has already shown a commitment to provide high quality pharmacy and medicines optimisation to all our patients.

Pharmacists at HDFT make over 13,000 interventions per year, ensuring a safe, effective and patient-focused service. The department is forward thinking and has already made large advancements in its service to include electronic prescribing, ward-based technical support and extended roles in prescribing and outpatient clinics.

HDFT Pharmacists play an active role in the Y+H clinical pharmacy network. This is constituted by each trust senior clinical lead and collaborates on standardisation of practice, audits, competency development, practice frameworks etc. This group has been instrumental in supporting consistency across Trusts in the interpretation of Carter recommendations.

Core clinical services for medicines optimisation have been defined by the Carter Programme as patient-facing including ward pharmacy, clinical support for discharge and organisational assurance and audit programmes. The programme requires organisations to review their clinical pharmacy service with the expectation that **80% of pharmacist time is focused on direct medicines optimisation activities.**

The table below describes the current and planned performance for this domain at HDFT.

Clinical Pharmacy and Direct Medicines Optimisation (Recommendation 3b i-ix)			
Carter Recommendation & Model Hospital Benchmark	**Current Position / Performance**	**Planned Position / Performance**	**Progress**
80% of Trust's pharmacist resource is utilised for direct medicines optimisation activities, medicines governance and safety	**78%.**	**80% by October 2017.** **85%-90%by April 2020.**	Areas of non-clinical activity identified for review. See action plan.
% Non-pharmacist ward-based activity to support front line patient care	**Pharmacy Technicians – 45%.** **Pharmacy Assistants – 40%.**	**75% by April 2019** **60% by April 2010.**	Ward-based team development to support nursing and ward pharmacy staff. See action plan.
% pharmacists actively prescribing	**10%**	**25% by Sept 2017** **60% by April 2018** **80% by April 2020**	Five pharmacists currently placed to qualify by 2017. Four more pharmacists identified for 2018.

% medicines reconciliation within 24hrs	**80%**	**90% by April 2018**	86.5% recorded by NHS England MO dashboard. See action plan.
% use of Summary Care Record	**Data not currently available.** **Summary Care Record available and accessed routinely by all ward pharmacists**		Current data being identified. Plan to roll out access to admitting doctors and nursing staff. See action plan.
Sunday "on ward" clinical pharmacy hours of service	**5 hrs [Note: Two pharmacists currently provide ward-based clinical cover on Saturdays and Sundays (over and above dispensing service provision)].**	**7 hrs by April 2018**	Business case developed for extension of weekend hours. See action plan.

c) PACS Vanguard Programme

As part of the PACS Vanguard Programme, HDFT has a funded intermediate care pharmacist post, working across the district in collaboration with health and social care colleagues. This role is working collaboratively with primary care, community pharmacy, hospital pharmacy and practice colleagues. An active professional network has been developed.

Working with the frail elderly population to optimise medicines use is a key element of this work and collaborative work with care homes is also in development.

d) Review of Pharmacy Infrastructure Services (Recommendation 3b (x))

HDFT is continuously reviewing the infrastructure services that are provided on site with a view to further regional collaboration as appropriate. There are well established services at a specialist level operating across Y+H that HDFT contributes funding to and therefore accesses.

- Y&H Regional Clinical Pharmacy Group
  - *Clinical standardisation; practice frameworks; regional audits and benchmarks*
- Y&H Medicines Optimisation and Procurement Group
  - *Collaborative procurement (includes CCGs and NHSE). National support to contracting; bespoke clinical tenders; biosimilar introduction; homecare etc.*
- Y&H QA Pharmacy Services
  - *EL Audits; aseptic and QA advice; unlicensed medicines advice; medical gas testing*
- Y&H / HEE Education and Training Services and School of Medicines Optimisation
  - *School of Medicines Optimisation includes collaborative E+T approach for support worker, technician, pharmacist pre and post registration training incl. NVQ, diploma, prescribing, PTQA, accuracy checking etc. Coordinated recruitment programmes.*

HDFT is an integrated community and acute trust and so community services are part of the organisation. We do not routinely provide services to other external organisations other than a clinical pharmacy service to the local hospice and an on call service to the local private Duchy hospital. These will continue.

The Trust is in its final stages of outsourcing the outpatient pharmacy service to Lloyds Pharmacy which will go live in March 2017. This is part of developing a wider community pharmacy partner to further optimise medicines use across the district.

The Trust has a technician-led Medicines Information Service. This is currently under review and collaboration with York NHS Trust is being considered.

There is a system-wide Area Prescribing Committee in place that makes joint formulary decisions and is well attended by primary care (Harrogate and Leeds) and Trust colleagues. There is significant sharing of work between Leeds, Harrogate and York Trusts to minimise duplication. HDFT will collaborate with the newly formed regional Medicines Optimisation Committee as this develops.

The Trust has an unlicensed aseptic unit that is appropriately staffed and resourced. This service benchmarks well in terms of medication errors and quality testing. The unit is currently undergoing a review of its catalogue as we continuously seek to outsource for ready to use and prepared items including dose banded chemotherapy. There are formal and reciprocal contingency arrangements with York NHS Trust. There are early discussions at Chief Pharmacist Network level re a strategic review of aseptic pharmacy provision across Y+H.

The Trust has well established links with Bradford School of Pharmacy and Leeds University Academic Pharmacy Practice Unit. We are actively involved with training pre and post registration students. We have a jointly appointed teacher practitioner post with Leeds University. We have appropriate NVQ assessors and verifiers within the department. We will continue to work closely with the new School of Medicines Optimisation to further develop our pharmacy teams.

HDFT is a member of the Y&H Medicines Optimisation and Procurement Group. The current HDFT Chief Pharmacist chairs this group. There is active involvement from HDFT at all subgroups and keen engagement in delivering work plans. Contract compliance is excellent and the services benchmark well across the country. HDFT is playing an active role in the regional project to develop a consolidated regional store.

HDFT plays a significant role in supporting research and development and is an active member of the Y&H Clinical Research Network. We have funded posts to support R+D development and this will remain an active part of our work going forward.

Review of Infrastructure Services (Recommendation 3b(x))

Carter Recommendation & Model Hospital Benchmark	**Current Position / Performance**	**Planned Position / Performance**	**Progress**
Aseptic Service Provision	Unlicensed unit. Sufficiently resourced. Outsourcing dose banded and ready to use products. Benchmarks well.	Continue to review catalogue. Lead Pharmacist to complete PTQA – 2018. Contribute to Y&H strategic review 2017/18. Complete NHS E template (June 2017)	Catalogue review continuous PTQA commenced in year 1. Early discussion commenced (to review outputs of East Midlands work)
Medicines Information Provision	Technician led service. Fully accredited. External review provides assurance.	Explore joint service provision with York NHS Trust (April 2017)	

Area Prescribing and Formulary Support	Net formulary in place. System wide APC in place.	Collaborate further with York and Leeds. Collaborate with regional Medicines Optimisation Committee when formed.	
Medicines Procurement	Strong regional collaborative supporting local and national procurement.	Strengthen local approach to procurement throughout (see section f). Active role in development of new regional store. (Business case March 2017)	Work programme commenced. Phase I complete. Phase II underway.
Education and Training	Regional collaboration well developed for all trainees. Active contribution to training pre and post registration students with Bradford, Huddersfield and Leeds Universities. Joint practice (Haxby) and HDFT pre-registration post. NVQ assessors, pharmacist and verifier in place for NVQ. Pharmacist Teacher Practitioner in post with Leeds University.	Support School of Medicines Optimisation – commenced 2016/17	
Dispensing Services	Standard range of services. One main inpatient, one outpatient and one aseptic service provision	Outsource Outpatient Pharmacy Service (March 2017)	Final stages of implementation.

e) Implementation of Electronic Prescribing and Medicines Administration (ePMA) (Recommendation 3c)

Electronic Prescribing and Administration (ePMA) is an important component of the safe use of medicines. HDFT implemented ePMA in 2012 and continues to have an active project group in place.

- ePMA is fully implemented throughout all inpatient ward and departments areas, including off site units / Community Hospital and the Emergency Department.
- HDFT continues to support upgrades to the system at a rate allowable by the supplier. The next development will include the prescription of intravenous fluids and complex infusions.
- Discharge letters from all inpatient ward areas are generated electronically supported by the core ePMA system interfacing with the e-discharge system.

- Chemocare^{TM} e-prescribing system is in place for the management of chemotherapy medicines.

Electronic Prescribing and Medicines Administration (3c)			
Carter Recommendation & Model Hospital Benchmark	**Current Position / Performance**	**Planned Position / Performance**	**Progress**
% e-Prescribing Inpatients	**100%**	**Inclusion of complex infusions by April 2018**	Carter recommendation complete. See action plan.
% e-Prescribing Outpatients	**0%**	**100% by April 2019**	Awaiting CSC development of outpatient module.
% e-Prescribing Chemotherapy	**100%**		Complete
% e-Prescribing Discharge	**100%**		Complete

f) Ensuring Accurate Coding of Medicines (Recommendation 3d)

The Trust has an identified lead for high cost drug reference costs. All high cost drugs are appropriately annotated on the pharmacy stock management system (Ascribe) which is interfaced with the Trust Finance Department.

Effective and regular communication between Finance and Pharmacy ensures ongoing and reactive identification and coding of high cost medicines.

Data for commissioners (NHS England and CCGs) is routinely provided. The NHS England CQUIN for medicines optimisation will be implemented in 2017.

Accurate coding of medicines (3d)			
Carter Recommendation & Model Hospital Benchmark	**Current Position / Performance**	**Planned Position / Performance**	**Progress**
Trust lead for High Cost Drugs identified	**Compliant**		Complete
High cost drugs accurately recorded within NHS reference costs	**Compliant**		Complete
NHS England Medicines Optimisation CQUIN	Baseline data being collected	Compliant with CQUIN Q1-Q4 2017	Work commenced

g) Delivering the Top 10 drug saving opportunities (Recommendation 3e)

HDFT has an active medicines savings programme that has consistently delivered recurrent medicines savings year on year. The programme is undertaken jointly with the local CCG and incorporates, for example:

- Implementation of national SCEP contracts;
- Implementation of Yorkshire and Humber Collaborative Medicines Contracts;
- Implementation of Biosimiliar medicines contracts;
- Therapeutic switching programmes;
- Joint CCG / Acute Trust prescribing programmes;
- Benchmarking of primary and secondary care use of medicines in line with national and local priorities.

An active medicine savings programme remains a priority and performance against Carter metrics is detailed below:

Top 10 drug savings opportunities (3e)			
Carter Recommendation & Model Hospital Benchmark	**Current Position / Performance**	**Planned Position / Performance**	**Progress**
NHS Improvement Top 10 savings opportunities	**Awaiting publication from NHSI.**		
% Total Infliximab Usage that is biosimilar product	**98%**	**100% by April 2017**	100% now subject to patient consent
% Total Etanercept Usage that is biosimilar product	**90%**	**100% by April 2017**	Product switch plan adopted. See action plan.
% Soluble Prednisolone of Total Prednisolone Uptake	**0%**		Complete Peer median 2.2% National median 3.6%

h) Reviewing medicines stockholding and supply chain (Recommendation 3f)

The Carter programme has identified medicines stockholding and effective supply chain management as a priority of the programme.

HDFT is in collaboration across the West Yorkshire Network of Acute Trusts and STP to rationalise and consolidate the supply chain management of medicines. In addition there is a work programme at HDFT to make further progress relating to electronic procurement and to rationalise stockholding. HDFT is currently an outlier in this latter regard.

Medicines stock-holding and supply chain (3f)			
Carter Recommendation & Model Hospital Benchmark	**Current Position / Performance**	**Planned Position / Performance**	**Progress**
Reduce average stock holding days to 15	**34 days**	**15 days by September 2017**	Task and Finish Group in place. See action plan.
Less than 5 daily deliveries (average)	**10**	**Less than 10 by April 2018**	Task and Finish Group in place. See action plan.
90% orders sent electronically	**50% full e trading** **[Note: remaining 50% electronic email orders]**	**70% by Oct 2017**	Task and Finish Group in place. Restricted by traders ability to fully e trade. See action plan.
90% invoices processed electronically	**40%**	**60% by Oct 2017**	Task and Finish Group in place. Restricted by traders ability to fully e trade. See action plan.

i) Safer Medicines Programme

HDFT has a safer medicines programme identified in the Organisation Medicines Management Strategy. Elements of the programme are incorporated in the Carter recommendations and benchmarks (e.g. implementation of ePMA, medicines reconciliation, use of summary care record, etc) and others are included below.

In addition HDFT has a Quality Improvement Priority to improve the safe use of Insulin management.

This is seen as a core component at HDFT and so included in our plan.

Safer Medicines Programme			
Carter Recommendation & Model Hospital Benchmark	**Current Position / Performance**	**Planned Position / Performance**	**Progress**
% annual diclofenac : ibuprofen : naproxen	**6.88%**	**0% by April 2017**	Peer median 11.4%, National median 13.6%.
% monthly diclofenac : ibuprofen : naproxen	**0%**	**0%**	Peer median 6.82%, National median

			8.85%.
Total antibiotic consumption DDD/1000 admissions	**3967**		Peer median 4335, National median 4168.
National Inpatient Survey – Medicines Related Questions	**80.3%**	**85% by 2018**	Peer median 76.9%, National median 75.8%.
Safe Use of Insulin	**Quality improvement plan in place.** **2 severe harm in 2015/16**	**Zero severe harms Reduce moderate harms and improve ratio of no/low harm ; moderate / severe harms**	Zero severe harms 92% no/low harm to moderate /severe harm

3. HPTP Summary / Action Plan

Assessment and analysis of the appropriate data / information packs and using the action planning tool has helped develop the Transformation Programme detailed below.

Recommendation	Action	Progress Update	Lead	Timescale
HPTP oversight	Implement HPTP board	Draft plan in place	Andrew Alldred Dr David Scullion	October 2016
80% of Trust's pharmacist resources utilised for direct medicines optimisation	Reduce non-clinical pharmacist activity in inpatient dispensary by full implementation of RP-free GPhC guidance and full use of Accredited Checking Technicians.	Partial implementation of RP-free GPhC guidance.	Janet Hobson Sara Moore	April 2017
	Reduce non-clinical pharmacist activity in outpatient pharmacy	Complete outpatient pharmacy outsourcing to community partner.	Sarah Abbas	March 2017
	Increase number of pharmacist prescribers	Pharmacists, specialty areas and mentors identified.	Sara Moore	80% by 2020
	Increase weekend ward clinical pharmacist hours	Business case developed and prioritised. Awaiting approval.	Andrew Alldred	2017/2018

Recommendation	Action	Progress Update	Lead	Timescale
Increase % non-pharmacist ward-based activity to support front line patient care	To reconfigure technician and assistant roles. To train in house technicians to support workforce requirements. To implement skills escalator for band 2 / 3 staff.	Service delivery at ward level. 6 students currently in training. Programme of career progression developed.	Janet Hobson Janet Hobson Janet Hobson	2016 2017/2018 2017
Increase % of medicines reconciliation within 24 hours from 80% to 90%	Increase weekend ward clinical pharmacist hours	Business case developed and prioritised. Awaiting approval.	Andrew Alldred	2017/2018
Increase % use of summary care record (SCR)	To identify current usage and assess against regional and national benchmarks. Roll out access of SCR to admitting doctors and nurses.		Sara Moore Sara Moore	2016 2016
Review Medicines Information Provision	Explore with York NHS Trust joint provision	Initial discussion commenced Jan 17	Sarah Abbas	June 2017
Strategic Review of Aseptic Service Provision	Complete NHS England template Continue to outsource as appropriate Contribute to review	Awaiting template	A Alldred / R Ventress R Ventress / R Orchard A Alldred	June 2017 2017 2017/18
Electronic prescribing and administration	Implement ePMA for inpatient complex infusions. Implement ePMA for outpatient prescribing	Software now released and due to go into test. Awaiting software release.	Emily Parkes Emily Parkes	April 2018 April 2019

Drug Savings Opportunities	NHS Improvement Top 10. Increase % Total Etanercept Usage that is biosimilar product from 90% to 100%.	Awaiting publication. Complete switch programme.	Sarah Abbas Sarah Abbas	2017 April 2017
Medicines Stock holding and Supply chain	Collaborate with West Yorkshire Supply Chain Consolidation Project. Reduce stockholding days to 15. Less than 10 daily deliveries. 70% of orders sent electronically and 60% of invoices processed electronically.	Business case submitted to West Yorkshire CEOs. Inventory review of medicines stockholding undertaken. Currently adjusting stockholding parameters Consolidating orders through wholesalers. Collaborating with suppliers to implement electronic trading platforms.	Andrew Alldred/ Yorkshire Chiefs / PWC Sarah Abbas / Ian Norman Sarah Abbas / Ian Norman Sarah Abbas / Ian Norman	Phase II Model 2017 September 2017 April 2018 October 2017

4. Risks, Issues and Mitigations

The table below describes the key risks / issues and mitigation to the timely implementation of the HPTP.

Recommendation / Action	Risks and Issues	Mitigation
80% of Trusts' pharmacist resources utilised for direct medicines optimisation	Delay in outsourcing Outpatient Pharmacy Ability to retain Accuracy Checking Technicians	Project team / plan in place. Board of Directors approved. In-house training plan in place.
Increase number of pharmacist prescribers	Ability to Retain pharmacists. Funding not secured and sourcing of prescribing mentors not delivered. University capacity to deliver training.	Track record of recruitment and retention through good development programme. Funding secured and mentors identified Places identified for 2016/17
Increase weekend ward clinical hours	Business case and funding not approved. Ability to recruit and retain pharmacists	Trust 7 day project in place. Track record of recruitment and retention through good development programme.
Increase % of non-pharmacist ward based activity	Lack of internal pharmacy training capacity. Business case not approved for skills escalator	Capacity if internal trainers regularly reviewed and succession plan in place. Slower progress likely to be made but will review as vacancies arise
Further roll out of ePMA	Lack of capacity to implement and train staff re complex infusions. Testing of software identifies major safety concerns Delay in release of Outpatient Prescribing software	Project Team and lead in place with Trust support Tested at pilot sites. Access to CSC. Project Lead and safety officer in place. Will delay implementation
Maximise opportunities relating to reducing stock holding, supplier review and e trading.	Business case not approved for West Yorks collaborative supply chain project E trading restricted by ability of suppliers to trade electronically	Working with external consultants to develop case and ROI. National working group commenced to move forward with traders.

Appendix 1: HPTP Action Plan Template

Assessment and Action Planning Tool (AAPT)

Organisational Information

Provider Trust Name: Harrogate and District NHS Foundation Trust

Date completed by Chief Pharmacist: 14/10/2016

Date agreed with trust nominated Director: 19/10/2016

Recommendation 3(a) - HPTP planning and governance

developing HPTP plans at a local level with each Trust board nominating a Director to work with their Chief Pharmacist to implement the changes identified, overseen by NHS Improvement and in collaboration with professional colleagues locally, regionally and nationally; with the Chief Pharmaceutical Officer for England signing off each region's HPTP plans (brigaded at a regional level) as submitted by NHS Improvement;

i. Has the Trust developed an overall HPTP planning process, approved by the Board, which specifically addresses implementation of the recommendations of the Carter report?
Yes ☑ No ☐

If the answer is 'Yes', please provide brief details.

The Trust has an overarching Carter Programme and is currenty in the process of establishing a Hospital Pharmacy Transformation Board with the Medical Director as the Executive Director.

Recommendation 3(b) - clinical pharmacy and infrastructure services

ensuring that more than 80% of Trusts' pharmacist resource is utilised for direct medicines optimisation activities, medicines governance and safety remits and reviewing the provision of all local infrastructure services, which could be delivered collaboratively with another Trust or through a third party provider

i. The Carter report defines core clinical services for medicines optimisation as patient-facing (ward pharmacy, medicines reconciliation, clinical support for discharge, prescribing, outpatient & pre-admission clinics, specialist pharmacists, medicines administration and support) and organisational assurance (medicines safety officer, the governance role of the Chief Pharmacist (including controlled drugs Accountable Officer role) and audit programmes.

Are there any other clinical services that you intend to include in your local definition? Please describe briefly.

Yorkshire and Humber Chief Pharmacist Group has agreed across the network that leadership and development directly impacting on patient care will be included within this figure.

ii. What percentage of available pharmacist resource is currently deployed to undertake core clinical services?

78%

iii. What percentage of available pharmacist resource do you plan to deploy to undertake core clinical services by 2020?

85-90%

iv. What changes will you need to make to ensure that more than 80% of pharmacist resource is deployed to undertake core clinical services?

Outsourcing Out-patient Pharmacy, review of ACT provision in dispensaries and increasing the numbers of pharmacist prescribers.

v. What percentage of pharmacy technician resource is currently deployed on ward-based activities?

45%

vi. What plans do you have to increase this in either scale or scope by 2020?

Increased ward based technician support to include medication history, self-administration assessment, use of mobile dispensing support and technician medicines administration. Currently training own cohort of technicians

vii. What percentage of pharmacy assistant time is currently deployed on ward based activities?

40%

viii. What plans do you have to increase this in either scale or scope by 2020?

Development of a skills escalator to increase the number and skill base of assistant workforce to support ward based teams.

ix. By what process will these changes be agreed and signed off?

Through internal pharmacy senior management and governance infrastructure after consultation with directorate and service user priorities. This will form part of the Trust's new clinical workforce strategy.

x. The Carter report defines infrastructure services as supply chain (stores/distribution, procurement, aseptics, production, QC, dispensing, homecare); education and training (pre-reg pharmacists and technicians, NVQ assistant staff, post-registration pharmacy staff), advisory services (medicines information, formulary); research and development (clinical trials, departmental research) and services to external organisations (community, mental health, hospices, prisons, care homes, GPs).

Are there any other infrastructure services that you intend to include in your local definition? Please describe briefly.

Provision of community services is integrated within the Trust

xi. Please indicate if you have **reviewed** the following infrastructure services (if they are provided) and whether you have **identified** potential collaboration partners. Click in the appropriate boxes.

	Not started	Review in progress	Review complete	Partners identified
Supply chain				
Dispensing	☐	☑	☐	☑
Stores and distribution	☐	☑	☐	☐
Procurement	☐	☐	☑	☑
Aseptic production	☐	☑	☐	☑
Production	☐	☐	☐	☐
Education and training				
Pre-registration pharmacists	☐	☐	☑	☑
Preregistration technicians	☐	☐	☑	☑
NVQ assistant staff	☐	☐	☑	☑
Post registration pharmacy staff	☐	☐	☑	☑
Advisory services				
Medicines information	☐	☐	☑	☐
Formulary	☐	☑	☐	☐
Research and Development				
Clinical trials	☐	☐	☑	☑
Departmental research	☐	☐	☑	☑
Services to external organisations				
Community	☐	☐	☑	☑
Mental Health	☐	☐	☑	☑
Hospices	☐	☑	☐	☑
Prisons	☐	☐	☑	☑
Care homes	☐	☐	☐	☐
General practitioners	☐	☐	☐	☐
Other organisations	☐	☐	☐	☐
Other locally-defined services	☐	☐	☑	☐

xii. Have you identified any potential barriers to collaboration?
Yes ☑ No ☐

Please provide details if appropriate.

Resources including time and headroom, capital investment, governance, sovereignty,

xiii. Have you considered any alternative processes for supplying medicines in your trust for the following activities? If so, click in the appropriate boxes.

Outpatient dispensing	☑
Discharge dispensing	☑
Homecare medicines	☑

Please provide brief details, if appropriate.

Outpatient dispensing is in the process of being outsourced, utilisation of regional supply chain consolidation, repatriation of homecare where appropriate

Recommendation 3(c) – Electronic prescribing and medicines administration

…each Trust's Chief Clinical Information Officer moving prescribing and administration from traditional drug cards to Electronic Prescribing and Medicines Administration systems (EPMA)

i. What are your plans for implementing electronic prescribing and medicines administration in the following areas? Click in the appropriate boxes

	Not started	Planning stage	Partially implemented	Fully implemented
Chemotherapy	☐	☐	☑	☐
Outpatients	☐	☑	☐	☐
Discharge medicines	☐	☐	☐	☑
In-patients	☐	☐	☐	☑

Any additional comments

Click here to type your response

Recommendation 3(d) – Accurate coding of medicines

…each Trust's Finance Director, working with their Chief Pharmacist, ensuring that coding of medicines, particularly high cost drugs, is accurately recorded within NHS Reference Costs;

i. Have you identified your trust's lead for High Cost Drug reference costs?
Yes ☑ No ☐

If the answer is 'No', then when do you expect this to be completed?

Click here to type your response

ii. Are high cost drugs accurately recorded within NHS Reference costs?
Yes ☑ No ☐ Don't know ☐

If the answer is 'No' or "Don't know" then by what date do you expect this to be completed?

Click here to type your response

Recommendation 3(e) – Top 10 drug saving opportunities

NHS Improvement publishing a list of the top 10 medicines with savings opportunities monthly for Trusts to pursue

i. Have you developed a process by which your trust will review the top 10 medicines with saving opportunities for your trust?
Yes ☑ No ☐

If the answer is 'Yes', please provide brief details.

If the answer is 'No', then when do you expect this to be completed?

Internal medicines savings programme embedded, await publication of NHS Improvement Top 10

Recommendation 3(f) – Medicines stock-holding and supply chain

...consolidating medicines stock-holding and modernising the supply chain to aggregate and rationalise deliveries to reduce stock-holding days from an average of 20 to an average of 15 days, deliveries to less than 5 per day and ensuring 90% of orders and 90% of invoices are sent and processed electronically

i. For each of the following Carter recommendations, please state the current value (average) and the date you plan to achieve the recommendation (click box and select from dropdown menu).

Carter recommendation	Current value	Date
Reduce average stock-holding days to 15	34	Oct 2017
Less than 5 daily deliveries (average)	10	Oct 2017
90% orders sent electronically	50%	Oct 2017
90% invoices processed electronically	40%	Oct 2017

Any additional comments?

Yorkshire and Humber challenge as to whether 5 deliveries is achievable, particularly with a view to reducing average stock holding.

Recommendation 3 – Overarching recommendation

Trusts should, through the Hospital Pharmacy Transformation Programme (HPTP), develop plans by April 2017 to ensure hospital pharmacies achieve their benchmarks such as increasing pharmacist prescribers, e-prescribing and administration, accurate cost coding of medicines and consolidating stock-holding, in agreement with NHS Improvement and NHS England by April 2020; so that their pharmacists and clinical pharmacy technicians spend more time on patient-facing medicines optimisation activities.

i. Briefly describe how you will use the Model Hospital benchmarks to drive service transformation in your trust.

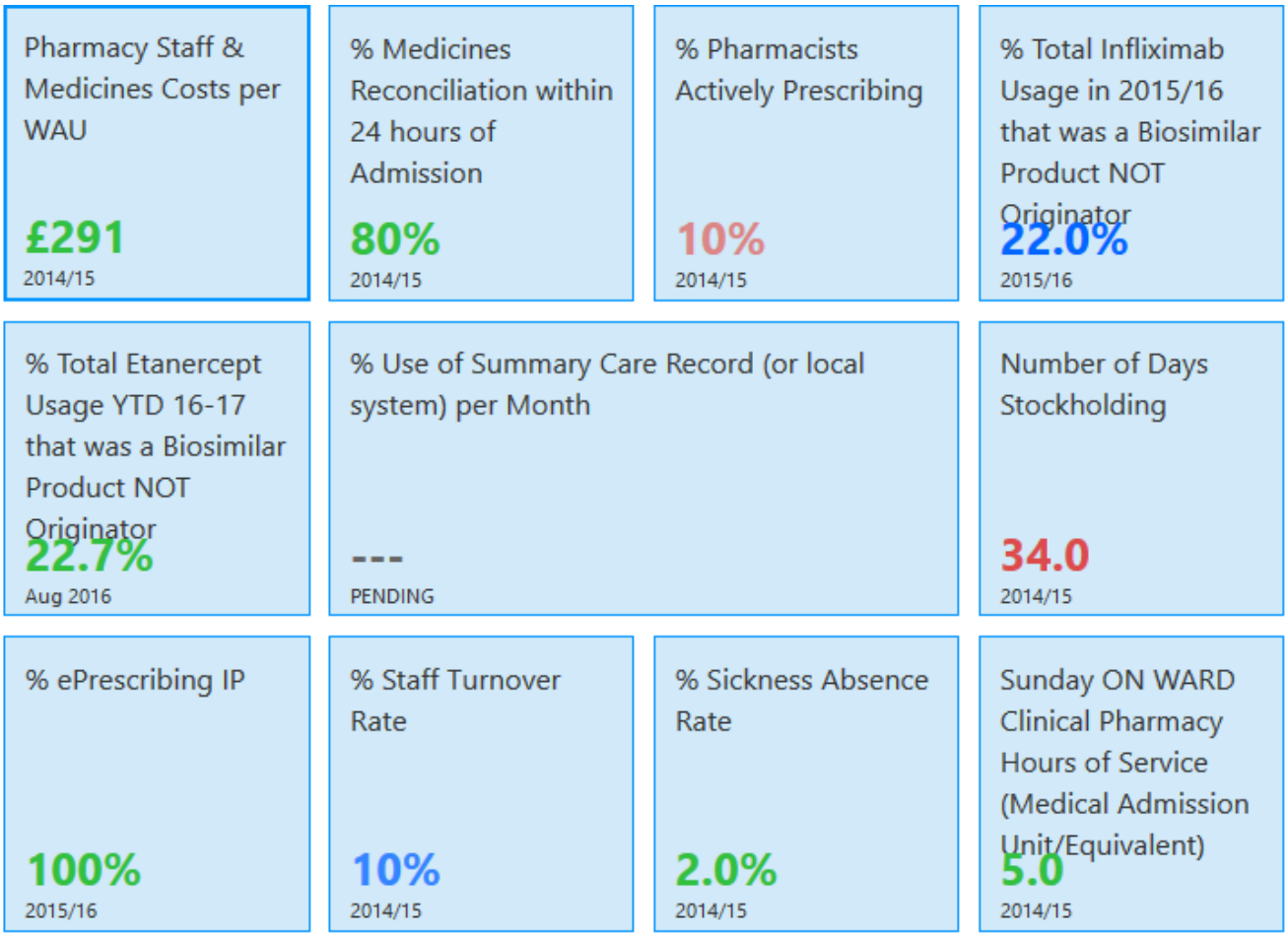
Benchmarks have identified areas of good practice and confirmation of high level performance. Areas for improvement have been identified using Model Hospital Benchmarks and Trust level indicators

ii. Briefly describe how you plan to increase the number of pharmacists actively prescribing

Pharmacists and funding have been identified and prioritised. Plan in place to deliver over 2+ years

Please return your AAPT and draft HPTP plan to productivity&efficiency@dh.gsi.gov.uk by Monday 31st October 2016.

Appendix 2: NHS Improvement Model Hospital Trust Level Metrics - HDFT



Pharmacy & Medicines, Trust Level

Money & Resources

	Period	Trust Actual	Peer Median	National Median	Info	Variation	Trend
Pharmacy Staff & Medicines Costs per WAU	2014/15	£291	£288	£335			No trendline available
Medicines Costs per WAU	2014/15	£257	£269	£298			No trendline available
High Cost Medicines per WAU	2014/15	£70	£66	£97			No trendline available
Non High Cost Medicines per WAU	2014/15	£187	£172	£189			No trendline available

Safe

	Period	Trust Actual	Peer Median	National Median	Info	Variation	Trend
% ePrescribing IP	2015/16	100%	20%	50%			No trendline available
% ePrescribing OP	2014/15	0%	20%	50%			No trendline available
% ePrescribing Discharge	2014/15	100%	100%	60%			No trendline available
% ePrescribing Chemotherapy	2014/15	100%	40%	50%			No trendline available
Total Antibiotic Consumption in DDD*/1,000 Admissions	2014/15	3,967	4,335	4,168			No trendline available
% Diclofenac vs Ibuprofen & Naproxen (Annual)	2015/16	6.88%	11.54%	13.60%			No trendline available
% Diclofenac vs Ibuprofen & Naproxen (Monthly)	Jun 2016	0.00%	6.82%	8.85%			

Effective

	Period	Trust Actual	Peer Median	National Median	Info	Variation	Trend
Number of Days Stockholding	2014/15	34.0	21.0	18.9			No trendline available
% Pharmacists Actively Prescribing	2014/15	10%	16%	14%			No trendline available
% Medicines Reconciliation within 24 hours of Admission	2014/15	80%	63%	62%			No trendline available
% Use of Summary Care Record (or local system) per Month	-	PENDING	-	-			
% Soluble Prednisolone of Total Prednisolone Uptake	May 2016	0.0%	2.2%	3.6%			
% Total Infliximab Usage in 2015/16 that was a Biosimilar Product NOT Originator	2015/16	22.0%	10.6%	12.1%			No trendline available
% Biosimilar Infliximab Uptake (Monthly)	Jun 2016	0.0%	70.8%	55.3%			
% Total Etanercept Usage YTD 16-17 that was a Biosimilar Product NOT Originator	Aug 2016	22.7%	0.5%	1.7%			
Total spend on Etanercept in 15-16	2015/16	£28k	£0.7m	£1.1m			No trendline available

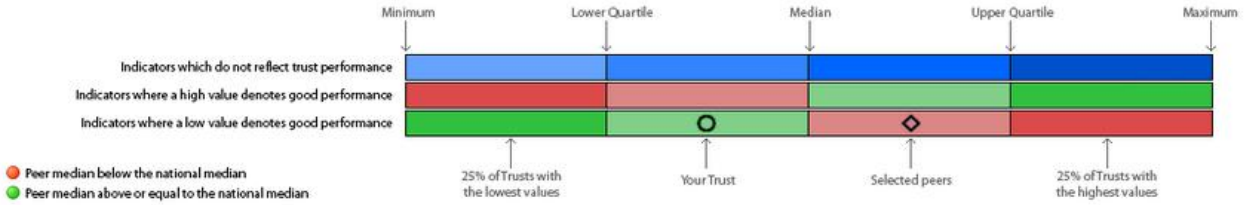
Caring

	Period	Trust Actual	Peer Median	National Median	Info	Variation	Trend
National Inpatients Survey - Medicines Related Questions	2014/15	80.3%	76.9%	75.8%			No trendline available

Responsive

	Period	Trust Actual	Peer Median	Benchmark Value	Info	Variation	Trend
Sunday ON WARD Clinical Pharmacy Hours of Service (Medical Admission Unit/Equivalent)	2014/15	5.0	2.0	5.0		Click for national variation	No trendline available

People, Management & Culture: Well-led	Period	Trust Actual	Peer Median	National Median	Info	Variation	Trend
% Sickness Absence Rate	2014/15	2.0%	3.4%	3.3%			No trendline available
% Staff with Appraisals Completed	2014/15	100%	92%	88%			No trendline available
% Staff with Statutory and Mandatory Training	2014/15	100%	91%	86%			No trendline available
% Staff Turnover Rate	2014/15	10%	12%	12%			No trendline available



Total Antibiotic Consumption in DDD*/1,000 Admissions	2014/15	3,967	4,335	4,168			No trendline available
% Diclofenac vs Ibuprofen & Naproxen (Annual)	2015/16	6.88%	11.54%	13.60%			No trendline available
% Diclofenac vs Ibuprofen & Naproxen (Monthly)	Jun 2016	0.00%	6.82%	8.85%			

National Inpatients Survey - Medicines Related Questions	2014/15	80.3%	76.9%	75.8%			No trendline available

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Board Committee report to the Board of Directors

Committee Name:	Quality Committee (QC)
Committee Chair:	LA Webster
Date of last meeting:	07/12/2016
Date of Board meeting for which this report is prepared	January 2017

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

- Hot Spots discussed:
  - Current operational pressures being experienced, including ED performance discussed
  - A recent 'near miss' relating to day time GI bleed support had resulted in an urgent review of cover and the Committee will hear the resulting action plan.
- Quality Priorities – 2 updates received:
  - Improving Stroke Care, including an update on progress with HASU, which we note was behind plan.
  - Reducing morbidity and mortality from Sepsis, good progress with this initiative.
- Reconfiguration of beds – good initiative, however we have heard that due to the pressures on the system and the need to increase bed numbers a decision to revert back to two wards has been taken. Although the good cross working initiatives will be carried forward and a further review will be carried out.
- Infection Prevention and Control report heard – 2 points for note
  - Flu vaccination concerns re low uptake. The Committee has requested in June 17 that a POA be brought for review suggesting a new approach and initiatives to encourage uptake of vaccinations for the next FY when a CQINN of achieving 75% uptake of Flu vaccination will be introduced.
  - The Committee is concerned about the Trusts ability to manage the *C.difficile* load within the hospital and reported issues around funding / staff availability to carry out deep-cleaning

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

No

Matters for decision

None

Action Required by Board of Directors:
To note there was no Quality Committee in January as the meeting was not quorate.

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Board Committee report to the Board of Directors

Committee Name:	Audit Committee
Committee Chair:	Chris Thompson, Non Executive Director
Date of last meeting:	Thursday 8th December 2016
Date of Board meeting for which this report is prepared	Wednesday 25th January 2017

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

1. Further to concerns that had been raised at previous meetings, the Committee was again concerned at the number of Limited Assurance audits that were highlighted and the progress that was being made on implementing the recommendations raised by Internal Audit. Of the 10 audits that had been finalised since the last meeting of the Committee, five had a limited assurance outcome. Over the previous nine months, 26% of audits had resulted in a limited assurance outcome.

   The five limited assurance audits were in the following areas:

   - Falls Prevention
   - Patient Access - Follow Up
   - Emergency Preparedness and Business Continuity
   - Legionella
   - IV Cannula Care – Follow Up

   The Committee have recognised that the new Controls Environment audit approach will be likely to result in a higher proportion of limited assurance outcomes as a higher proportion of audits result from management highlighting areas of concern.

2. The Committee was also concerned in relation to the KPI's reported in respect of two complementary areas.

   a. The percentage of management responses to draft report recommendations received within 15 working days had fallen from 100% to 89%, with two particular audits proving to be difficult to finalise.
   b. The percentage of agreed Internal Audit recommendations that had been implemented had fallen from 84% reported in September to only 44%

3. The Committee is aware that Trusts and CCG' across Yorkshire are all concerned at the considerable pressures that are currently being placed upon their senior management teams. Despite the impact of these pressures, it is critical that the control environment in operation across the Trust remains effective and in evidence. In these circumstances, whilst the senior management team cannot delegate their responsibilities, they can and must efficiently delegate the implementation and monitoring of internal controls to their teams.

4. The Committee are very aware that the Senior Management Team has discussed the outcomes from recent Internal Audits and the concerns raised at the December Audit Committee meeting. The next Audit Committee meeting takes place on Friday 27th January and an assessment will be carried out on the extent to which Management have been able to address the concerns. The conclusions reached at that meeting will be reported to the Trust Board at its meeting on 22nd February.

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

The notes above set out the concerns of the Committee with regard to the maintenance of an effective internal control environment.

Matters for decision

There were no new risks identified and discussed by the Committee which are to be brought to the attention of the Board.

Action Required by Board of Directors:

There are no matters that require a decision to be taken by the Board

Board meeting 25 January 2017

Audit Committee – Annual Review of Committee Terms of Reference

Report from: Chris Thompson, Non-Executive Director

Report Purpose: For discussion and approval

Background

The Committee's Terms of Reference were changed in 2015 to reflect the establishment of the Quality Committee and also the attendance at Committee meetings of members of the Board of Governors.

There are no changes proposed this year to the Terms of Reference. The Audit Committee approved the current Terms of Reference at its December 2016 meeting and the Board is asked to approve the continued adoption of the Terms of Reference in their present form.

Proposal

The Board is asked to approve the Terms of Reference

January 2017

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AUDIT COMMITTEE TERMS OF REFERENCE

Accountable: to the Board of Directors

Reporting: to the Board of Directors

Constitution

The Board hereby resolves to establish a Committee of the Board to be known as the Audit Committee (the Committee). The Committee is a non-executive committee of the Board and has no executive powers, other than those specifically delegated in these Terms of Reference.

Membership

The Committee shall be appointed by the Board from amongst the non-executive directors of the Trust and shall consist of not less than three members. One member of the Committee should have recent and relevant experience (e.g. audit/financial accounting/financial management). One of the members will be appointed Chair of the Committee by the Board. The Chairman of the organisation shall not be a member of the Committee.

Quorum

A quorum shall be two members.

Attendance

The Finance Director, members of the Senior Finance Team, the Deputy Director of Governance, the Deputy Director of Corporate Affairs and appropriate internal and external audit representatives shall normally attend meetings. The Local Counter Fraud representative shall also attend twice per year and the Local Security Management Specialist on an annual basis. At least once a year the Committee should meet privately with the external and internal auditors.

The Chief Executive should be invited to attend and should discuss at least annually with the Audit Committee the process for assurance that supports the Annual Governance Statement. He or she should also attend when the Committee considers the annual accounts. All other executive directors should be invited to attend, particularly when the Committee is discussing areas of risk or operation that are the responsibility of that director.

Governors are also invited to attend the Audit Committee meetings in an observational capacity.

A secretary appointed to the Committee shall attend to take minutes of the meeting and provide appropriate support to the Chair and Committee members.

Frequency

Each Committee must consider the frequency and timing of meetings needed to allow it to discharge all of its responsibilities. A benchmark of six meetings per annum at appropriate times in the reporting and audit cycle is suggested. The External Auditor or Head of Internal Audit may request a meeting if they consider that one is necessary.

Authority

The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary. Details of the estimated cost of such advice should be advised to the Finance Director for budgetary, cash flow and control purposes.

Duties

The duties of the Committee can be categorised as follows:

Governance, Risk Management and Internal Control

The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives.

In particular, the Committee will review the adequacy and effectiveness of:

- All risk and control related disclosure statements (in particular the Annual Governance Statement), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board
- The underlying assurance processes that indicate the degree of achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements
- The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certification
- The policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the Counter Fraud and Security Management Service
- The procedures for detecting fraud and whistle blowing (HDFT's Whistle Blowing Policy) and ensure that arrangements are in place by which staff may, in confidence, raise concerns about possible improprieties in matters of financial reporting, financial control or any other matters.

In carrying out this work the Committee will primarily utilise the work of internal audit, external audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate,

concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

This will be evidenced through the Committee's use of an effective Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

Internal Audit

The Committee shall ensure that there is an effective internal audit function that meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board. This will be achieved by:

- Consideration of the provision of the internal audit service, the cost of the audit and any questions of resignation and dismissal
- Review and approval of the internal audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework
- Considering the major findings of internal audit work (and management's response), and ensuring co-ordination between the internal and external auditors to optimise audit resources
- Ensuring that the internal audit function is independent; adequately resourced and has appropriate standing within the organisation
- Annual review of the quality and effectiveness of internal audit.

External Audit

The Committee shall review the work and findings of the external auditors appointed by the Council of Governors and consider the implications and management's responses to their work. This will be achieved by:

- Consideration of the appointment and performance of the external auditors, and reporting annually to the Council of Governors by way of an evaluation of the external auditors' performance and whether they should be reappointed
- Recommendation of the audit fee to the Board (and Governors if a new appointment) and pre-approve any fees in respect of non-audit services provided by the external auditors and to ensure that the provision of non-audit services does not impair the independence or objectivity of the external auditor
- Discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the annual plan, and ensuring co-ordination, as appropriate, with other external auditors in the local health economy
- Discussion with the external auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee
- Review of all external audit reports, including the report to those charged with governance, agreement of the annual audit letter before submission to the Board and any work undertaken outside the annual audit plan, together with the appropriateness of management responses
- Annual review of the quality and effectiveness of external audit.

The External Auditor or Head of Internal Audit may, at any time, request a meeting if they consider it necessary.

Clinical Assurance

The Audit Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications for the governance of the organisation.

These will include, but will not be limited to, any reviews by Department of Health Arms Length Bodies or Regulators/Inspectors (for example, the Care Quality Commission, NHS Litigation Authority, etc.) and professional bodies with responsibility for the performance of staff or functions (for example, Royal Colleges, accreditation bodies, etc.)

The Quality Committee will provide assurance from the clinical audit function. The Audit Committee will review the work of the Quality Committee by receiving minutes, and exception reports from the non-executive director who is a member of both committees. In addition, the Deputy Director of Governance also attends both committees.

The Audit Committee will receive minutes and regular reports from the Corporate Risk Review Group.

Counter Fraud

The Committee shall satisfy itself that the organisation has adequate arrangements in place for countering fraud and shall review the outcomes of counter fraud work and receive the counter fraud annual report.

Security Management Service

The Committee shall satisfy itself that the organisation has adequate arrangements in place for Security Management Services and that the Committee will receive from the Local Security Management Specialist an annual report on its activities and plan for the following year.

Management

The Committee shall request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

The Committee may also request specific reports from individual functions within the organisation (for example, clinical audit) as they may be appropriate to the overall arrangements.

Financial Reporting

The Audit Committee shall monitor the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance.

The Committee should ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.

The Audit Committee shall review the annual report and financial statements before submission to the Board, focusing particularly on:

- The wording in the Annual Governance Statement and other disclosures relevant to the terms of reference of the Committee
- Changes in, and compliance with, accounting policies, practices and estimation techniques
- Unadjusted miss-statements in the financial statements
- Significant judgements in preparation of the financial statements
- Significant adjustments resulting from the audit
- Schedule of losses and special payments
- Letter of representation
- Qualitative aspects of financial reporting
- The going concern assumption
- The extent to which the financial statements are affected by any unusual transactions in the year and how they are disclosed
- Any reservations and disagreements between the external auditors and management which had not been satisfactorily resolved.

Standing Orders, Standing Financial Instructions and Standards of Business Conduct

The Committee will review, on behalf of the Board, the operation of and proposed changes to the Standing Orders, Standing Financial Instructions, and HDFT's Code of Business Conduct, including Staff Registers of Interest.

Quality Account

The Quality Committee will approve the Quality Account and present it to the Audit Committee. The Audit Committee will review the Quality Account and submit it to the Board.

Other Matters

The minutes of Audit Committee meetings shall be formally recorded by the Secretary and submitted to the Board. The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure to the full Board, or require executive action.

The Committee will report to the Board at least annually on its work in support of the Annual Governance Statement, specifically commenting on the fitness for purpose of the Assurance Framework, the completeness and 'embeddedness' of risk management in the organisation, the integration of governance arrangements and the appropriateness of the self-assessment against external regulations including the Care Quality Commission.

The Committee shall also:

- Review third party assurances (both clinical and relating to financial management)
- Review Post Project Evaluations and Single Tender Actions
- Receive an annual report on procurement activity and savings
- Review the Treasury Management Policy, on behalf of the Board, and receive the annual report on treasury activity.

The Committee shall be supported administratively by the Secretary, whose duties in this respect will include:

- Agreement of agenda with Chair and attendees and collation of papers
- Taking the minutes
- Keeping a record of matters arising and issues to be carried forward
- Advising the Committee on pertinent areas

Where disagreements between the Audit Committee and the Board cannot be resolved, the Audit Committee shall report the issue to the Governors. If the issue still cannot be resolved the Audit Committee shall report the issue as part of the report on its activities in the Annual report and Financial Statements.

As agreed with the Governors, the Audit Committee Chairman shall be available to attend the AGM and shall answer questions through the Chairman of the Board of Governors on the Audit Committee's activities and responsibilities.

Review

These Terms of Reference will be reviewed annually, in conjunction with a review of the effectiveness of the Committee.

January 2017

Harrogate and District NHS
NHS Foundation Trust

Board Committee report to the Board of Directors

Committee Name:	Finance Committee
Committee Chair:	Maureen Taylor
Date of last meeting:	19th December 2016
Date of Board meeting for which this report is prepared	25th January 2017

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

1. The financial position at month 8 shows a surplus of £37k, excluding S&T funding which is £1,184k behind plan. Two quarters of S&T funding have been received and this has resulted in an overall surplus of £2,337k for the Trust. S&T funding for quarter 3 has not been assumed at this stage.
2. There is an underlying adverse income variation to date of £2,363k and a favourable expenditure variance to date of £748K. There continues to be pressure on staffing costs.
3. The new single oversight framework introduced from November shows a use of resources rating of 1, which is the highest rating.
4. Cash at the end of September was £1.14m, compared to the re-profiled cash plan of £7.75m. Cash flow management will become difficult if HaRD CCG is unable to pay for activity.
5. 2015/16 Reference Costs reporting is positive with the Trust comparing favourably with the national position at 96%.
6. The Carter Review dashboard includes some valuable data and when populated further will highlight areas where efficiency work can be focussed.
7. A Business Development update was received. Noted specifically the areas for collaboration agreed with Leeds Teaching Hospital Trust.
8. The Operational Plan 2017/18 - 2018/19 was considered in detail and commissioning and activity levels discussed. The challenges associated with the contract negotiation were acknowledged. The plan to be considered for approval at the Extraordinary Board meeting on 21st December2016.

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

- Cash Management and collection of sums due through to year end.
- Agreeing the contract with HaRD CCG for the next two years.

Matters for decision

None

Action Required by Board of Directors:
None

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Terms of Reference

Finance Committee

1. **Accountable to:** Board of Directors

2. **Purpose of the group**

The Finance Committee is a committee of the Board of Directors of Harrogate and District NHS Foundation Trust, with oversight of the development and delivery of the financial plan of the organization.

3. **Responsibilities**

The key responsibilities of the group are:

- To scrutinise the development of the Trust's financial and commercial strategy, both revenue and capital.
- To scrutinise the assumptions and methodology used in developing the financial strategy, including activity modelling and efficiency assumptions.
- To recommend to the Board the financial plan for submission to Monitor/NHS Improvement.
- To scrutinise and ensure appropriate due diligence is undertaken in relation to any significant transactions as defined by Monitor / NHS Improvement
- To scrutinise the annual Cost improvement Programme and review the impact on the Trust.
- To ensure that annual financial plan is consistent with financial strategy.
- To scrutinise the Trust budget prior to approval by the Board.
- To review the capital programme in line with the financial plan.
- To review the activity plans in line with the financial planning assumptions.
- To review quarterly financial performance before submission to Monitor / NHS Improvement
- To assess the impact of financial performance on the Financial Services Risk Rating
- Oversee implementation of service line reporting

- To review service line information, profitability of service lines and the impact of activity delivery on financial performance

- To undertake any relevant matter as requested by the Board of Directors

4. Audit Committee

The Audit Committee will maintain full oversight of the Annual Accounts process and also Treasury Management policy, as well as areas such as SFIs which are part of the Trust's system of control.

5. Membership

The core membership comprises:

Title	Deputy	Attendance
Mrs Maureen Taylor, Non-Executive Director (Chair)	n/a	Full
Mr Ian Ward, Non-Executive Director		Full
Mr Chris Thompson, Non-Executive Director		Observer
Mrs Lesley Webster, Non-Executive Director		Full
Mr Jonathan Coulter, Director of Finance		Full
Mr Robert Harrison, Chief Operating Officer		Full
Mr Paul Nicholas, Deputy Director of Performance and Informatics		Full
Mr Jordan McKie, Deputy Director of Finance		Full
Mrs Catherine Gibson – Corporate PA (Admin support)		Full

Ad hoc attendance may be by invitation of the Chair.

6. Quorum

Quorum will be 3 members of the Committee, with at least 2 Non-Executive and 1 Executive Director at each meeting.

7. Administrative support

Admin support will be provided by Mrs Catherine Gibson, Corporate PA

8. Frequency of meetings

The Committee will meet 6 times per year.

For 2016/17 these meetings will be in April, June, September, October, December and February.

Additional meetings may be scheduled if necessary and agreed by the Chair of the Committee.

Minutes will be reported to the Board of Directors and copied to the Audit Committee.

9. Date

January 2017

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