Board of Directors Meeting (Public)
will be held on Wednesday 24th November 2021 from 9.00am – 1.00pm
at the Pavilions, Great Yorkshire Show Ground,
Harrogate North Yorkshire, HG2 8QZ

AGENDA

Item No.	Item	Lead	Action	Paper	Time
SECTION 1: Opening Remarks and Matters Arising					
1.1	**Welcome and Apologies for Absence**	Chairman	Note	Verbal	9.00
1.2	**Patient Story**	Deputy Director of Nursing	Note/ Discuss	Verbal	
1.3	**Declarations of Interest and Register of Interests** *To declare any new interests and any interests in relation to open items on the agenda*	Chairman	Note	**Attached**	
1.4	**Minutes of the Previous Board of Directors meeting held on 29th September 2021**	Chairman	**Approve**	**Attached**	
1.5	**Matters Arising and Action Log**	Chairman	Discuss/ Note/ Approve	**Attached**	
1.6	**Overview by the Chairman**	Chairman	Discuss/ Note	Verbal	9.30
SECTION 2: CEO Updates					
2.1	**Chief Executive Report**	Chief Executive	Discuss/ Note	**Attached**	9.40
2.2	**Corporate Risk Register**	Chief Executive	Discuss/ Note	**Attached**	
SECTION 3: Patients and Service Users (Quality and Safety)					
3.1	**Quality Committee Chair's Report**	Quality Committee Chair	Note	**Attached**	9.50
3.2	**Integrated Board Report –** Indicators from Safe, Caring and Effective domains	Executive Directors	Note/ Discuss	**Attached**	
3.3a	**Director of Nursing Report**	Director of Nursing, Midwifery and AHPs	Note/ Approve	**Attached**	10.00
3.3b	**Safeguarding Annual Report**		Discuss / Note	**Attached**	10.10
3.3c	**Strengthening Maternity and Neonatal Safety**		Note	**Attached**	10.20
3.3d	**Safer Nursing Care Tool Report**		Discuss/ Note	**Attached**	

3.4a	**Medical Director Report**	Executive Medical Director	Note	**Attached**	10.40
3.4b	**Learning from Deaths Quarterly Report – Quarter 2 2021-22**		Note	**Attached**	10.45
3.4c	**Infection Prevention and Control Annual Report**		Note	**Attached**	10.55
Comfort Break (11.00 – 11.15)					
SECTION 4: People and Culture					
4.1	**People and Culture Committee Chair's Report**	People and Culture Committee Chair	Note	**Attached**	11.15
4.2	**Integrated Board Report –** Indicators from Workforce domain	Executive Directors	Note/ Discuss	**Attached**	
4.3	**Workforce Report**	Director of Workforce and Organisational Development	Note/ Approve	**Attached**	
SECTION 5: Strategy & Partnerships					
Board Reports					
5.1	**Board Assurance Framework**	Chairman	Note	**Attached**	12.00
5.2a	**Director of Strategy Report**	Director of Strategy	Note	**Attached**	
5.2b	**Development of the Trust and Clinical Strategy**	Director of Strategy	Note	**Attached**	
5.3	**H2 Strategy**	Director of Finance	Note	**Attached**	
SECTION 6: Use of Resources and Operational Performance					
6.1	**Resource Committee Chair's Report**	Resource Committee Chair	Note/ Discuss	**Verbal** *(timing of meeting)*	12.15
6.2	**Integrated Board Report –** Indicators from Responsive, Efficiency, Finance and Activity Domains	Executive Directors	Note	**Attached**	
6.3	**Director of Finance Report**	Deputy Chief Executive / Finance Director	Note/ Approve	**Attached**	
6.4	**Chief Operating Officer's Report**	Chief Operating Officer	Note/ Approve	**Attached**	
6.5	**Organisational Development Report**	Director of Workforce and Organisational Development	Note	**Attached**	

SECTION 7: Governance Arrangements					
7.1	**Audit Committee Chair's Report (not met in time period)**	Committee Chair	Note	**Note**	12.30
7.2a	**Senior Management Team Report October 2021**	Senior Management Team Chair	Note	**Attached**	
7.2b	**Senior Management Team Report November 2021**		Note	**Attached**	
7.3	**2021-22 Board Workplan**	Chairman	Note	**Attached**	
7.4	**Treasury Management Policy**	Director of Finance	Approve	**Attached**	
7.5	**0-19 Task and Finish Group**	Chairman	Approve	**Attached**	
8.0	**Any Other Business** *By permission of the Chairman*	Chairman	Note/ Discuss/ Approve	Verbal	12.45
9.0	**Board Evaluation**	Chairman	Discuss	Verbal	12.55
10.0	**Date and Time of next meeting** Wednesday, 26th January 2022				

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.

NHS
Harrogate and District
NHS Foundation Trust

Board of Directors Register of Interest
As at 24th November 2021

Board Member	Position	Relevant Dates From	To	Declaration Details
Angela Schofield	Chairman	2018	Date	1. Member of WYAAT Committee in Common 2. Vice-Chair, West Yorkshire and Harrogate ICS Partnership 3. Member of the Yorkshire & Humber NHS Chairs' Network 4. Volunteer with Supporting Older People (charity). 5. Member of Humber Coast and Vale ICS Partnership
Jacqueline Andrews	Medical Director	June 2020	Date	Familial relationship with managing partner of Priory Medical Group, York
Sarah Armstrong	Non-executive Director	October 2018	Date	1. Director of Harrogate Healthcare Facilities Management Limited t/a Harrogate Integrated Facilities (a wholly owned subsidiary company of Harrogate and District NHS Foundation Trust) 2. Company director for the flat management company of current residence 3. Chief Executive of the Ewing Foundation
Jonathan Coulter	Deputy Chief Executive/ Finance Director	November 2017	Date	(Interim Chief Executive) Director of Harrogate Healthcare Facilities Management Limited t/a Harrogate Integrated Facilities (a wholly owned subsidiary company of Harrogate and District NHS Foundation Trust)
Jeremy Cross	Non-executive Director	January 2020	Date	1. Chairman, Mansfield Building Society 2. Chairman, Headrow Money Line Ltd (ended September 2021) 3. Director and Shareholder, Cross Consulting Ltd (dormant) 4. Chairman – Forget Me Not Children's hospice, Huddersfield 5. Governor – Grammar School at Leeds 6. Director, GSAL Transport Ltd 7. Member - Kirby Overblow Parish Council
Jill Foster	Chief Nurse	July 2020	April 2021	Director of Harrogate Healthcare Facilities Management Limited t/a Harrogate Integrated Facilities (a wholly owned subsidiary company of Harrogate and District NHS Foundation Trust)
Tim Gold	Interim Chief Operating Officer	August 2020	March 2021	Seconded from Bradford Teaching Hospitals NHS Foundation Trust post of Director of Operations
Matt Graham	Director of Strategy	September 2021		Governor (Chair of Finance & Premises Committee) – Malton School
Dr Kat Johnson	Clinical Director (Planned and Surgical Care)	No interests declared		
Dr Natalie Lyth	Clinical Director (Children's and County Wide Community Care)			1. Member of North Yorkshire Local Safeguarding Children's Board and sub-committees. 2. Chair of the Safeguarding Practice Review Group. 3. Chair of the North Yorkshire and York Looked After Children Health Professionals Network. 4. Member of the North Yorkshire and York Safeguarding Health Professionals Network. 5. Member of the national network of Designated Health Professionals. 6. Member of the Royal College of Paediatrics and Child Health Certificate of Eligibility of Specialist Registration (CESR) Committee and assessor of applications for CESR.
Emma Nunez	Director of Nursing	April 2021	Date	No interests declared.
Andrew Papworth	Non-executive Director	March 2020	Date	Director of People Insight and Cost at Lloyds Banking Group
Laura Robson	Non-executive Director	September 2017	Date	Familial relationship with Alzheimer's Society
Steve Russell	Chief Executive	March 2020	Date	1. Chief Executive of NHS Nightingale Hospital Yorkshire and Humber (ended July 2021) 2. Member of NHS England and Improvement North East and Yorkshire Regional People Board

				3. Lead Chief Executive for Workforce in Humber Coast and Vale ICS 4. Co-Chair of WY&H Planned Care Alliance 5. Chair of Non-Surgical Oncology Steering Group 6. NHS Employers Policy Board Member (September 2020 and ongoing) 7. Chair of Humber Coast and Vale ICS BAME Network (August 2020 and ongoing) 8. Joint SRO for planned care West Yorkshire and Harrogate ICS (June 2020 and ongoing)

Board Member	Position	Relevant Dates From	To	Declaration Details
Wallace Sampson OBE	Non-executive Director	March 2020	Date	1. Chief Executive of Harrogate Borough Council 2. Director of Bracewell Homes – wholly owned Harrogate Borough Council housing company. 3. Chair of Harrogate Public Services Leadership Board 4. Member of North Yorkshire Safeguarding Children Partnership Executive 5. Member of Society of Local Authority Chief Executives 6. Director of Brimhams Active - wholly owned Harrogate Borough Council leisure company.
Mrs Laura Angus	NExT Non-executive Director	January 2021	Date	1. Strategic Lead Pharmacist/Head of Prescribing, NHS Vale of York CCG 2. Chair of York and Scarborough Medicines Commissioning Committee 3. Interim Chief Pharmacist at Humber, Coast and Vale ICS 4. MTech Associate; Council Member PrescQIPP 5. Chair of Governors at Kirby Hill Church of England Primary School
Dr Matthew Shepherd	Clinical Director (Long Term & Unscheduled Care)	April 2017	Date	Director of Shepherd Property Ltd
Richard Stiff	Non-executive Director	May 2018	Date	1. Director of (and 50% owner) Richard Stiff Consulting Limited 2. Director of NCER CIC (Chair of the Board from April 2019) 3. Director and Trustee of TCV (The Conservation Volunteers) 4. Chair of the Corporation of Selby College 5. Member of the Association of Directors of Children's Services 6. Member of Society of Local Authority Chief Executives 7. Local Government Information Unit Associate 8. Local Government Information Unit (Scotland) Associate 9. Fellow of the Royal Society of Arts
Maureen Taylor	Non-executive Director			No interests declared
Angela Wilkinson	Director of Workforce and Organisational Development	October 2019	Date	Director of ILS and IPS Pathology Joint Venture

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

Name	Position	Declaration Details
Dr Dave Earl	Deputy Medical Director	1. Director of Earlmed Ltd, provider of private anaesthetic services 2. Treasurer of Harrogate Anaesthesia Services, administration and co-ordination of Anaesthetic Private Practice
Jordan McKie	Deputy Director of Finance	No interests declared
Paul Nicholas	Deputy Director of Performance and Informatics	No interests declared
Shirley Silvester	Deputy Director of Workforce and Organisational Development	No interests declared
Lynn Hughes	Interim Company Secretary (until June 2021)	Familial relationship with KLS Martin Ltd, a company providing services to the NHS
Kate Southgate	Company Secretary (from June 2021)	No interests declared

Harrogate and District
NHS Foundation Trust

Board of Directors Meeting
Wednesday, 29th September 2021 from 9.00am – 1.00pm
at the Pavilions, Great Yorkshire Show Ground,
Harrogate North Yorkshire, HG2 8QZ

Present
Angela Schofield, Chairman
Sarah Armstrong, Non-executive Director
Andy Papworth, Non-executive Director
Laura Robson, Non-executive Director/Senior Independent Director
Wallace Sampson OBE, Non-executive Director
Richard Stiff, Non-executive Director
Maureen Taylor, Non-executive Director
Steve Russell, Chief Executive
Jacqueline Andrews, Executive Medical Director
Jonathan Coulter, Finance Director/Deputy Chief Executive
Emma Nunez, Executive Director of Nursing, Midwifery and Allied Health Professionals
Matthew Graham, Director of Strategy
Angela Wilkinson, Director of Workforce and Organisational Development

In attendance
Laura Angus, NExT Non-Executive Director
Kat Johnson, Clinical Director for Planned and Surgical Care Directorate
Natalie Lyth, Clinical Director for Community and Children's Directorate
Matt Shepherd, Deputy Chief Operating Officer/Clinical Director for Long Term and Unscheduled Care Directorate
Kate Southgate, Company Secretary

Charly Gill, Freedom to Speak Up Guardian (in attendance for BD/9/21/12)
Matthew Milsom, Guardian of Safe Working (in attendance for BD/9/21/15)
Jayne Upperton, Named Nurse for Adult Safeguarding for patient story (in attendance for BD/9/21/2)

Observing
One member of the public Mr Wailes, Doug Masteron, Governor
Sarah Quinn, Chief Registrar

Item No.	Item
BD/9/21/1	**Welcome and Apologies for Absence**
1.1	The Chairman welcomed everyone to the meeting.
1.2	Apologies for absence were noted from Russell Nightingale, Chief Operating Officer.
BD/9/21/2	**Patient Story**
2.1	Jayne Upperton, Named Nurse for Adult Safeguarding, attended the meeting to share a patient story. It was noted that this was in relation to a patient that struggled with alcohol misuse and who had subsequently died. A safeguarding adult review was launched to review the care and treatment of the patient across multiple discipline and care settings.
2.2	The individual was 41 years old and was found to have died in a flat with a diagnosis of acute fatty liver. They had periods of homelessness and self-neglect. They had paid

privately for detoxification but this had been unsuccessful. They had moved around the UK, their relationship with their wife had broken down, and they no longer had access to see their daughter following a court order. They were described by a family member as a kind person, who helped others in need.

2.3 There had been missed opportunities to raise a safeguarding concern for this patient. They had 22 attendances and 11 admissions in a short period of time and had also attended another NHS Trust over the same time period of 6 months. When presenting they were often under the influence of alcohol and unresponsive. They would often leave the Emergency Department (ED) before onward referrals were made

2.4 At the beginning of February 2020 they presented at the Trust for the last time. If a safeguarding referral had been raised, then a multi-agency self-neglect assessment would had been completed and potentially a best interest review would have been undertaken. This may not have changed the outcome for the patient, it was however a missed opportunity.

2.5 Learning was noted from the case, whereby the Trust needed to continue to identify patients in a holistic capacity and see past the challenges of individuals. In order to move forward with this, HDFT had appointed new post to the Safeguarding Team that will support and forge strong relationships across multi-disciplinary teams internally and externally.

2.6 It was noted that this patients story had been a source of learning across the Trust and now formed part of face to face safeguarding training packages delivered trust-wide.

2.7 To conclude the patient story, a poignant poem was shared, that had been written by the patient about the relationship they had with alcohol.

2.8 The Chairman gave thanks to the Jayne Upperton for sharing the moving and emotional story.

2.9 Richard Stiff noted that there were wider systemic issues and that it was very challenging in public services to instigate a system wider approach to such complex cases and issues.

2.10 Andy Papworth noted the need for partnership services to use data to identify themes and patterns.

2.11 Matt Shepherd noted that HDFT had monthly meetings to review frequent attenders to the ED to discuss cases and care plans. This had been paused during the pandemic but would now be reinstated

2.12 Sarah Armstrong agreed that it was very important to share the story with the Board. Sarah queried if charities had been involved with the patient. It was confirmed by the Named Nurse that charities had been involved including the local Homeless Charity. Sarah offered to share further contact details with the Named Nurse of charity consortiums who could provide assistance in the future.

2.13 **Resolved:** the patient story was noted.

Jayne Upperton, Named Nurse for adult safeguarding left the meeting.

2.14 The Chairman welcomed Mr Wailes to the meeting who was attending to share his experiences.

2.15	Mr Wailes noted that his wife had a brain haemorrhage in March 2019. She had then been an inpatient in HDFT for two and a half months. On discharge, Mr Wailes praised the care received from the community teams.
2.16	Mr Wailes explained that his wife now required the use of a wheelchair. They had attended HDFT on several occasions for appointments. As disabled parking was limited he often parked on the upper level of the car park where spaces were larger. They had experienced difficulties entering the building as the doors were heavy and not automatic on the upper levels. This had led to difficulties with getting into the building.
2.17	Mr Wailes explained that he had raised this previously.
2.18	The Chairman thanked Mr Wailes for sharing his story and apologised that he had not received a satisfactory response previously.
2.19	Jonathan Coulter, Deputy Chief Executive, (also Interim Chief Executive for Harrogate Integrated Facilities) thanked Mr Wailes and also expressed his apologies for the experience he had had. He confirmed that he had visited the car park to review the situation. He had spoken to the relevant team and an automatic mechanism would be installed as soon as possible. He also confirmed that a review would be undertaken on the number of disabled access spaces available in the car park. Apologies were expressed that the previous response had not be satisfactory and the Deputy Chief Executive agreed that the message about walking in someone else’s shoes was very important.
2.20	Sarah Armstrong thanked Mr Wailes for sharing his story and confirmed that charities and Healthwatch can road test new facilities for access requirements.
2.21	**Resolved:** the patient story was noted.
BD/9/21/3	**Declarations of Interest and Register of Interests**
3.1	The register of interests was received and noted.
3.2	It was noted that Jonathan Coulter is Interim Chief Executive of HIF. Sarah Armstrong is a Director of Harrogate Integrated Facilities (HIF). Wallace Sampson is Chief Executive of Harrogate Borough Council, Emma Nunez is seconded from NHS Improvement and England (NHSE/I) and Angela Wilkinson and Russell Nightingale are Directors of the ILS and IPS Pathology Joint Venture.
3.3	**Resolved:** the declarations were noted.
BD/9/21/4	**Minutes of the Previous Board of Directors meeting held on 28th July 2021**
4.1	A correction was noted at minute 14.2. It was noted that the minutes should read *Andy Papworth highlighted the risks in relation to staffing and the funding arrangements* ***if*** *the resources provided are lower than the estimated requirement.*
4.2	**Resolved:** the minutes of the last meeting held on 28th July 2021 were agreed as an accurate record subject to the change noted above.
BD/9/21/5	**Matters Arising and Action Log**
5.1	One matter arising was noted from the previous meeting that was not noted on the action tracker or included on the agenda. It was confirmed that following the anonymous email in July 2021, a report had been submitted to NHSEI.

5.2 The following updates were noted

5.3 BoD/05/21/8/2 – Modern Day Slavery Declaration. It was noted that safeguarding training had been reviewed and updated. Level 3 training has modern slavering training included. The Board undertaken Level 1 training and can access Level 3 if they wish. It was agreed to close the action

BoD/7/21/7/7.8 CQC Inspection Regime – it was confirmed that the CQC Inspection Framework had been added to the Board Workshop for December 2021. It was agreed to close the action.

BoD/7/21/9/9.2 Interpreting IBR charts. It was confirmed that the NHSIE Making Data Count Team would attend the February 2022 Board Workshop. It was agreed to close the action.

BoD/7/21/11/11.5 Safe staffing. It was confirmed that this would be a Board report in November 2021 rather than a board workshop. To remain on the tracker until delivered in November 2021.

BoD/7/21/22/22.6 Avoidable admissions. It was confirmed that information was included in the IBR, however, further information would be brought to the November 2021 Board. Laura Robson queried if there were any links between avoidable admission in children and the increase in ED attendances. The Deputy Chief Operating Officer noted that undertaking extended observations on children who attend the ED is very important. Some organisation have an area of the Emergency Department where they can undertake extended observations for 6 – 12 hours. HDFT do not have this due to size so a 6-hour observation takes place on the ward and is recorded as an admission.

BoD/7/21/22/22.5 RTT. It was confirmed that an updated report had been circulated to Board members. It was agreed that this action be closed.

BoD/01/21/15.4 Medical appraisals. The Company Secretary noted that this action had been missed out of the pack of information. The Executive Medical Director confirmed that 64% of medical appraisal had been completed in last 12 months. 29% had been approved to miss appraisal (due to eg. maternity, sickness, NHSE/BMA agreed relaxation of appraisal cycles during COVID), 2% had suspended appraisals due to ongoing formal processes and 5% had no appraisal in last 12 months. It was noted that all were being actively managed within medical staffing SOP for missed appraisals. It was agreed that this action could be closed.

5.4 A further action was noted for the December Board Workshop whereby partners from North Yorkshire and Harrogate would be invited to discuss the area as a PLACE.

5.5 **Resolved:** sufficient assurance was received to update and / or close actions as detailed.

BD/9/21/6 **Overview by the Chairman**

6.1 The Chairman extended a warm welcome to Matt Graham, new Director of Strategy for HDFT.

6.2 The Chairman noted that on Friday 1st October 2021, the Northumberland 0-19 team would formally become part of HDFT. The welcome events had been well received and thanks were expressed to all involved in the transition.

6.3 The Chairman noted that new governors had joined the Council following the Summer elections as well as new stakeholder governors.

6.4	Thanks were expressed to all involved in the organisation and production of the Annual Members Meeting in September 2021.
6.5	It was noted that in October 2021 two important topics were being focused on nationally, Black History Month and Speak Up.
6.6	Confirmation was given that the ICS were in the process of appointing senior leaders, including a Chairman and Chief Executive.
6.7	The vaccination in school's programme for 12-15 year olds had commenced. The Clinical Director for Community and Children's Directorate confirmed that this had been a team effort with the first session running smoothly. It was noted that this would be a challenging programme with lessons being learnt and implemented for future sessions. In addition, it was noted that the Covid-19 booster vaccination programme had commenced.
6.8	The Chairman confirmed that she had issued her notice of retirement. The process was in train for recruitment of the new Chairman.
6.9	There had been continued work on the Board agenda structure with the IBR distributed throughout the agenda for ease of reference.
6.10	The October Board Workshop would be held in Morpeth 10am – 4pm with a general focus on 0-19 services.
6.11	The Chairman noted that it was a challenging time for all, with a high degree of uncertainty moving into the winter months. It was confirmed that this was recognised by the Board and the Board offered their full support to all teams across HDFT and the wider health and social care community.
6.12	**Resolved:** The Chairman's report was noted.
BD/9/21/7	**Chief Executive Report**
7.1	The Chief Executive noted the contents of his report as read and highlighted a number of key points.
7.2	The next few months would be a time of high activity as well as uncertainty as we move into autumn and winter. It was clear that this would bring challenges for all.
7.3	Since the Board last met, there had been a significant announcement in respect of NHS and social care funding, and the priorities for this additional funding. Recovery of elective waiting times as a major priority now has significant financial support, and there are significant expectations about delivery of reduced waiting times.
7.4	This is however, set against significant challenges in terms of staffing HDFT needs to consider measures to boost supply which will take effect in 2-3 years' time as well as other pathway transformation and collaborative working to meet the expectation of a 10% increase in activity in each year. 104 week waits will need to be eliminated by March 2022 and 52 week waits will need to be back to pre-pandemic levels for September 2022. The organisation is awaiting planning guidance on this.
7.5	The Chief Executive reiterated the comments made by the Chairman in relation to progress being made with the transfer of the 0-19 Northumberland Team.
7.6	The Senior Management Team had a very significant workshop session in September on leading the Becoming and Anti-Racist organisation work.

7.7 The headline financial allocations for the second half of the year (H2) had been confirmed but the local allocations and planning guidance had not yet been published. The Trust is continuing to plan for a 3% reduction in spend, and are working to the end of September 2021 to finalise the internal plan.

7.8 The financial framework for 2022/23 was not yet known, however it was being signalled that there would be a move back towards a ‘needs based allocation’ rather than a ‘cost based allocation’.

7.9 Significant challenges in social care staffing and care packages were highlighted HDFT were reviewing how any mutual aid or support could be provided. It was important to note, that as an organisation, HDFT place as much priority on those who need care in their own homes as those in hospital and to act as a strong system partner.

7.10 Sarah Armstrong noted that this was a sobering moment heading into winter. She noted the target for vaccinating 12-15 year olds was 100% and how challenging this would be. She also noted a positive experience of a family member who had attended the ED recently.

7.11 Jeremy Cross queried with more capital made available, were the organisation confident that our priorities were in the correct place. The Chief Executive confirmed that it had been discussed at the recent Resources Committee. It was confirmed that a review of schemes currently in place was being undertaken by the executive team later in the week. Maureen Taylor as Chair of the Resources Committee confirmed that a review of the large capital schemes was underway and that this had been discussed at the Committee. She noted that whilst HDFT did not want to change priorities, an assessment of the options available was paramount to determine the most effective approach the situation

7.12 Andy Papworth noted the significant amount of work that was being progressed across the organisation. He confirmed that it was productive to have the funding required, however the challenge would be having the people to deliver key elements of work. He queried if there was anything further the Board could do to support. The Chief Executive confirmed that it was important to have the funding, but recruitment and retention could be a challenge in the current market. HDFTs top priority needed to be supporting the social care sector moving into winter.

7.13 **Resolved:** The Chief Executive’s Report was noted.

BD/7/21/8 **Corporate Risk Register**

8.1 The Chief Executive outlined the changes made to the Corporate Risk Register since the last meeting, including the mitigation of risks. The following risks were discussed in greater detail:

8.2 The Health and Safety Risk was noted as a long standing issue. The recruitment process for a Health and Safety Manager had commenced and the team were working with partner organisations to ensure an additional layer of support.

8.3 Richard Stiff confirmed that the Audit Committee had discussed the new process and agreed that this was a much more robust process than previously in place.

8.4 Laura Robson queried the Mental Health risk and asked if the 12 hour waits for mental health support were classed as 12 hour breaches. The Deputy Chief Operating Officer confirmed that they were not, however it was not the experience we want our patients to have. The issue was being reviewed through the A&E Delivery Board as HDFT did not have the ability to resolve the wider issue without the input of partner organisations.

8.5 Andy Papworth confirmed his assurance on the rigour around the RTT process

8.6 **Resolved:** the updates were noted.

BD/9/21/9 **Quality Committee Chair Report**

9.1 Laura Robson as Chair of the Quality Committee presented her report as read and highlighted a number of key issues.

9.2 The Medical Director had highlighted the current shortage of blood bottles and the potential impact. Action had been taken and usage had reduced by 25% which was noted as a considerable achievement. Work was ongoing regarding the sustainability of this position.

9.3 The Medical Director also updated the committee with regard to Glaucoma patients, waiting for follow up. It was estimated that it would take 12 months to clear the backlog but the team were working on a range of measures to see approximately 120 patients per week. The Committee noted their concern about the potential impact this may have on patients and their treatment. The Committee were assured that the patients were prioritised, with high risk patients seen as soon as possible.

9.4 The Clinical Director for Planned and Surgical Care Directorate confirmed that there were 2,500 glaucoma patients and assured the Board that all had been risk assessed. The Directorate were closely monitoring the situation and have a 12 month recovery programme in place including a virtual Glaucoma clinic. The issue would be monitored through Quality Governance Management Group (QGMG) and escalated to Quality Committee for assurance.

9.5 The 12-15 Vaccination programme was discussed at the Committee in relation to consenting of patients as well as the potential risk of duplication of vaccinating a child twice. The Clinical Director for Community and Children's Directorate confirmed that there was a national issue in relation to consent. E-consent from parents was in place, at the appointment itself the patient themselves could withdraw their consent and they would then not receive the vaccination. Gillick competency would be assessed for a child and a discussion would occur between the child and the parent if they had differing views on receiving the vaccine to try to facilitate an agreement. Further work was required for situations where a child wished to be vaccinated, when their parent / guardian would not consent. In terms of the potential for a child to have a duplicated vaccination, measures had been put in place to mitigate the risk including a live system to record who had been vaccinated.

9.6 The Committee had discussed inviting a governor to the Making Experience Count meeting and had sought the Board's view of this. The Chairman confirmed that this would sit outside of a governors remit and it would be more appropriate to seek patient representation.

9.7 **Resolved:** The Board noted the content of the report**.**

BD/9/21/10 **Integrated Board Report**

10.1 The IBR Indicators linked to Quality were noted.

10.2 Laura Robson noted that some indicators were not completed with data yet. The Deputy Chief Executive / Director of Finance agreed to circulate the timeline for all indicators to have data.

10.3 **Action:** Deputy Chief Executive / Director of Finance to circulate to Board members a timeline for including all data metrics in the IBR.

10.4 Jeremy Cross noted the safer staffing numbers. It was confirmed that these would be discussed as part of the Director of Nursing report.

10.5 Jeremy Cross queried the metrics used for the re-admissions to the same speciality.

10.6 **Action:** Deputy Chief Executive / Director of Finance to review the metrics for re-admissions

10.7 Wallace Sampson noted the complaints indicators. It was confirmed that this would be discussed as part of the Director of Nursing report.

10.8 Richard Stiff noted the friends and family test and queried why this was red when the Trust was meeting its target. The Executive Director of Nursing noted that it was due to how the Trust compared at a national level.

10.9 **Resolved:** The Board noted the content of the report**.**

BD/9/21/11 **Director of Nursing Report**

11.1 The Director of Nursing, Midwifery and Allied Health Professionals noted her report as read and highlighted the following issues in relation to the indicators in the IBR.

11.2 Indicator 1.1 Pressure Ulcers (hospital acquired) had seen a slight improvement which was impacted on by the additional recruitment to the tissue viability team and the full introduction of quality panels.

11.3 Indicator 1.2 Pressure Ulcers (community acquired) had seen a slight increase which was being impacted on by social care workforce challenges.

11.4 Indicator 1.3 Inpatient falls was noted as continuing to see an increase in falls. Work was ongoing with thematic reviews and the implementation of the learning from these.

11.5 Indicator 1.7 Serious Incidents, was noted to have thematic reviews taking place. 1 new SI relating to Theatres (medication administration error) had been declared. The investigation was underway and the team were cognisant of two never events and a previous SI with similar themes. The Quality Matron was working with the theatre team to identify immediate actions.

11.6 Indicator 1.8.1 Safer Staffing had shown a significant decline in the fill rate. Nurse staffing gaps were noted across the hospital and community and increased enhanced care requests were being received. Theatre staffing gaps remain across ODPs and Scrub teams were being impacted by annual leave and sick leave. In terms of mitigation, the teams were utilising agencies and internal incentives.

11.7 In addition to the IBR it was noted that 12-15 years COVID vaccination programme would likely have a significant impact on school nursing teams and 0-19 services due to likely delivery timelines.

11.8 It was noted that the Perfect Ward procurement process was underway. Quality boards were in the final stages of being reviewed for non-ward areas and Directorate risk registers were being transitioned and updated onto Datix.

11.9 Wallace Sampson queried whether there was anything that could be done to proactively managing people's expectations on complaints. The Executive Director of Nursing noted that a combination of issues has led to this situation. Discharge complaints had highlighted a lack of communication. Complaints training has therefore increased across the trust to assist in dealing with issues immediately as well as the formal complaints route.

11.10	Sarah Armstrong noted that the culture of reporting was important and positive, but queried when the balance would tip to more incidents being a concern rather than a positive position of open reporting. The Executive Director of Nursing confirmed that this was a challenge nationally to understand the tipping point for organisations. HDFT now has a stronger reporting culture and assurance was given that this was the case and not that we were in a situation when the increase was worrying. In was noted that HDFT was still a low reporter of low harm incidents and that this was an area for improvement.
11.11	The Chairman noted that there was a high level of scrutiny of Serious Incidents in the board meeting held in private.
11.12	The Chairman queried the staffing situation and the impact of it. The Executive Director of Nursing confirmed that it was challenging situation but not unique to HDFT.
11.13	Laura Robson noted that theatres was a high risk area and there appeared to be staffing issues and an SI had been declared. The Chief Executive confirmed that this was a high risk environment and in the context of the increased challenges it was a heightened risk. The Executive Director of Nursing and the Chief Operating Officer were supporting the team proactively and were working with agency supply, as well as looking proactively at international recruitment. It was also confirmed that additional medical, nursing and operational leadership were to be implemented in the area. Maureen Taylor confirmed that Resource Committee were monitoring the situation.
11.4	**Resolved:** the report and updates against IBR were noted and assurance against progress was confirmed.
BD/9/21/12	**Freedom To Speak Up Report**
12.1	Charly Gill attended the meeting in her role as Interim Freedom to Speak Up (FTSU) Guardian to provide a quarterly report.
12.2	It was noted that Freedom to Speak Up e-learning had been developed nationally with Health Education England and was freely available to all. It was also noted that October would be Freedom To Speak Up month and the team would be working to promote their role.
12.3	It was confirmed that 6 contacts with the Freedom to Speak Up team had been made in the last quarter. This was an increase from the previous quarters. The key theme had been around communication issues.
12.4	Andy Papworth queried if there was adequate support for the Interim FTSU Guardian. She confirmed that there was and that she was working closely with HR colleagues and others as needed.
12.5	The Chairman confirmed that the Interim FTSU Guardian had the Board's full support and that support would be given for a FTSU training programme.
12.6	Laura Robson noted that of the 6 contacts none were medical staff. It was queried if they were using other routes. The Executive Medical Director noted that medics utilise different routes such as through the Guardian of Safe Working (GSW). It was confirmed that the FTSU and GSW would work closely together to triangulate information. The Executive Director of Nursing also confirmed that medics had been appointed to fairness champions which would also encourage colleagues to speak up when required.
12.7	The Board passed on their thanks and appreciation to the Interim Freedom to Speak Up Guardian.
12.8	**Resolved:** The Board noted the content of the report**.**

	Charly Gill, Interim Freedom to Speak Up Guardian left the meeting
BD/9/21/13	**Strengthening Maternity and Neonatal Safety**
13.1	The Executive Director of Nursing presented the report as read and noted the following.
13.2	As part of implementing a revised perinatal quality surveillance model the LMS were leading on the production of a local quality dashboard which brought together a range of sources of intelligence relevant to both maternity and neonatal services from provider trusts within the LMS.
13.3	Discussions were continuing within the West Yorkshire & Humber Local Maternity System about the content of maternity dashboards and the current variation between all six maternity units within the LMS.
13.4	In August, there was 1 new qualifying case for Perinatal Mortality Review Tool review.
13.5	**Resolved:** The Board noted the content of the report.
BD/9/21/14	**Medical Director's Report**
14.1	The Executive Medical Director introduced her report as read and noted that updates on the blood bottle shortage had been highlighted earlier in the meeting.
14.2	As part of the Digital Aspirant Programme, HDFT had commissioned a review of HDFT digital services. A final report from the external consultant was awaited highlighting key recommendations and actions.
14.3	The Caring at Our Best programme was noted as having a project manager in place , scoping workshops had been completed and monthly reports to Quality Committee and SMT were commencing.
14.4	**Action:** For the Digital Programme to be included on the Trust Board work plan at an appropriate time
14.5	**Resolved:** the report and updates against IBR were noted and assurance against progress was confirmed.
BD/9/21/15	**Guardian of Safe working Quarterly Report**
15.1	Dr Matt Milsom, Guardian of Safe Working (GSW) attended the meeting to present the Quarterly report.
15.2	The report provided the Board with up-dated quarterly evidence to support its assurance that the issues of safety within the Guardian's remit were in a satisfactory state.
15.3	70 exception reports had been received from trainees in Q1 (63 in Q4) and 58 so far in Q2. This was a continuation of the higher-than-normal numbers seen in the last report. These had mainly concerned over-runs of working hour owing to the busy state of the wards and to individual patient matters in General Medicine. Most concerning was the increase in exception reports concerning missed or compromised educational opportunities – there were 5 reports submitted in Q1 and 7 so far in Q2, compared to a total of 3 for the whole of 2020/21 and 8 for the whole of 2019/20. Exception reporting remains comparable to other Trusts across the region although it was unclear whether the other trusts are seeing the same increase in educational exception reports.

15.4 There have been no reported breaches of the European Working Time Directive, as such no fines have been levied. National trends in medical post-graduate training and medical workforce numbers overall continue to be adverse.

15.5 Vacancies had increased slightly to 11 (8%) of established training posts. Of these vacancies 2 are in the process of recruitment.

15.6 The GSW provided the Board with some verbatim comments from exception reports as requested at the previous quarterly update. The theme was in relation to workload and rest breaks.

15.7 Sarah Quinn, Chief Register provided an update on rotas and exception reporting and noted that she was working to bring themes together and look at potential actions for the future.

15.8 Sarah Armstrong queried if the organisation was carrying additional patient risks. The GSW confirmed that there was no additional patient risk, however it was impacting on colleague’s morale.

15.9 Maureen Taylor queried if HDFT was an outlier for allocating to wards. The GSW confirmed that HDFT was not, although other Trusts allocate in differing ways.

15.10 Dr Matt Milsom and Dr Sarah Quinn were thanked for their time and comprehensive report.

15.11 **Resolved:** The Board noted the content of the report.

Dr Matt Milsom and Dr Sarah Quinn left the meeting.

BD/9/21/16 Learning from Deaths Report – Quarter 1 2021-22

16.1 The Executive Medical Director presented the report and took it as read. She highlighted the following points.

16.2 Crude mortality rates for HDFT continued to track the national trends. Standardised mortality rates continued to be within the expected range.

16.3 13 Structured Judgement Reviews had been undertaken since the last report. 10 cases had overall care described as good or excellent. No cases had overall care described as “poor”. There have been 2 Covid-19 deaths in this quarter.

16.4 Mortality from patients admitted to Critical Care rose in the period January - March 2020. A report from the Clinical Lead for Critical Care is awaited.

16.5 A review into the death of patients following a stroke was undertaken following a previous HSMR alert. This has highlighted a number of good practice points and did not find any significant lapses in care.

16.6 **Resolved:** The Board noted the content of the report.

BD/9/21/17 Infection Prevention Control Service Annual Plan and Progress 2020-21

17.1 The Executive Medical Director presented the report as read and noted the progress that had been made in year despite the impact of the Covid-19 pandemic. It was confirmed that any actions and recommendations that had been stood down due to the pandemic had been included in the 2021-22 plan.

17.2	Laura Robson noted that the business case for an additional member of staff was turned down and queried if the post was still required. The Executive Medical Director confirmed that it was no longer needed due to other changes in the corporate structure.
17.3	**Resolved:** The Board noted the content of the report and were assured of the progress made.
BD/9/21/18	**People and Culture Committee Chair's Report**
18.1	Andy Papworth presented the report on behalf of the People and Culture Committee in Jeremy Cross's absence at the meeting.
18.2	The Committee had received a presentation from Emily Reid and Elaine Burata on the working experiences of OSCE nurses at HDFT. This presentation covered the excellent support given to help nurses already in the UK to gain their qualifications.
18.3	The Chief Executive had updated on the Culture Plan, where HDFT continued to embed the values and supporting tools. Inpulse, the new staff feedback mechanism, had been launched and the first output was with line managers and was providing valuable insight.
18.4	The Committee was updated on the work to become an anti-racist organisation. The Allyship programme by Leeds Community Healthcare Trust had also started (13 colleagues in cohort one) with positive feedback noted.
18.5	The Director of Workforce and OD had presented a deep dive into sickness absence. The depth of information was welcomed and the Committee were assured by the breakdown of data.
18.6	The FTSU guardian provided her first update to the committee.
18.7	The Committee received the draft reports for the Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES), Gender pay and Ethnicity pay and had approved their content
18.8	It was confirmed that the Committee would be revisiting exit interviews at the next meeting.
18.9	Wallace Sampson queried the difficulties in recruiting an EDI lead. The Director of Workforce and OD confirmed it was a market issue, with a number of similar roles being advertised and failing to appoint across the NHS. To mitigate the risk, HDFT has commissioned Diverse Mackenzie to support the EDI agenda.
18.10	Jeremy Cross noted that a wide range of organisations were suffering a spike in turnover. Wallace Sampson agreed and noted that people were making conscious decisions around lifestyle choices following the pandemic.
18.11	The Chairman queried if flexible working had been reviewed by the Committee. The Director of Workforce and OD confirmed it had not.
18.12	**Action:** Flexible Working Deep Dive to be included on the People and Culture Committee Agenda
18.13	**Resolved:** The Board noted the content of the report**.**

BD/9/21/19 **Director of Workforce and Organisational Development Report**

19.1 The Director of Workforce and Organisational Development presented the IBR indicators and escalation report as read. An update was provided on current workforce issues.

19.2 In relation to sickness absence, HDFT had seen an increasing trend since the beginning of the financial year, with August seeing a further increase to 5.02%. Covid related sickness had seen a small decrease in August from 0.36% last month to 0.32%. The majority of Covid sickness cases were within the community Children's Services. An increase in both short term and long term sickness rates in August had contributed to the overall rise in sickness rate this month. Short term sickness had increased from 1.44% last month to 1.59% and long term sickness had increased from 3.34% to 3.42%. A deep dive had taken place at People and Culture Committee.

19.3 In relation to turnover, HDFT has seen a further increase this month from 13.48% in July to 14.19%, however this remained below the Trust threshold of 15%.

19.4 The appraisal rate in August was 55.23%, which was a small decrease from July when the rate was 55.95%.

19.5 Larger departments were transferring over to HealthRoster. This had been more complex than expected and may need further support. This may impact further on the roll-out, the E-Rostering Manager and the Project Manager are monitoring the project plan closely.

19.6 Sarah Armstrong noted that in the transition to the new system of monitoring mandatory training, some compliance figures may not be as up to date as possible.

19.7 **Resolved:** the report and updates against IBR were noted and assurance against progress was confirmed.

BD/9/21/20 **Board Assurance Framework**

20.1 The Chief Executive presented the updated Board Assurance Framework and confirmed the revised process for review. Colleagues had reviewed and tightened up the mitigation actions and reviewed the definition

20.2 **Resolved:** the report and updates were noted.

BD/9/21/21 **Healthy Partnership 0-19 Services**

21.1 The Deputy Chief Executive / Director of Finance presented the report as read.

21.2 The Board of Directors was previously updated on the approach made by Northumberland County Council (NCC) to consider entering into a Partnership Arrangement to provide the 0-19 Healthy Families Service from 1 October 2021 at its meeting in May 2021.

21.3 At the private Board of Directors meeting in August 2021, approval was granted to enter into a partnership agreement with NCC and to delegate any amendments required to the Section 75 Agreement to the Chief Executive and Deputy Chief Executive which would be signed prior to partnership commencement.

21.4 The report outlined the current position, including the ongoing work to mobilise and TUPE transfer the workforce for the partnership commencement on 1 October 2021.

21.5 **Resolved:** The Board approved the partnership and signing of the Section 75 as discussed previous at Private Board in August 2021.

BD/9/21/23	**Resources Committee Chair's Report**
23.1	Maureen Taylor as Chair of Resources Committee presented the report.
23.2	The Trust had continued to maintain its planned break-even position in July. A surplus of £379k had been achieved due to the Salix grant being received. As previously noted earlier in the Board meeting the Elective Recovery Fund and expectations were highlighted.
23.3	The Trust had continued to maintain its planned break-even position in August. A surplus of £382k has been achieved due to the Salix grant received.
23.4	The capital programme spend was £10m behind plan at the end of August of which £3.6m relates to the Salix programme. As noted earlier in the Board meeting reviews on major schemes were being conducted.
23.5	There was a strong recruitment pipeline across all staff groups with over 200 wte staff due to join the Trust between October and December 2021. Temporary staffing at £453k in August exceeded the NHSEI plan of £405k.
23.6	The Salix update report was received and noted. Formal confirmation of the extended deadline had been received.
23.7	The annual report of the Digital Strategy Board was presented and noted.
23.8	Andy Papworth queried how substantive staff were ahead of plan when the Trust were carrying substantial vacancies. The Deputy Chief Executive / Director of Finance noted that the Trust has to submit a plan to NHSI at the start of the year, the plan is slightly lower than establishment which leads to the discrepancy.
23.9	**Resolved:** The Board noted the content of the report**.**
BD/9/21/24	**Finance Report**
24.1	The Finance Director discussed with the Board the points raised in relation to the Month 5 position. It was noted that the majority of key issues had been discussed earlier in the Board agenda.
24.2	There continue to be a number of areas of pressure that were being offset by underspends in relation to activity delivery and the 0-19 service vacancies. It was noted that the wards were overspent against current establishment.
24.3	The Chairman queried how the effectiveness of the ARCHS programme would be assessed. The Deputy Chief Executive / Director of Finance confirmed that bed modelling in the first 6 months had been demonstrated to be accurate. The key to success would be what our activity and bed numbers were going forward. The effectiveness would also be assessed in terms of a quality improvement programme. It was confirmed that the Post Project Evaluation would be taken through the Resource Committee.
24.4	**Resolved:** the report and updates against IBR were noted and assurance against progress was confirmed.
BD/9/21/25	**Chief Operating Officer's Report**
25.1	The Deputy Chief Operating Officer highlighted key themes from the report and IBR indicators.

25.2	In relation to elective recovery there was no weekend working uptake and there was limited evening work underway. This combined with holiday and theatre staffing gaps highlight a difficult August position in a number of theatre lists running (indicator 7.3.1). 176 elective theatres list had run, out of a possible 224 (78.5%). The lost lists primarily due to theatre staffing across August.
25.3	Two week wait cancer performance was 86% performance against target, the trajectory was still on track for September achievement (indicator 5.1). The main issues were now in Urology due to sickness and annual leave.
25.4	Referral to treatment waiting list continued to increase in August as the Trust continued at full capacity (whilst maintaining social distancing) to stem increased referral demand. Longer waits had been seen in Trauma and Orthopaedics, Ophthalmology and Community Dental. The referral to treatment 92nd centile was 40 weeks (indicator 5.1.3) and demand for new outpatient ECHO had increased by 37% based on 2019 demand c.70 referrals (indictor 5.3)
25.5	The Emergency Department Front Door trial continued at weekends for the month of September 2021.
25.6	Laura Robson queried if the York independent capacity used York Surgeons. The Deputy Chief Operating Officer confirmed that York surgeons were used.
25.7	Laura Robson queried the increased emergency paediatric support beyond the Trust's normal boundary. The Deputy Chief Operating Officer confirmed that this equated to one or two additional ambulances a week with the slight change in boundaries. It was not putting significant pressure on HDFT.
25.8	**Resolved:** the report and updates against IBR were noted and assurance against progress was confirmed.
BD/9/21/26	**Organisational Development**
26.1	The Director of Workforce and OD noted that on the agenda were a range of reports requiring approval for submission to NHSEI.
26.2	In addition, the Inpulse quarterly staff survey had closed on 27 August, with a 14.5% return rate. The results had been sent to line managers and follow-up actions were in place.
26.3	**Resolved:** the report and updates against IBR were noted and assurance against progress was confirmed.
BD/9/21/27	**Workforce Race Equality Standards (WRES) Annual Report**
27.1	The Director of Workforce and OD presented for approval the WRES Annual Report.
27.2	The data analysed suggests that during recruitment processes the proportion of BME candidates shortlisted and appointed did not mirror the proportion of BME applicants. The data indicates, that of all the applicants, 59% are white and 41% are BME, however the split of those who were shortlisted is 77% white to 23% BME, and the split of those who were appointed is 86% white to 14% BME. This data suggests that more white applicants were progressed through the recruitment process.
27.3	In terms of harassment, bullying and abuse / discrimination data, BME employees experience more abuse from patients or service users, or their relatives in comparison to white employees.

27.4	By developing and implementing a robust anti-racist organisation programme teamHDFT and HIF can make a positive difference to the lived experience of BAME colleagues and help create a more diverse and inclusive culture.
27.5	**Resolved:** the report was noted and approved.
BD/9/21/28	**Workforce Disability Equality Standards (WDES) Annual Report**
28.1	The Director of Workforce and OD presented for approval the WDES Annual Report.
28.2	The proportion of staff experiencing harassment, bullying or abuse was greater for disabled staff in comparison to non-disabled staff, with the exception of abuse from patients in the 2020 Staff Survey, where the level of abuse has been about the same for both disabled and non-disabled staff.
28.3	The proportion of both disabled and non-disabled staff that believe that the Trust provides equal opportunities for career progression and promotion has decreased from 2019 to 2020.
28.4	**Resolved:** the report was noted and approved.
BD/9/21/29	**Gender Pay Gap Report**
29.1	The Director of Workforce and OD presented for approval the Gender Pay Gap Annual Report.
29.2	The total number of staff eligible for inclusion in this report was 4,252. The gender split of the workforce was 85% female to 15% male, however as a greater proportion of the male workforce were in higher banded roles and Medical and Dental positions in comparison to the female workforce, this impacted the gender gap as these roles have a greater hourly rate.
29.3	Including Medical and Dental, the mean gender pay gap was 27.61%, meaning males are paid 27.61% more than women. Excluding Medical and Dental, the mean gender pay gap was 7.40%, meaning males are paid 7.40% more than women.
29.4	**Resolved:** the report was noted and approved.
BD/9/21/30	**Ethnicity Pay Gap Report**
30.1	The Director of Workforce and OD presented for approval the Ethnicity Pay Gap Annual Report.
30.2	The total number of staff eligible for inclusion in this report was 3,986 from a workforce of 4,252. The data in this report was based on those who have chosen to disclose their ethnicity which accounts for 94% of the workforce.
30.3	The ethnicity split of the workforce was 89% white colleagues to 11% BME colleagues, however as a greater proportion of the BME workforce are in Medical and Dental positions in comparison, this impacts the ethnicity gap as these roles have a greater hourly rate for this group of staff.
30.4	Including Medical and Dental, the mean ethnicity pay gap was -21.26%, meaning BME colleagues are paid 21.26% more than white colleagues. Excluding Medical and Dental, the mean ethnicity pay gap is -0.29%, meaning BME colleagues are paid 0.29% more than white colleagues, which is almost equal.

BD/9/21/31	**Audit Committee Chair’s Report**
31.1	Richard Stiff as Audit Committee Chair presented the report.
31.2	The Committee had reviewed the new corporate risk register arrangements and had been given sufficient assurance that the new process would provide strong and robust monitoring of the Corporate Risk Register. The Committee discussed in particular the absence of a Health and Safety Manager post in the Trust’s management structure, the current rating of RTT risks and risks related to on site security arrangements.
31.3	The Committee received the annual review of the Trust’s Treasury Management Policy and the annual report on treasury activity. There was some discussion of the Trust’s investment approach in the context on an unfavourable investment market. The updated Policy, including only non-material revisions, was approved.
31.4	There was no representative of KPMG at the meeting. The Committee received and noted their report and the usual sector technical update. There was a discussion on the positioning of climate change risk outlined in the technical update. The annual review of external audit effectiveness was considered. This showed a slight reduction on scores from the previous year.
31.5	It was noted that the current external audit contract with KPMG expires in March 2022 and that a tender process would begin shortly. Jeremy Cross agreed to be the second NED member of the procurement panel alongside the Audit Committee Chair, representative governors, and senior finance officers.
31.6	There were no single tender actions or post project evaluations for review at this meeting.
31.7	The Deputy Chief Executive / Director of Finance noted that the Board lead for Health and Safety moving forward would be the Director of Workforce and OD. The Board noted the previous discussion on the risks associated with the Health & Safety Post being currently unfilled.
31.8	Wallace Sampson noted the climate change risk and queried if the risk was more relating to the reduction of carbon. The Director of Strategy noted that there was a– need to look at the consequences of climate change, not just the impact we have on climate change. Sarah Armstrong noted the links to business continuity planning.
31.9	**Resolved:** The Board noted the content of the report**.**
BD/9/21/32	**Senior Management Team Report**
32.1	The Chief Executive noted the contents of the two SMT reports for August and September. They were taken as read and noted that all key issues had been discussed in other agenda items throughout the meeting.
32.2	**Resolved:** The Board noted the content of the report
BD/9/21/33	**2021-22 Board Workplan**
33.1	**Action:** A workplan for Board Workshops to be developed.
33.2	**Resolved:** The content of the workplan was agreed.
BD/9/21/34	**Any Other Business**
34.1	There were no other areas of business raised.
BD/9/21/35	**Board Evaluation**

35.1	The Chairman posed the question about what had worked well and not as well with the revised format of the reports presented.
35.2	Jeremy Cross noted that the Guardian of Safe Working report had indicated robust triangulation of information. It was noted that the Board gave full support to the work.
35.3	Wallace Sampson noted that the digital strategy developments were encouraging.
35.4	Jeremy Cross noted that RTT remained a challenge as did surgical capacity.
35.5	Sarah Armstrong noted the stark remainder of the challenges to come. The Chief Executive agreed that we would be need to balance the challenges of today with progress towards tomorrow.
BD/9/21/36	**Date and Time of the Next Meeting**
36.1	The next meeting would be held on Wednesday, 24th November 2021
BD/9/21/27	**Confidential Motion**
37.1	**Resolved:** to exclude members of the press and public in accordance with the Health Services Act 2006 (Schedule 7, Section 18 (E)) (as amended by the Health and Social Care Act 2012) and in view of publicity being prejudicial to the public interest.

Board of Directors (held in Public) Action Log
for 29 September 2021 Board Meeting

Minute Number	**Date of Meeting**	Subject	**Action Description**	**Responsible Officer**	**Due Date**	**Comments**	**Status -** completed is defined as confirmation received from ED responsible lead that the proposed action is completed as described in the comments column. Completed actions will not be closed until the Board has confirmed that action taken is satisfactory.
BoD/7/21/11/11.5	28 July 2021	Safe Staffing Report	Safer Staffing Report to be submitted to the September 2021 Board	Director of Nursing	~~29/09/2021~~ 24 November 2021	**Update for the November Board meeting** The report is included onthe agenda. Recommneded that the action is closed. **Update from September 2021 Board Meeting** It was confirmed that this would be a Board report in November 2021 rather than a board workshop. To remain on the tracker until delivered in November 2021. **Update September 2021** Report required to be submitted through internal governance systems. To be submitted to the November 2021 Board	Completed
BoD/7/21/16/16.9	28 July 2021	Management Restructure	For a Board Workshop to be held on the management restructure	Director of Workforce and OD	01 December 2021	**Update September 2021** Action agreed at the September 2021 Board. Not yet due.	Open
BoD/7/21/22/22.6	28 July 2021	Avoidable Admissions	Further information to be provided on 6.8 Avoidable admissions in the IBR	Chief Operating Officer	~~29/09/2021~~ November 2021	**Update from September 2021 Board Meeting** It was confirmed that information was included in the IBR, however, further information would be brought to the November 2021 Board.	Completed
BoD/9/21/5/5.4	29 November 2021	PLACE	Workshop to be held in December 2021 - partners from North Yorkshire and Harrogate to be invited	Company Secretary	01 December 2021	**Update November 2021** **Recommendation to close** PLACE added to the December Workshop,	Completed
	29 November 2021	Digital Programme	Workshop to be held in April 2022 on the Digitial Aspirant Programme	Medical Director	01 December 2021	**Update November 2021** **Recommendation to close** Digital Aspirant Programme added to the April 2022 Workshop,	Completed
	29 November 2021	Flexible Working Deep Dive	Flexible working deep dive to be included on the People and Culture Agenda	Company Secretary	01 December 2021	**Update November 2021** **Recommendation to close** Flexible working deep dive has been included on the January 2022 People and Culture Committee Agenda	Completed
	29 November 2021	Trust Board Workshop Plan	Workshop plan to be developed	Company Secretary	01 December 2021	**Update November 2021** **Recommendation to close** Workshop plan developed and circulated to Board Members	Completed
	27 January 2021	Guardian of Safe Working Quarter 3 Report	Jackie Andrews agreed that she would request that a collection of verbatim comments is included in future reports	Medical Director	26/05/2021 29/09/21	**Update from September 2021 Board Meeting** **Update September 2021** The GSW is included on the agenda for the September 2021 Board meeting. A range of comments are included in the report. **Update July 2021** - The GSW report is due at the September 2021 board meeting. Appropriate verbatium comments will be included as appropriate (information that could identify an individual will not be included). Action to close once GSW report received in September 2021	Closed - Sept 2021 Trust Board
BoD/7/21/17/17.2	28 July 2021	Medical Appraisals	Figures for medical appraisals to be provided	Medical Director	29 September 2021	**Update from September 2021 Board Meeting** 64% completed appraisal in last 12 months 29% approved to miss appraisal (due to eg. maternity, sickness, NHSE/BMA agreed relaxation of appraisal cycles during COVID) 2% suspended appraisals due to ongoing formal processes 5% no appraisal in last 12 months- all being actively managed within medical staffing SOP for missed appraisals	Closed - Sept 2021 Trust Board

BoD/05/21/8.2	26 May 2021	~~CEO Report - Corporate Manslaughter Annual Statement~~ Modern Slavery Decleration	Safeguarding training for all staff to cover Modern Slavery	Director of Nursing	29 September 2021	**Update from September 2021 Board Meeting** It was noted that safeguarding training had been reviewed and updated. Level 3 training has modern slavering training included. The Board undertaken Level 1 training and can access Level 3 if they wish. It was agreed to close the action **Previous Update** At the July 2021 Board Meeting, the action was revised to reflect the action required. I.e. that modern slavery be included in Safeguarding Training	Closed - Sept 2021 Trust Board
BoD/7/21/7/7.8	28 July 2021	CQC Inspection Regime	For a Board Workshop to be held on the CQC inspection Framework	Director of Nursing	01 December 2021	**Update from September 2021 Board Meeting** it was confirmed that the CQC Inspection Framework had been added to the Board Workshop for December 2021. It was agreed to close the action. **Update September 2021** Action agreed at the September 2021 Board. Not yet due.	Closed - Sept 2021 Trust Board
BoD/7/21/9/9.2	28 July 2021	IBR - Interpreting SPC Charts	For a Board Workshop to be held on interpreting statistical processing charts - invitation to be extended to NHSI	Director of Finance	01 December 2021	**Update from September 2021 Board Meeting** It was confirmed that the NHSIE Making Data Count Team would attend the February 2022 Board Workshop. It was agreed to close the action. **Update September 2021** Action agreed at the September 2021 Board. Not yet due.	Closed - Sept 2021 Trust Board
BoD/7/21/22/22.5	28 July 2021	RTT	The RTT by deprivation report that was discussed at the July 2021 WYATT meeting would be circulated to Board members for information	Chief Operating Officer	29 September 2021	**Update from September 2021 Board Meeting** It was confirmed that an updated report had been circulated to Board members. It was agreed that this action be closed.	Closed - Sept 2021 Trust Board

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NHS
Harrogate and District
NHS Foundation Trust

Board of Directors (Public)
24th November 2021

Title:	Report of the Chief Executive
Responsible Director:	Chief Executive
Author:	Chief Executive

Purpose of the report and summary of key issues:	For noting and information	
BAF Risk:	AIM 1: To be an outstanding place to work	
	BAF1.1 to be an outstanding place to work	x
	BAF1.2 To be an inclusive employer where diversity is celebrated and valued	x
	AIM 2: To work with partners to deliver integrated care	
	BAF2.1 To improve population health and wellbeing, provide integrated care and to support primary care	x
	BAF2.2 To be an active partner in population health and the transformation of health inequalities	x
	AIM 3: To deliver high quality care	
	BAF3.1 and 3.4 To provide outstanding care and outstanding patient experience	x
	BAF3.2 To provide a high quality service	x
	BAF3.3 To provide high quality care to children and young people in adults community services	x
	BAF3.5 To provide high quality public health 0-19 services	x
	AIM 4: To ensure clinical and financial sustainability	
	BAF4.1 To continually improve services we provide to our population in a way that are more efficient	x
	BAF4.2 and 4.3 To provide high quality care and to be a financially sustainable organisation	x
	BAF4.4 To be financially stable to provide outstanding quality of care	x
Corporate Risks	As per CRR report	
Report History:	none	
Recommendation:	The Board of Directors to note and approve	

Board of Directors
24th November 2021

Report of the Chief Executive

Introduction

1. Since the last Board meeting there has been a significant focus on confirming our plans for urgent and emergency care, elective care and our 0-19 services for the second half of the financial year (H2) following the confirmation of the financial settlement for the NHS and the national expectations, which focus particularly on elective recovery.

2. Our plan for elective care is to treat all patients who would be waiting over 103 weeks by the end of March 2022, to reduce the number of patients waiting over 52 weeks and to reduce the number of patients on the waiting list overall. This is compliant with the national expectations. Further resource to reduce risk and to improve upon the position has been made available to the ICS.

3. System capital was made available to ICS in 2021/22. In West Yorkshire these are focused on the development and expansion of three existing ‘green’ sites, and trust based digital and equipment. In Humber Coast and Vale the capital has been allocated for the development of two green sites. These are likely to be of marginal benefit to the Trust’s population and as part of this we agreed with the ICS that some capital would support the Wharfedale scheme in West Yorkshire. The level of capital made available was very modest in the scheme of the allocation to HCV.

4. We have a financial plan for H2 that has an efficiency requirement and have further work to ensure that the proposals are recurrent to ensure that our exit run rate will not be at a level significantly above the likely financial changes next year. Whilst not finalised, the expectation is a significant reduction in the COVID allocation and a move back to the allocation formula overall. This will need to be aligned with the dissolution of CCGs and the creation of the ICBs subject to the legislation passing, and so there remains considerable uncertainty about the implications of how all these changes will come together.

5. Our colleagues continue to work under a high degree of sustained pressure, and in the context of both the previous year and concerns about the upcoming winter, the effects of this can be seen in our absence rates.

6. Collaboration, mutual support and partnership working remain the central tenants of our approach both internally and across the wider system. Many of the challenges we face are common to all teams, and all organisations in health and care and whilst many cannot be immediately solved, the environment can be positively influenced by a spirit of working together and remaining connected.

7. Whilst many of our teams are under pressure, the challenges faced in Social Care remain even greater and we continue to try to support our colleagues in North Yorkshire. Across the ICS, local government and the NHS are working together as part of a dedicated workstream of the Workforce Board to consider interventions that can improve supply, resilience and retention. The North Yorkshire and York work is being led by Polly McMeekin and has developed a comprehensive set of short and medium term actions.

8. The West Yorkshire Association of Acute Trusts has led two events for the Executive Teams of all six Trusts to agree areas in which we would collaborate. These are focused on seven key areas covering (i) sharing of good practice, (ii) co-ordinated use of the independent sector, (iii) additional activity at weekends, (iv) a consistent approach to prioritisation, (v) level loading of capacity, (vi) WYAAT wide theatre recruitment and retention and (vii) use of alternative vehicles such as LLPs.

Urgent and Emergency Care

9. During the month of October there has been significant pressure on urgent and emergency care services, and COVID-19 admissions rose to a peak of just over 30. Performance against the four-hour standard was challenged during this period primarily driven by high levels of occupancy, and unfortunately there have been just over ten 60 minute ambulance handover and 12 hour trolley waits in A&E. Performance in England overall was 73.9% indicating the challenges the Trust faces are replicated across the NHS.

10. The Trust has received an indicative allocation of funding to support Winter Resilience and the Chief Operating Officer has led the development of a winter plan through the Operational Management Group. Through listening events and feedback from the safe staffing reviews, and in the context of challenges in recruiting registered nurses we have heard a strong desire for improved support to ward clinical teams from associated roles such as ward clerks, improved support for stock and mealtimes. A piece of work to support resilience in ward teams is taking this forward alongside ensuring there is a consistent approach to the use of incentives.

Maternity Services

11. The Trust team received positive feedback from NHS Improvement’s regional team about the evidence that had been submitted to demonstrate the degree of compliance with the Ockenden requirements. The assessment showed the Trust’s compliance was in line with other Maternity Units and there were no ‘outlier’ or ‘unexpected’ issues identified. There are some areas where further work is required and the key bit of feedback was to ensure that compliance against the standards was embedded and assurance could be provided on an ongoing basis.

12. Senior Management Team reviewed the Strengthening Maternity and Neonatal Safety report. There remains further work to develop this report. The key risk identified related to an issue related to staffing levels. This had been raised with the Maternity Safety Champions and the Executive Team. Some immediate actions have been taken to ensure a better oversight of staffing on a daily basis and a review of how the situation arose is underway.

13. Despite a number of midwives starting in post this month, there have also been a number of resignations. Further detail is provided in the Director of Nursing, Midwifery & AHP’s report.

0-19 services

14. The level of pressure across our 0-19 services remains high, with the services operating at OPEL level 3 (1 being the lowest, and 4 the highest levels of pressure). The number of safeguarding strategies, which is a marker of complexity and demand, has continued at the previous levels and remains higher than in previous years. Whilst investment in the

service has been made to support the team, vacancies and sickness mean that only 70% of the planned workforce is available. The team continue to meet the statutory requirements which is due to the significant efforts of the team. Across the broader 0-19 services we continue to clinically prioritise which means that in some cases our enhanced offer is being impacted.

15. Despite the challenges, performance against the mandated contacts remains high. Further detail is in the Chief Operating Officers report.

Adult community services

16. There continues to be significant work to mobilise the new ARCHs model and to further consider how this can provide additional support in the context of the likely upcoming winter demands, and the challenges that social care face. 68% of the planned staffing level is available to rosters and the service continues to operate at OPEL level 3. Work continues to take place to consider options to improve supply and retention, including the potential development of a new senior community nurse role.

Planned Care

17. A dedicated team have started in roles to support the theatre improvement programme, which is primarily focused on culture. There has been very positive engagement in the current phase. Feedback has been challenging to date, but there appears to be confidence in the process and the commitment to see improvements.

Regulation and Governance

18. The Trust has been placed in Segment 2 of the NHS Oversight Framework. This means NHS Improvement considers the Trust is not in breach of the Provider License and has only targeted support needs.

19. The NHS has been notified that the UK Terror Threat level has been changed to **severe** following the terrorist incident at Liverpool. There is no indication that there is a specific threat to NHS sites but all Trusts have been asked to ensure there is appropriate awareness of our Incident Response Plans and security arrangements. This is being led by the Chief Operating Officer, who is the Trust's Accountable Emergency Officer.

20. The Department of Health and Social Care (DHSC) has announced that individuals who are undertaking CQC regulated activities must be fully vaccinated against COVID-19 to protect patients. This is known as Vaccination as a condition of deployment. The regulations are expected to come into effect from 1st April 2022 and this means all individuals in scope must have their first dose by 3rd February 2022. The CQC will regulate this requirement, and the requirement is on the organisation providing the regulated activity to ensure they do not deploy an unvaccinated employee to care for patients. Whilst vaccination uptake is high for colleagues, there are significant implications of this regulation.

21. The NHS has been asked to review security in Mortuary facilities to ensure certain criteria are met. We have reviewed the criteria and have developed a plan to ensure we become fully compliant and the Board will be updated in Part 2.

Strategy

22. The Board Workshop, which took place in Northumberland was focused on the strategy for our 0-19 services and stimulated a very positive discussion about our ambition for children and families across the North East and Yorkshire. With over half a million children living in the areas we work, resources of £46m and the long term impact that 0-19 services can have on health and wellbeing we agreed that in addition to clarifying our strategy for 0-19 services it was important to ensure strong Board input to develop and oversee this and our relationships into the places we work. In the context of our wider governance arrangements it will be important to reflect on whether the current constitution adequately reflects the scope of services we now provide.

23. The initial phase of the development of our Strategy and our Clinical Services Strategy is due to take place between November 2021 and February 2022. Further detail is provided in the Director of Strategy's report.

People and Culture

24. Our programme of work on becoming an anti-racist organisation continues with a particular emphasis on Cohort 1 of our Reciprocal Mentoring programme and Cohort 1 of our Allyship Programme. The pilot of measures in our recruitment process showed a material impact. Where there was an intervention to ensure BAME candidates who met the essential criteria were shortlisted 1.8x the proportion of BAME applicants were shortlisted, and 2.3x the proportion of candidates were appointed. This was an approach developed and designed by our HR team and our Deputy COO who put significant effort into creating the right conditions for the pilot and supporting line managers.

25. We continue to analyse inequalities in waiting times for patients, and have expanded this to consider referrals. This early work has highlighted a material difference in the proportion of referrals to the Trust in 2021/22 compared to 2019/20 between different populations. Referral rates for BAME patients are 75% of the level of 2019/20, and 97% for patients who are white. The difference is even more stark when looking at deprivation. Referral rates to the Trust for patients living in the most deprived areas (IMD 1 and 2) are 56% the level of 2019/20 whilst for patients living in the most affluent areas (IMD 9 and 10) they are 101% the level of 2019/20. Our Deputy COO is reviewing this in more detail to consider the drivers of this, and whether the Trust can provide any support to ensure patients who may have health needs are supported to access services.

26. Finally, Our COVID19 booster campaign continues with 72% of colleagues now having had the jab, and 67% of colleagues having had the flu vaccine.

Steve Russell

Chief Executive

November 2021

Board of Directors (Public)
24th November 2021

Title:	**Corporate Risk Register**
Responsible Director:	Chief Executive
Author:	Company Secretary

Purpose of the report and summary of key issues:	The report provides the Trust Board with key updates and actions since the previous meeting held in on 29th September 2021. All Corporate Risks have been reviewed via the Directorate Review Meetings, the Executive Risk Review Meeting and the Senior Management Team meeting. Details of key indicators, mitigation, target risk ratings and current risk ratings are detailed in the report.	
BAF Risk:	AIM 1: To be an outstanding place to work	
	BAF1.1 to be an outstanding place to work	X
	BAF1.2 To be an inclusive employer where diversity is celebrated and valued	X
	AIM 2: To work with partners to deliver integrated care	
	BAF2.1 To improve population health and wellbeing, provide integrated care and to support primary care	X
	BAF2.2 To be an active partner in population health and the transformation of health inequalities	X
	AIM 3: To deliver high quality care	
	BAF3.1 and 3.4 To provide outstanding care and outstanding patient experience	X
	BAF3.2 To provide a high quality service	X
	BAF3.3 To provide high quality care to children and young people in adults community services	X
	BAF3.5 To provide high quality public health 0-19 services	X
	AIM 4: To ensure clinical and financial sustainability	
	BAF4.1 To continually improve services we provide to our population in a way that are more efficient	X
	BAF4.2 and 4.3 To provide high quality care and to be a financially sustainable organisation	X
	BAF4.4 To be financially stable to provide outstanding quality of care	X
Corporate Risks	All	
Report History:	Previous updates submitted to Public Board meetings. The November 2021 report has been reviewed at the Executive Risk Review Meeting (October 2021) and the Senior Management Team meeting (October 2021).	
Recommendation:	The Board is asked to note this report, and identify any areas in which further assurance is required, which is not covered in the Board papers.	

Harrogate and District NHS Foundation Trust
Board of Directors (Public)
October 2021

Corporate Risk Register

1.0 INTRODUCTION

The Corporate Risk Register consist of operational risk scoring 12 or above. It is reviewed monthly at the Directorate Performance Reviews and at the Executive Risk Management Group.

2.0 CORPORATE RISKS

2.1 CRR5 – Nursing Shortages

Each directorate provided key updates on Nurse Staffing. Contained on the agenda for further context is the Safer Staffing Paper.

It was noted that pressures were being felt in a number of areas including Adult Community Nursing and the Community Care Teams. Mitigation has been implemented with a Task and Finish group set up to work up actions. Additional 1.8wte Band 7 Team Leaders have been appointed to strengthen clinical leadership and also capacity as new posts will have a case load. In 0-19 Band 6 SCPHN, Band 6 vacancies have improved due to the SCPHN trainees qualifying and moving into substantive posts. A recruitment event is planned for November 21. The NHSP for 0-19 services is due to go live in December 21.

Theatre staffing remains a concern and is impacting on the capacity of Theatres, resulting in same day and short notice cancellations.

Across the directorates overseas recruitment is underway to address national nursing shortfalls. In addition, dialogue with universities/local educational organisations continues with visits to discuss career opportunities at HDFT.

Further mitigation includes supernumerary time for new employees to ensure staff feel supported, robust recruitment processes, Safer Nursing Care Tool Audit being completed to assess current patients' needs to accurately agree RN and CSW workforce requirements. In addition, a Workforce Matron has been appointed to provide strategic support and direction.

The Target Risk is 9 (3x3) – revised to March 2020 (from October 2021).

The Current Risk is 12 (3x4) –October 2021. This is the same rating as September 2021

2.2 CRR6 – Wellbeing of Staff

Both ward based and community colleagues are experiencing high demand and pressure.

External funding has been secured to allow recruitment of Mental Health Nurse – Band 5 as well as to allow for procurement of external Counselling psychology support as unable to recruit to 0.5 WTE Clinical Psychologist.

Further mitigation includes:

- Recruitment & Retention team to develop retention programme
- Recruitment pipeline being actively progressed for HCA and RNs

- £80,000 external funding successfully bid for and received to support - mental health training champions 18 of them to help tackle stigma, plans to train further cohort with target of 50 people.
- MH awareness training half day session with line manages,
- Work ongoing to provide support around Critical Incident Stress Management,
- Thrive wellbeing conversations have been implemented, but need to do more to encourage and support these.
- Normalise wellbeing and recovery through messaging from Senior Leadership Teams.
- Occupational Health Business Case under development to enable development of service into pro-active wellbeing service.
- Letter being issued to all colleagues home address w/c 9.08 with KITE behaviours and an information card with H&WB contacts on reverse to provide easier access to relevant support.

Further detail is provided in the Workforce and Organisational Development updates on the agenda.

The Target risk 8 (2x4) has been amended from July 2021 to September 2022.

Current risk is 12 (3x4) –October 2021 this is the same rating as September 2021.

2.3 CRR34 – Autism Assessment

The numbers on the waiting list is currently 487 (down from 500 in August). The Referral rate for a 6 month rolling average is now 50. The longest wait is 71 weeks.

Based on the current additional funding being available for 12 months this would reduce the waiting list to 256 at the end of this period with a longest wait of 34 weeks. Additional staff associated with the waiting list initiatives are all now in post and we have seen a month on month reduction in the waiting list since June 21.

A session was held with professional leads on the 17th September 2021 to work through the longer-term demand vs capacity issue and some models have been put forward on how we can improve utilisation and space required. This is being pulled into a plan to discuss with commissioners in October 21.

The Target Risk is 6 (3x2) – March 2022

The Current Risk is 12 (3x4) –October 2021. This is the same rating as September 2021

2.4 CRR41 – RTT

The position at 27/09/2021 is:

- Total incomplete pathways – 23,283
- Greater than 104 weeks – 26
- Greater than 52 weeks – 1032
- Greater than 40 weeks – 1999
- % of 18 weeks 71.86%

Oversight of performance takes place at weekly meetings and also further oversight at weekly operational SLT meeting. Categorisation of patients according to clinical need /

urgency (P) is taking place as is weekly directorate management team meeting to review waiting lists. The Theatre utilisation meeting takes place twice weekly.

Further mitigation includes seeking a 3 month locum via agency to cover anaesthetic gaps. The Trauma and Orthopaedic consultants planning to set up LLP. Ophthalmology - Virtual Glaucoma clinic commenced 17/5/21 (20 pts per clinic, increasing to 60 pts).

The Target Risk is 6 (3x2) – March 2023, amended from March 2021

The Current Risk is 12 (3x4) –October 2021. This is the same rating as September 2021

2.5 CRR48 – Mental Health Services for ED Patients

The current position stands at:

- 12 attendances > 6 hour stays in ED awaiting mental health assessment/ admission (arrival to discharge)
- attendances > 12 hour stays in ED awaiting mental health assessment/ admission (arrival to discharge)
- Longest wait 29 hours from arrival to discharge.
- In the September 2021 there were 27 breaches awaiting MH review. The longest wait was 13th September – 29 hours waiting for an inpatient bed to be identified in order for application for detention under the MHA to be made.

The acute liaison service based at HDFT respond to patients when they present in ED usually within 1hr. Following this, the patient may either:

1) require further assessment by the crisis team- this is the Harrogate crisis team which covers Harrogate and Rural district, or

2) need a mental health act assessment (MHAA) which requires a Section 12 approved doctor (from TEWV) and an AMHP (approved mental health practitioner) from NYCC. During the day, AMHPs cover Harrogate and Craven, but at night they are North Yorkshire wide (leading to delays at night). Also coordinating the doctor and AMHP to carry out MHAA leads to delays.

In terms of mitigation:

- Staff request support from TEWV where available.
- Long waits escalated to TEWV monthly
- Core 24 ALS service now in place (Sept 2020) which ensure rapid response for initial assessment
- Escalated at A&E Delivery Board (AEDB)
- Environmental risk assessments conducted annually to minimise risk of harm
- Access to assistance from porters where capacity allows
- Staff have violence and aggression training, but are not trained in restraining patients.
- Patients are risk assessed at triage. Able to increase level of observations if required. Ligature risks and mitigation forms part of ED environmental risk assessment. Environment of cubicle can be made safe by removing items etc. when required.

Data shows the following delays related to mental health:

Month	Total Breaches	6 hour waits	12 hour waits
June	14	7	1
July	14	6	1

August	19	11	2
September	27	12	3

The Target Risk is 9 (3x3) – March 2022 (amended from October 2021)

The Current Risk is 12 (3x4) – October 2021. This is the same rating as September 2021

2.6 CRR57 – Safeguarding Demand

The impact of school holidays saw a reduction in the number of safeguarding strategies in August on previous months but this number was still higher than the same period over the last three years.

High levels of sickness in September have meant the specialist team have lost capacity

The 0-19 teams are running at OPEL 2/3 and continue to have to deliver some activity virtually to ensure safeguarding policy requirements are achieved.

The Northumberland 0-19 service are currently being supported by the existing specialist safeguarding team while we await recruited staff coming into post which is also impacting on capacity.

Posts within the Safeguarding Business Case now all appointed and in place.
Posts to support the new Northumberland service appointed to with named nurse starting on the 1st Nov and Specialist Nurse on the 18th October.

Unfortunately, sickness within the Safeguarding specialist team has meant the risk remains unchanged despite the actions taken. As this sickness resolves we should be able to review the risk to reflect the actions taken.

Target risk is 8 (2x4) with an amended date of November 2021 (originally July 2021)

Current risk is 16 (4x4) - October 2021. This is the same rating as September 2021

2.7 CRR61 – ED 4 hour Standard

A&E 4 hour standard remains below the 95% standard at 81.13%
Significant improvement has been made in 6 hour harm indicator (276 >6 hour stays total for September) equates to 2.7 harms due to longer stay in September (1 per week reported in June). 12 hour breaches were0 in September 2021, 12 hour stays for Ambulance handover performance improved to 90.4% in September. There were 20 over 30-minute handover breaches including 1 over 60-minute breach in September.

Business case for formal move to new walk in streaming model has been developed. Hospital flow work to support ED flow is also commencing. Capital works over next 6 months to centralise acute services at the front door and provide enhanced access to diagnostics. Community 2 hour response to reduce admissions/attendances will be implemented over the next 6 months.

The Target Risk is 6 (3x2) – March 2022. This is a change in target risk from 8 (4x2)

The Current Risk is 15 (3x5) –October 2021. This is the same rating as September 2021

2.8 CRR63 – Violence and Aggression (ED)

The number of incidents relating to violence and aggression were:

- Datix incidents for aggression in the ED – 31 episodes through July
- Datix incidents for aggression in the ED – 28 episodes through August.
- Datix incidents for aggression in the ED – 12 episodes through September.

A review of security has taken place, and the following controls are being introduced – body cameras, CCTV, additional training for portering staff, the creation of a designated security responder, a structured 'threat response' standard operating procedure and a more structured approach to follow up with patients. The Trust also plans to engage with the police to seek advice on the organisational approach. This should address the majority of the current gaps in control.

There are some remaining gaps in control relating to the ability to secure specific parts of the site which is being reviewed and in the timeliness of the police response on occasions.
Bodycam equipment to be rolled out Oct 21 to 2x ED staff and porters.

1st Responder Training being developed for porters to take on limited security roll.

The Target Risk is 8 (2x4) – November 2021- target risk rating changed from September 2021

The Current Risk is 12 (3x4) –September 2021. This remains the same position as July 2021.

2.9 Health and Safety

A review has taken place on the provision of Health and Safety leadership in the Trust.

Health and Safety Law states that employers must:

- Assess risks to employees, customers, partners and other people wo could be affected by their activities
- Arrange for effective planning, organisation, control, monitoring and review of preventative and protective measures
- Have a written health and safety policy if they have 5 or more employees
- Ensure they have access to competent health and safety advice
- Consult employees about their risks at work and current preventative and protective measures

Failure to comply with these requirements can have serious consequences for both organisations and individuals. Sanctions include fines and imprisonment.

Mitigation has been implemented including seeking peer support from a regional Trust to provide review and oversight of current arrangements. The recruitment process has commenced with a job description drafted and early conversations with potentially interested parties.

The Target Risk is 8 (4x2) –December 2021

The Current Risk is 16 (4x4) – October 2021, this rating is the same as August 2021.

3.0 RECOMMENDATIONS

It is recommended that the information is noted for assurance.

Kate Southgate
Company Secretary

November 2021

Harrogate and District
NHS Foundation Trust

Board Committee Report to the Board of Directors

Committee Name:	Quality Committee
Committee Chair:	Laura Robson, Non-executive Director
Date of meeting:	20th October 2021
Date of Board meeting this report is to be presented	24th November 2021

Summary of key issues

- The Quality Committee met via teleconference. The meeting was observed by Doug Masterton, Public Governor.
- Progress on the limited assurance audit - management of waste materials in the hospital was discussed. A range of work to raise awareness and improve practice has been undertaken and work between the HIF team and the Trust nursing team continues. The matrons will be including audit of waste management in their reviews and it will be incorporated into the Perfect Ward App as an item for audit when this is launched.
- The shortage of blood bottles has now abated and practice is returning to normal.
- The Staff App uptake was discussed. This is progressing well and being monitored through the People and Culture Committee.
- Patient safety Day (17/9/21) had been used to raise awareness, the Deputy Director of Nursing and Quality Matron had visited wards and departments to raise the profile of the quality initiatives and safety measures currently underway and the ‘Caring at our Best’ work. Nationally the day was devoted to Safer Maternity and Neonatal Services.
- Following discussions at the Board in September the committee discussed delays in ED for patients in mental health crisis. It is considered by some that ED is the safest place to wait for attention. Patients are offered admission to inpatient wards but would often prefer to wait in ED. Every patient who waits a long time in ED is scrutinised and consideration given to how the wait may have been prevented. The Safer Nursing Care tool has been adapted for use in ED and this will give some indication of staffing requirements or current deficiencies. Work is also underway to review skill mix and competencies required to manage the current caseload in the department. Charity organisations that work with patients who are in mental health crisis was also discussed with an aim of providing alternative routes for support. It was noted that there has been no progress on providing a secure room in the department. QC will continue to monitor this situation and seek assurance of patient and staff safety.
- The IBR was moved to the beginning of the agenda to ensure that the

committee could scrutinise the items allocated to it and provide assurance to the Board that thorough discussion had taken place. Unfortunately the copy received by the committee had not yet been populated by the Executives resulting in a considerable number of questions. It was also of concern that the committee was informed that those items of the IBR not populated will take approximately 6 months for data to be collected. Therefore assurance cannot be provided for those items. We noted an increase in patient falls and an associated reduction in Care Hours Per Patient Day. The DON provided an explanation of actions being taken to ensure nursing staff were appropriately allocated to areas where the dependency of patients was highest. This forms part of the daily meeting to review risk and dependency. It was noted that visiting is still by prior arrangement and acknowledged the important role that visitors have in calming distressed patients. When required special arrangements can be made. Decrease in Sepsis screening results in ED was discussed and work with the ED matron is in place to improve results. Complaints performance was discussed as the report did not tally with the recent verbal assurances given. It is noted that there are significant gaps in the corporate clinical governance team and the MD and DON are taking steps to review structure in order to match the structure with the new processes in place. Complaints themes are related to waits in ED and Discharge processes.

- The QC received the limited assurance audit report on Discharge and Mike Forster attended to give a presentation on the current progress improving discharge processes in the hospital and support in the community. The presentation was very comprehensive and provided insight to the work and the difficulties experienced. A whole system management of the process, not only to safely discharge but keep patients safe at home without coming into the hospital, is underway. Concern was expressed about the lack of 7 day response from Leeds services, resulting in Leeds patients potentially staying in hospital unnecessarily over a weekend.
- The committee was presented with an explanation of the Perfect Ward App. The launch is scheduled to take place of the 10th January 2022. The App will be populated from the matrons audits of their areas and provide pictorial evidence of the performance of wards and departments against the quality standards. This will be posted on the Quality Boards in each ward and department.
- The MD and DON provided assurance regarding actions from the QRMG. These included colleague wellbeing due to increase in COVID related absence and increasing prevalence in the local community. The 12-15 vaccination programme which is particularly challenging in North Yorkshire. The Caring at Our Best programme manager has been seconded to assist in this process which has resulted in a gap and delay in implementation of some of the work. Steps are being taken to address the current gap. Moderate Harm incidents and evidence that HDFT was an outlier, this appears to be the result of notification of community acquired pressure ulcers as a moderate harm incident which is being allocated to the Trust. An update was provided on the Trust vaccination programme for COVID boosters and Flu. Progress update on the backlog of Glaucoma review cases was provided.
- The delivery of drugs to recently discharged patients following an incident was discussed. Action is being taken to ensure the system is more secure.

Any significant risks for noting by Board? (list if appropriate)
None additional to those currently identified.
Any matters of escalation to Board for decision or noting (list if appropriate)
The Board should note The importance of the IBR being fully populated prior to the Board Committees. Impact of COVID related absence on quality of care. Mental Health patients waiting in ED. Discharge difficulties resulting in ‘Stranded patients’ in hospital.

Harrogate and District
NHS Foundation Trust

Board Committee Report to the Board of Directors

Committee Name:	Quality Committee
Committee Chair:	Laura Robson, Non-executive Director
Date of meeting:	17/11/2021
Date of Board meeting this report is to be presented	24/11/2021

Summary of key issues

- The Quality Committee met via teleconference. The meeting was observed by Doug Masterton Public Governor. Dave Stott, Public Governor also attended and observed the meeting.
- The Committee received a presentation on a Deep Dive into moderate harm incidents. The Trust had been identified as an outlier, having more moderate harm incidents than comparable organisations. The deep dive had identified that the Trust was reporting pressure ulcers present on admission as moderate harm when the Trust had no input into the care of the patient. It was concluded that HDFT was reporting pressure ulcers inaccurately compared to our neighbouring Trusts. The recommendations to bring the Trust in line with others were agreed. The information will still be gathered, but designated as no harm, to ensure that development work can be undertaken with our community partners.
- The committee was updated on the Waiting list management. Assurance was given of prioritisation of cases and increased activity over a weekend to improve the situation.
- The DON and Deputy DON gave further information on ‘Making patient experience count’ and provided an open and honest account of what we do well, what we could do better and how we are planning to ensure we use patient feedback to improve patient experience. It is evident that a lot of action is being taken and we were assured of significant grip on the issues. As this is a quality priority for the Trust we will continue to receive regular updates.
- The QC will receive completed action plans for internal audits that fall within its remit.
- Considerable discussion took place regarding the IBR. The complete version was received the morning of the meeting. The NEDs cannot provide assurance to the Board in relation to all the standards allocated to it without the completed paper. The Company Secretary is reviewing dates of meetings to identify ways in which timescales can be adjusted in order that Board committees have all relevant information to be fully assured. As a consequence there was considerable discussion on the IBR.
- 12 trolley waits that exceeded the 12 hour rule had been reported in the IBR.

Following validation it was considered that 4 did not fulfil the criteria of a 12 hour wait. Root cause analysis was not yet complete so the committee could not be assured that the wait was not preventable or that the patient had not suffered as a result of the wait. The Directorate Senior Nurse will report back to the meeting in December.

- A number of issues were identified that could all be linked to increased activity and pressure on staff. Activity was extremely high with 117% bed occupancy reported. Sickness was at 6%. Care hours per patient day had fallen. The metrics give a picture of the pressure in the system. The committee acknowledged the pressure that colleagues were experiencing. We will continue to monitor the safety and experience indicators to ensure that risk is being mitigated as winter approaches.
- The Quality Governance Management group report was received. A number of issues were reported. A temporary project manager for the Caring at Our Best Programme has been appointed. The Quality and Patient Safety teams have been reviewed and portfolios for the DON and MD agreed. A workshop to agree the structure is planned. Complaints response time continues to see improvement and we were assured that there has been no increase in returns.
- The Senior Nurse for Long Term and Unscheduled Care gave a presentation on a deep dive that the directorate has undertaken into falls, pressure ulcers, staffing levels on each of its wards. The evidence provided assurance that there was no deterioration, against the two indicators, even when wards had additional beds due to expansion to cope with pressure.
- The DON gave an explanation of current staffing pressures in the safeguarding team due to sickness and maternity leave. We were informed that colleagues received appropriate support to manage safeguarding cases where required. The HOM gave information regarding the appointment of a new safeguarding midwife who will work with the wider team. The HOM also explained the positive feedback received regarding our Ockenden submission.
- The Quality account is still under review and has not been received by the committee.

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

Escalating ED attendances, Long Stay Patients, Bed Pressures and Sickness rates presenting a risk to patient safety.

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

The Board is aware of the current pressures across the system and the potential for patient harm and colleague fatigue.

12 hour trolley waits in ED

teamHDFT
At our best

NHS
Harrogate and District
NHS Foundation Trust

Board of Directors (Public)
24th November 2021

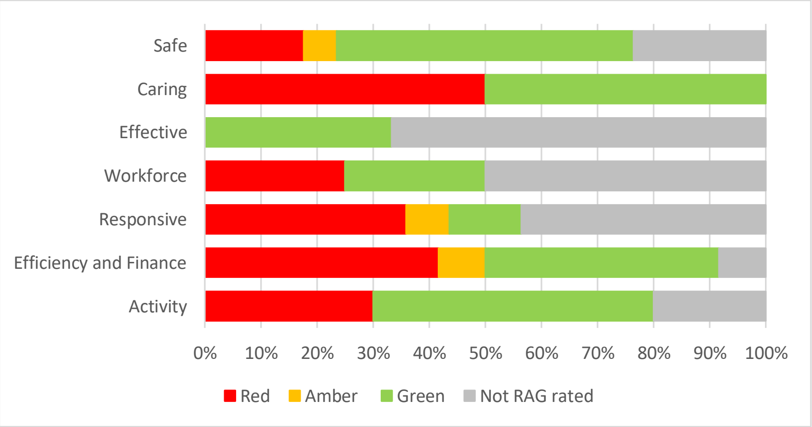
Title:	Integrated Board Report
Responsible Director:	Executive Directors
Author:	Head of Performance & Analysis

Purpose of the report and summary of key issues:	The Trust Board is asked to note the items contained within this report. This month's report presents data for the set of indicators proposed for the new style Integrated Board Report. This month's report includes charts and narrative for each indicator as previously agreed with Trust Board.	
BAF Risk:	AIM 1: To be an outstanding place to work	
	BAF1.1 to be an outstanding place to work	Y
	BAF1.2 To be an inclusive employer where diversity is celebrated and valued	Y
	AIM 2: To work with partners to deliver integrated care	
	BAF2.1 To improve population health and wellbeing, provide integrated care and to support primary care	Y
	BAF2.2 To be an active partner in population health and the transformation of health inequalities	Y
	AIM 3: To deliver high quality care	
	BAF3.1 and 3.4 To provide outstanding care and outstanding patient experience	Y
	BAF3.2 To provide a high quality service	Y
	BAF3.3 To provide high quality care to children and young people in adults community services	Y
	BAF3.5 To provide high quality public health 0-19 services	Y
	AIM 4: To ensure clinical and financial sustainability	
	BAF4.1 To continually improve services we provide to our population in a way that are more efficient	Y
	BAF4.2 and 4.3 To provide high quality care and to be a financially sustainable organisation	Y
	BAF4.4 To be financially stable to provide outstanding quality of care	Y
Corporate Risks	None	
Report History:	A draft version of this report was presented to Senior Management Team earlier this month.	
Recommendation:	The Trust Board is asked to note the items contained within this report.	

Integrated Board Report - Summary of indicators - October 2021

1. This report presents data for the set of indicators proposed for the new style Integrated Board Report.
2. As with the previous report, the indicators have been grouped into sections based largely around the domains defined by CQC.
3. Some indicators are still in the development phase and so data is not available at this stage.
4. The list of indicators will continue to be refined, in discussion with Executive Team members, in the coming weeks including agreeing RAG rating thresholds.
5. The report includes charts and narrative sections for all indicators as previously agreed.

		RAG ratings			
Domain	Total indicators	Red	Amber	Green	Not RAG rated
Safe	17	3	1	9	4
Caring	4	2	0	2	0
Effective	6	0	0	2	4
Workforce	8	2	0	2	4
Responsive	39	14	3	5	17
Efficiency and Finance	12	5	1	5	1
Activity	10	3	0	5	2
Total	**96**	**29**	**5**	**30**	**32**



NHS System Oversight Framework (SOF) 2021/22

1. The NHS System Oversight Framework (SOF) provides clarity to Integrated Care Systems (ICSs), Trusts and Commissioners on how NHS England and NHS Improvement will monitor performance; sets expectations on working together to maintain and improve the quality of care; and describes how identified support needs to improve standards and outcomes will be co-ordinated and delivered.

2. It will be used by NHS England and NHS Improvement’s regional teams to guide oversight of ICSs at system, place-based and organisation level as well as decisions about the level and nature of delivery support they may require.

3. It describes how NHS England and NHS Improvement will work with the Care Quality Commission (CQC) and other partners at national, regional and local level to ensure our activities are aligned.

4. It introduces a new integrated and system focused Recovery Support Programme (RSP) that replaces the previously separate quality and finance ‘special measures’ regimes for provider trusts.

5. In total, there are 81 metrics in this year’s framework, 47 of which are applicable to Trusts. The technical guidance documents that provide the detail around these metrics were expected in August but have not yet been published.

6. We have recently received confirmation from NHS England and NHS Improvement that HDFT has been placed in **Segment 2**. This indicates that there are targeted areas of challenges with plans in place that have the support of system partners.

Integrated Board Report - Summary of Oct-21 performance

Domain	Indicator number	Indicator name	Latest position
Safe	1.1	Pressure ulcers - hospital acquired - cat 3 or above - per 1,000 bed days	0.60
Safe	1.2	Pressure ulcers - community acquired - cat 3 or above - per 1,000 patient contacts	0.56
Safe	1.3	Inpatient falls per 1,000 bed days	5.9
Safe	1.4	Infection control - C.diff hospital acquired cases due to a lapse in care	0
Safe	1.5	Infection control - MRSA hospital acquired cases due to a lapse in care	0
Safe	1.6	Incidents - ratio of low harm incidents	26.00
Safe	1.7.1	Incidents - comprehensive serious incidents (SI)	0
Safe	1.7.2	Incidents - Never events	0
Safe	1.8.1	Safer staffing levels - fill rate	87.4%
Safe	1.8.2	Safer staffing levels - CHPPD	7.2
Safe	1.9	Maternity - % women seen by a midwife (or healthcare professional) by 12w 6d	100.0%
Safe	1.10	Maternity - % women with Continuity of Care pathway	
Safe	1.11	Infant health - % women smoking at time of delivery	3.0%
Safe	1.12	Infant health - % women initiating breastfeeding	81.1%
Safe	1.13	VTE risk assessment - inpatients	97.1%
Safe	1.14.1	Sepsis screening - inpatient wards	91.5%
Safe	1.14.2	Sepsis screening - Emergency department	89.3%

Domain	Indicator number	Indicator name	Latest position
Caring	2.1.1	Friends & Family Test (FFT) - Patients	93.4%
Caring	2.1.2	Friends & Family Test (FFT) - Adult Community Services	90.5%
Caring	2.2.1	Complaints - numbers received	13
Caring	2.2.2	Complaints - % responded to within time	50%
Effective	3.1	Mortality - HSMR	96.84
Effective	3.2	Mortality - SHMI	0.96
Effective	3.3.1	Readmissions to the same specialty within 30 days - following elective admission	1.6%
Effective	3.3.2	Readmissions to the same specialty within 30 days - following non-elective admission	7.9%
Effective	3.4	Returns to theatre	
Effective	3.5	Delayed Transfer of Care	24.7%
Workforce	4.1	Staff appraisal rate	52.8%
Workforce	4.2	Mandatory training rate	86.0%
Workforce	4.3	Staff sickness rate	6.04%
Workforce	4.4	Staff turnover rate	14.6%
Workforce	4.5.1	Children's Services - 0-5 Service - vacancies	
Workforce	4.5.2	Children's Services - 5-19 Service - vacancies	
Workforce	4.6.1	Workforce Race Equality Standard (WRES) - Relative likelihood of staff being shortlisted across all posts	
Workforce	4.6.2	Workforce Race Equality Standard (WRES) - Relative likelihood of staff being appointed from shortlisting	

Domain	Indicator number	Indicator name	Latest position
Responsive	5.1.1	RTT Incomplete pathways performance - median	10
Responsive	5.1.2	RTT Incomplete pathways performance - 92nd centile	41
Responsive	5.1.3	RTT Incomplete pathways - total	22423
Responsive	5.1.4	RTT Incomplete pathways - 52-<104 weeks	1037
Responsive	5.1.5	RTT Incomplete pathways - 104+ weeks	33
Responsive	5.2.1	RTT waiting times - by ethnicity	
Responsive	5.2.2	RTT waiting times - by level of deprivation	
Responsive	5.2.3	RTT waiting times - learning disabilities	
Responsive	5.3	Diagnostic waiting times - 6-week standard	79.7%
Responsive	5.4	Outpatients lost to follow-up - number of follow up patients past due date	
Responsive	5.5	Data quality on ethnic group - inpatients	94.3%
Responsive	5.6	A&E 4 hour standard	75.9%
Responsive	5.7	Ambulance handovers - % within 15 mins	87.4%
Responsive	5.8	A&E - number of 12 hour trolley waits	8
Responsive	5.9.1	Cancer - 62 day wait for first treatment from urgent GP referral to treatment	82.7%
Responsive	5.9.2	Cancer - 62 day wait for first treatment from urgent GP referral to treatment - number of 104 days waiters	3
Responsive	5.10	Cancer - 14 days maximum wait from urgent GP referral for all urgent suspect cancer referrals	84.0%
Responsive	5.11	Cancer - 28 days faster diagnosis standard (suspected cancer referrals)	79.6%
Responsive	5.12	Cancer - 31 days maximum wait from diagnosis to treatment for all cancers	98.0%

Domain	Indicator number	Indicator name	Latest position
Responsive	5.13.1	Children's Services - 0-12 months caseload	
Responsive	5.13.2	Children's Services - 2-3 years caseload	
Responsive	5.14.1	Children's Services - Safeguarding caseload - number of strategy meetings	
Responsive	5.14.2	Children's Services - Safeguarding caseload - number of initial Child Protection case conferences	
Responsive	5.14.3	Children's Services - Safeguarding caseload - number of court reports	
Responsive	5.14.4	Children's Services - Safeguarding caseload - number of Looked After Children	
Responsive	5.15	Children's Services - Ante-natal visits	83.9%
Responsive	5.16	Children's Services - 10-14 day new birth visit	94.4%
Responsive	5.17	Children's Services - 6-8 week visit	89.3%
Responsive	5.18	Children's Services - 12 month review	95.4%
Responsive	5.19	Children's Services - 2.5 year review	91.0%
Responsive	5.20	Children's Services - % children with all 5 mandated contacts	
Responsive	5.21	Children's Services - Delivery of Immunisation trajectory	
Responsive	5.22	Children's Services - OPEL level	
Responsive	5.23	Community Care Adult Teams - performance against new timeliness standards	
Responsive	5.24	Community Care Adult Teams - Number of virtual beds delivered in Supported Discharge Service	
Responsive	5.25	Community Care Adult Teams - Number of cancelled routine visits	
Responsive	5.26	Community Care Adult Teams - OPEL level	
Responsive	5.27	Out of hours - telephone clinical assessment for URGENT cases within 20 minutes of call prioritisation	42.1%
Responsive	5.28	Home visit: Face to face consultations started for URGENT cases within 2 hrs	92.1%

Domain	Indicator number	Indicator name	Latest position
Efficiency and Finance	6.1	Agency spend	£ 389
Efficiency and Finance	6.2	Surplus / deficit and variance to plan	-
Efficiency and Finance	6.3	Capital spend	£ 8,006
Efficiency and Finance	6.4	Cash balance	£ 40,738
Efficiency and Finance	6.5.1	Long stay patients - stranded (>7 days LOS)	146
Efficiency and Finance	6.5.2	Long stay patients - superstranded (>21 days LOS)	56
Efficiency and Finance	6.6	Occupied bed days per 1,000 population	61.4
Efficiency and Finance	6.7.1	Length of stay - elective	2.22
Efficiency and Finance	6.7.2	Length of stay - non-elective	4.72
Efficiency and Finance	6.8	Avoidable admissions	204
Efficiency and Finance	6.9	Theatre utilisation (elective sessions)	80.4%
Efficiency and Finance	6.10	Day case conversion rate	1.9%

Domain	Indicator number	Indicator name	Latest position
Activity	7.1.1	GP Referrals against plan	
Activity	7.1.2	GP Referrals against 2019/20 baseline	
Activity	7.2.1	Outpatient activity (consultant led) against plan (new and follow up)	102.8%
Activity	7.2.2	Outpatient activity (consultant led) against 2019/20 baseline (new and follow up)	79.7%
Activity	7.3.1	Elective activity against plan	99.3%
Activity	7.3.2	Elective activity against 2019/20 baseline	72.8%
Activity	7.4.1	Non-elective activity against plan	95.1%
Activity	7.4.2	Non-elective activity against 2019/20 baseline	94.0%
Activity	7.5.1	Emergency Department attendances against plan	101.6%
Activity	7.5.2	Emergency Department attendances against plan, 2019/20 baseline	106.6%

Integrated Board Report - List of indicators

													Monthly RAG thresholds:		
Domain	Indicator number	Indicator name	Clinical Directorate(s) metric is applicable to	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Exec Lead	Committee reported to:	Red	Amber	Green
Safe	1.1	Pressure ulcers - hospital acquired - cat 3 or above - per 1,000 bed days	PSC, LTUC	0.37	0.00	0.61	0.34	0.55	1.05	0.60	EN	Quality	tbc		
Safe	1.2	Pressure ulcers - community acquired - cat 3 or above - per 1,000 patient contacts	LTUC	1.31	1.36	0.60	0.99	1.24	0.64	0.56	EN	Quality	tbc		
Safe	1.3	Inpatient falls per 1,000 bed days	PSC, LTUC	5.1	6.1	4.9	5.9	7.3	8.5	5.9	EN	Quality	above HDFT average for 2020/21	0-20% below HDFT average for 2020/21	>20% below HDFT average for 2020/21
Safe	1.4	Infection control - C.diff hospital acquired cases due to a lapse in care	All	0	0	0	1	0	0	0	EN	Quality	>19 YTD		<=19 YTD
Safe	1.5	Infection control - MRSA hospital acquired cases due to a lapse in care	All	0	0	0	0	0	0	0	EN	Quality	>0 YTD		0 YTD
Safe	1.6	Incidents - ratio of low harm incidents	All	16.49	21.29	19.98	27.63	19.58	25.29	26.00	EN	Quality	HDFT in bottom 25% of Acute Trusts	HDFT in middle 50% of Acute Trusts	HDFT in top 25% of Acute Trusts
Safe	1.7.1	Incidents - comprehensive serious incidents (SI)	All	3	1	4	1	3	0	0	EN	Quality	>0		0
Safe	1.7.2	Incidents - Never events	All	0	1	0	0	0	0	0	EN	Quality			
Safe	1.8.1	Safer staffing levels - fill rate	All	93.8%	93.1%	92.5%	92.6%	90.1%	85.9%	87.4%	EN	Quality	<80%	80% - 95%	>=95%
Safe	1.8.2	Safer staffing levels - CHPPD	All	8.6	8.4	8.6	8.0	7.9	7.8	7.2	EN	Quality	tbc		
Safe	1.9	Maternity - % women seen by a midwife (or healthcare professional) by 12w 6d	PSC	99.4%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	EN	Quality	<90%		>=90%
Safe	1.10	Maternity - % women with Continuity of Care pathway	PSC								EN	Quality			
Safe	1.11	Infant health - % women smoking at time of delivery	PSC	6.6%	2.9%	7.4%	5.2%	3.0%	4.3%	3.0%	EN	Quality	>15%		<=15%
Safe	1.12	Infant health - % women initiating breastfeeding	PSC	83.6%	82.6%	84.8%	83.8%	79.2%	87.4%	81.1%	EN	Quality	<75%		>=75%
Safe	1.13	VTE risk assessment - inpatients	PSC, LTUC	96.7%	97.1%	96.9%	96.3%	96.6%	95.7%	97.1%	EN	Quality	<95%		>=95%
Safe	1.14.1	Sepsis screening - inpatient wards	All	91.8%	96.1%	93.2%	93.5%	92.5%	90.8%	91.5%	EN	Quality	<90%		>=90%
Safe	1.14.2	Sepsis screening - Emergency department	LTUC	85.9%	89.2%	88.9%	86.6%	88.0%	88.8%	89.3%	EN	Quality	<90%		>=90%
Caring	2.1.1	Friends & Family Test (FFT) - Patients	All	94.2%	92.7%	93.7%	93.7%	92.8%	93.3%	93.4%	EN	Quality	<90%		>=90%
Caring	2.1.2	Friends & Family Test (FFT) - Adult Community Services	CC	94.7%	95.5%	96.5%	96.1%	95.3%	96.0%	90.5%	EN	Quality	<90%		>=90%
Caring	2.2.1	Complaints - numbers received	All	14	24	18	20	32	20	13	EN	Quality	above HDFT average for 2020/21		On or below HDFT average for 2020/21
Caring	2.2.2	Complaints - % responded to within time	All		50%	35%	56%	56%	48%	50%	EN	Quality	<95%		>=95%
Effective	3.1	Mortality - HSMR	All	94.93	95.13	91.94	96.11	96.84			JA	Quality	Higher than expected		Within expected range or below expected
Effective	3.2	Mortality - SHMI	All	0.918	0.962						JA	Quality	Higher than expected		Within expected range or below expected
Effective	3.3.1	Readmissions to the same specialty within 30 days - following elective admission - as % of all elective admissions	All	1.8%	1.6%	1.6%	1.7%	2.1%	1.6%		RN	Resources	tbc		
Effective	3.3.2	Readmissions to the same specialty within 30 days - following non-elective admission - as % of all non-elective admissions	All	9.5%	8.2%	7.3%	8.2%	8.4%	7.9%		RN	Resources	tbc		
Effective	3.4	Returns to theatre	PSC								RN	Resources	tbc		
Effective	3.5	Delayed Transfer of Care - % inpatients not meeting the criteria to reside	LTUC	22.0%	14.5%	20.6%	24.0%	10.6%	21.9%	24.7%	RN	Resources	tbc		
Workforce	4.1	Staff appraisal rate	All	56.3%	58.3%	58.9%	55.9%	55.2%	54.0%	52.8%	AW	People and Cult	<70%	70% - 90%	>=90%
Workforce	4.2	Mandatory training rate	All	91.7%	92.1%	92.0%	92.0%	87.0%	86.0%	86.0%	AW	People and Cult	<50%	50% - 75%	>=75%
Workforce	4.3	Staff sickness rate	All	3.74%	3.94%	4.04%	4.77%	5.02%	5.26%	6.04%	AW	People and Cult	>3.9%		<=3.9%
Workforce	4.4	Staff turnover rate	All	12.9%	13.0%	13.3%	13.5%	14.2%	14.5%	14.6%	AW	People and Cult	>15%		<=15%
Workforce	4.5.1	Children's Services - 0-5 Service - vacancies	CC								AW	People and Culture			

													Monthly RAG thresholds:		
Domain	**Indicator number**	**Indicator name**	**Clinical Directorate(s) metric is applicable to**	**Apr-21**	**May-21**	**Jun-21**	**Jul-21**	**Aug-21**	**Sep-21**	**Oct-21**	**Exec Lead**	**Committee reported to:**	**Red**	**Amber**	**Green**
Workforce	4.5.2	Children's Services - 5-19 Service - vacancies	CC								AW	People and Culture			
Workforce	4.6.1	Workforce Race Equality Standard (WRES) - Relative likelihood of staff being shortlisted across all posts	All								AW	People and Cultu	tbc		
Workforce	4.6.2	Workforce Race Equality Standard (WRES) - Relative likelihood of staff being appointed from shortlisting	All								AW	People and Cultu	tbc		
Responsive	5.1.1	RTT Incomplete pathways performance - median	All	8	8	8	9	9	10	10	RN	Resources	>10	08 - 10	<=8
Responsive	5.1.2	RTT Incomplete pathways performance - 92nd centile	All	44	43	41	40	40	41	41	RN	Resources	>24	18 - 24	<=18
Responsive	5.1.3	RTT Incomplete pathways - total	All	18156	19476	20631	21785	22168	22648	22423	RN	Resources	>15,000	14,000 - 15,000	<=14,000
Responsive	5.1.4	RTT Incomplete pathways - 52-<104 weeks	All	1196	1082	993	968	932	1008	1037	RN	Resources	>0		0
Responsive	5.1.5	RTT Incomplete pathways - 104+ weeks	All	3	5	13	20	23	24	33	RN	Resources	>0		0
Responsive	5.2.1	RTT waiting times - by ethnicity	All								RN	Resources			
Responsive	5.2.2	RTT waiting times - by level of deprivation	All								RN	Resources			
Responsive	5.2.3	RTT waiting times - learning disabilities	All								RN	Resources			
Responsive	5.3	Diagnostic waiting times - 6-week standard	All	79.7%	85.4%	79.2%	75.1%	74.0%	80.5%	79.7%	RN	Resources	<99%		>=99%
Responsive	5.4	Outpatients lost to follow-up - number of follow up patients past due date	All								RN	Resources			
Responsive	5.5	Data quality on ethnic group - inpatients	All	93.0%	95.3%	94.6%	94.3%	94.8%	93.6%	94.3%	RN	Resources	<97%		>=97%
Responsive	5.6	A&E 4 hour standard	LTUC	86.3%	82.7%	82.6%	79.4%	80.6%	83.7%	75.9%	RN	Resources	<90%	90-95%	>=95%
Responsive	5.7	Ambulance handovers - % within 15 mins	LTUC	93.7%	93.6%	87.9%	89.2%	90.4%	93.9%	87.4%	RN	Resources	<90%	90-95%	>=95%
Responsive	5.8	A&E - number of 12 hour trolley waits	LTUC	0	0	0	0	0	0	8	RN	Resources	>0		0
Responsive	5.9.1	Cancer - 62 day wait for first treatment from urgent GP referral to treatment	LTUC	85.5%	87.1%	93.5%	84.1%	91.7%	88.8%	82.7%	RN	Resources	<85%		>=85%
Responsive	5.9.2	Cancer - 62 day wait for first treatment from urgent GP referral to treatment - number of 104 days waiters	LTUC	3	2	2	5	2	6	3	RN	Resources	>0		0
Responsive	5.10	Cancer - 14 days maximum wait from urgent GP referral for all urgent suspect cancer referrals	LTUC	81.7%	85.7%	88.2%	83.3%	86.0%	92.1%	84.0%	RN	Resources	<93%		>=93%
Responsive	5.11	Cancer - 28 days faster diagnosis standard (suspected cancer referrals)	LTUC	69.6%	71.8%	68.9%	70.6%	74.7%	74.0%	79.6%	RN	Resources	<70%	70-75%	>= 75%
Responsive	5.12	Cancer - 31 days maximum wait from diagnosis to treatment for all cancers	LTUC	97.0%	96.6%	100.0%	100.0%	98.9%	94.5%	98.0%	RN	Resources	<96%		>=96%
Responsive	5.13.1	Children's Services - 0-12 months caseload	CC								RN	Resources			
Responsive	5.13.2	Children's Services - 2-3 years caseload	CC								RN	Resources			
Responsive	5.14.1	Children's Services - Safeguarding caseload - number of strategy meetings	CC								RN	Resources			
Responsive	5.14.2	Children's Services - Safeguarding caseload - number of initial Child Protection case conferences	CC								RN	Resources			
Responsive	5.14.3	Children's Services - Safeguarding caseload - number of court reports	CC								RN	Resources			
Responsive	5.14.4	Children's Services - Safeguarding caseload - number of Looked After Children	CC								RN	Resources			
Responsive	5.15	Children's Services - Ante-natal visits	CC	85.9%	86.7%	89.8%	88.3%	89.4%	86.8%	83.9%	RN	Resources	<75%	75% - 90%	>=90%
Responsive	5.16	Children's Services - 10-14 day new birth visit	CC	95.4%	95.4%	95.4%	95.7%	95.4%	93.2%	94.4%	RN	Resources	<75%	75% - 90%	>=90%
Responsive	5.17	Children's Services - 6-8 week visit	CC	91.9%	92.4%	93.3%	93.3%	92.7%	90.1%	89.3%	RN	Resources	<75%	75% - 90%	>=90%
Responsive	5.18	Children's Services - 12 month review	CC	93.1%	91.2%	92.6%	94.0%	95.0%	93.5%	95.4%	RN	Resources	<75%	75% - 90%	>=90%
Responsive	5.19	Children's Services - 2.5 year review	CC	91.5%	91.7%	93.4%	92.3%	92.8%	92.2%	91.0%	RN	Resources	<75%	75% - 90%	>=90%

Domain	Indicator number	Indicator name	Clinical Directorate(s) metric is applicable to	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Exec Lead	Committee reported to:	Monthly RAG thresholds: Red	Amber	Green
Responsive	5.20	Children's Services - % children with all 5 mandated contacts	CC								RN	Resources	<75%	75% - 90%	>=90%
Responsive	5.21	Children's Services - Delivery of Immunisation trajectory	CC								RN	Resources			
Responsive	5.22	Children's Services - OPEL level	CC								RN	Resources	tbc		
Responsive	5.23	Community Care Adult Teams - performance against new timeliness standards	CC								RN	Resources	tbc		
Responsive	5.24	Community Care Adult Teams - Number of virtual beds delivered in Supported Discharge Service	CC								RN	Resources			
Responsive	5.25	Community Care Adult Teams - Number of cancelled routine visits	CC								RN	Resources			
Responsive	5.26	Community Care Adult Teams - OPEL level	CC								RN	Resources			
Responsive	5.27	Out of hours - telephone clinical assessment for URGENT cases within 20 minutes of call prioritisation	LTUC	36.7%	35.5%	39.9%	38.6%	45.9%	47.2%	42.1%	RN	Resources	<95%		>=95%
Responsive	5.28	Home visit: Face to face consultations started for URGENT cases within 2 hrs	LTUC	78.6%	86.2%	75.9%	79.2%	88.5%	93.5%	92.1%	RN	Resources	<95%		>=95%
Efficiency and Finance	6.1	Agency spend	All	£ 419	£ 307	£ 414	£ 517	£ 453	£ 429	£ 389	JC	Resources	>3% of pay bill	1% - 3%	<= 1%
Efficiency and Finance	6.2	Surplus / deficit and variance to plan	All	£ -	£ -	£ -	-	-	-	-	JC	Resources	>1% behind plan	0 - 1% behind plan	On plan
Efficiency and Finance	6.3	Capital spend	All	£ 518	£ 834	£ 1,856	£ 2,330	£ 3,188	£ 4,274	£ 8,006	JC	Resources	>25% behind plan	10% - 25% behind plan	On plan or <10% behind plan
Efficiency and Finance	6.4	Cash balance	All	£ 39,900	£ 34,587	£ 32,007	£ 32,386	£ 33,600	£ 42,000	£ 40,738	JC	Resources	>10% behind plan	0 - 10% behind plan	On plan
Efficiency and Finance	6.5.1	Long stay patients - stranded (>7 days LOS)	All	119	114	103	119	129	121	146	RN	Resources	>90	70-90	<=70
Efficiency and Finance	6.5.2	Long stay patients - superstranded (>21 days LOS)	All	48	44	40	42	51	47	56	RN	Resources	>40	30-40	<=30
Efficiency and Finance	6.6	Occupied bed days per 1,000 population	All	50.8	53.9	50.7	55.3	56.5	52.9	61.4	RN	Resources	tbc		
Efficiency and Finance	6.7.1	Length of stay - elective	All	2.26	2.60	2.57	2.66	2.76	2.31	2.22	RN	Resources	>2.75	2.5-2.75	<=2.5
Efficiency and Finance	6.7.2	Length of stay - non-elective	All	4.69	4.27	4.49	3.99	4.81	4.82	4.72	RN	Resources	>4.5	4-4.5	<=4.0
Efficiency and Finance	6.8	Avoidable admissions	All	189	219	242	261	215	204		RN	Resources	>270		<=270
Efficiency and Finance	6.9	Theatre utilisation (elective sessions)	PSC	81.2%	83.9%	83.4%	82.0%	83.7%	82.4%	80.4%	RN	Resources	<85%	85%-90%	>=90%
Efficiency and Finance	6.10	Day case conversion rate	PSC	2.2%	1.7%	1.9%	1.6%	1.6%	1.5%	1.9%	RN	Resources	>2%	1.5%-2%	<=1.5%
Activity	7.1.1	GP Referrals against plan	All								RN	Resources			
Activity	7.1.2	GP Referrals against 2019/20 baseline	All								RN	Resources			
Activity	7.2.1	Outpatient activity (consultant led) against plan (new and follow up)	All	113.7%	106.9%	123.2%	84.2%	87.0%	93.3%	102.8%	RN	Resources			
Activity	7.2.2	Outpatient activity (consultant led) against 2019/20 baseline (new and follow up)	All	90.8%	86.5%	98.7%	85.3%	88.6%	95.2%	79.7%	RN	Resources	<95% (from Jul-21)		>=95% (from Jul-21)
Activity	7.3.1	Elective activity against plan	All	102.5%	97.3%	109.3%	77.4%	75.4%	84.9%	99.3%	RN	Resources			
Activity	7.3.2	Elective activity against 2019/20 baseline	All	74.8%	80.6%	90.4%	73.9%	69.6%	80.7%	72.8%	RN	Resources	<95% (from Jul-21)		>=95% (from Jul-21)
Activity	7.4.1	Non-elective activity against plan	All	96.5%	97.4%	105.2%	104.3%	94.5%	93.5%	95.1%	RN	Resources			
Activity	7.4.2	Non-elective activity against 2019/20 baseline	All	89.9%	98.6%	104.8%	98.3%	92.7%	90.6%	94.0%	RN	Resources			
Activity	7.5.1	Emergency Department attendances against plan	LTUC	98.9%	106.6%	111.2%	103.4%	104.0%	105.7%	101.6%	RN	Resources			
Activity	7.5.2	Emergency Department attendances against plan, 2019/20 baseline	LTUC	98.9%	106.6%	110.8%	103.7%	104.1%	105.7%	106.6%	RN	Resources			

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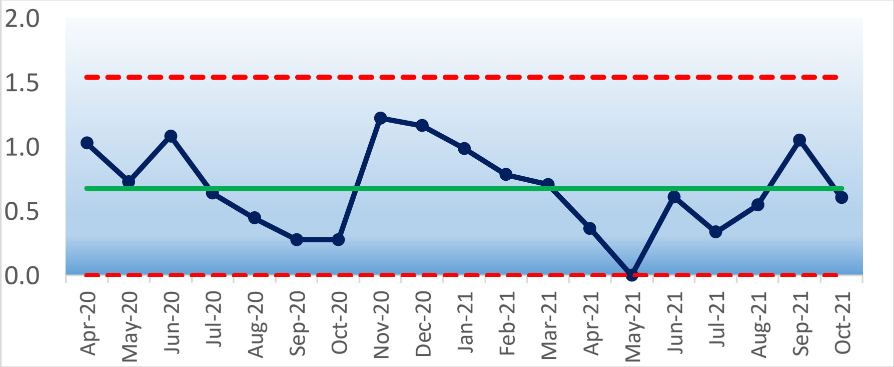
Domain 1 - Safe

Indicator	**1.1 - Pressure ulcers - hospital acquired - cat 3 or above - per 1,000 bed days**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Oct-21
Value / RAG rating	0.60

Indicator description

The number of hospital acquired category 3 and above pressure ulcers reported (including device related and device related mucosal) expressed as a rate per 1,000 bed days.

SPC chart



Narrative

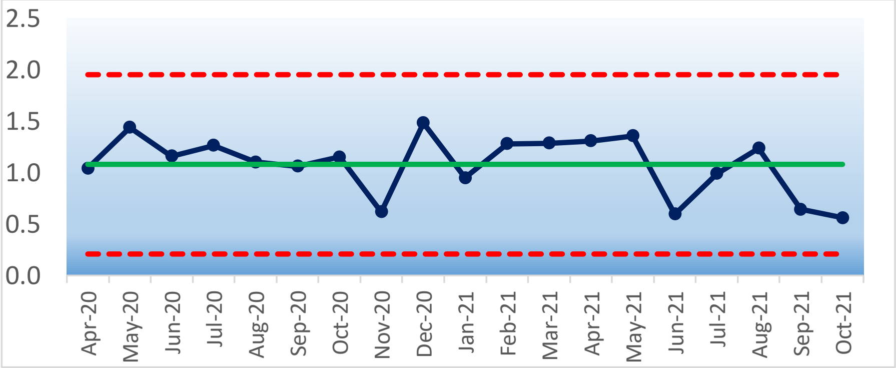
Improved position on Category 3 pressure ulcers for the month of October. Themes from previous RCAs (Root Cause Analyses) shared with teams to embed learning. The TVN (Tissue Viability Nurse) Team are providing ward based learning, stronger links and improved working relationships.

Indicator	**1.2 - Pressure ulcers - community acquired - cat 3 or above - per 1,000 patient contacts**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Oct-21
Value / RAG rating	0.56

Indicator description

The number of community acquired category 3 and above pressure ulcers reported (including device related and device related mucosal) expressed as a rate per 1,000 community patient contacts.

SPC chart



Narrative

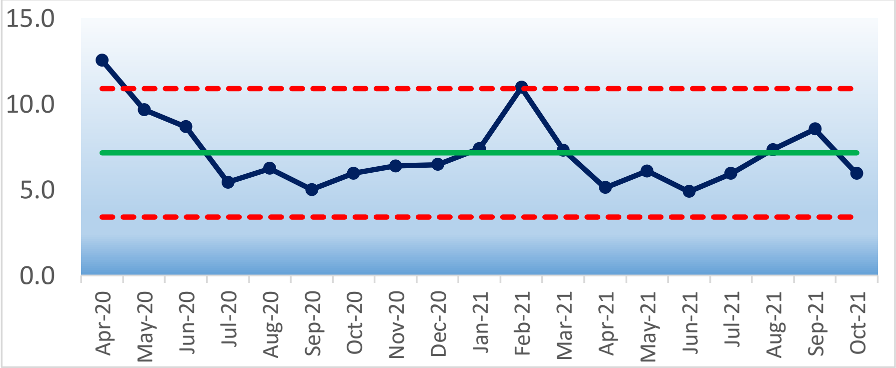
Community pressure ulcer rates continue to reduce. Revised definition of community acquired has contributed to the downward trend as well as thorough and transparent learning from RCAs.

Indicator	**1.3 - Inpatient falls per 1,000 bed days**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Oct-21
Value / RAG rating	5.95

Indicator description

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.

SPC chart



Narrative

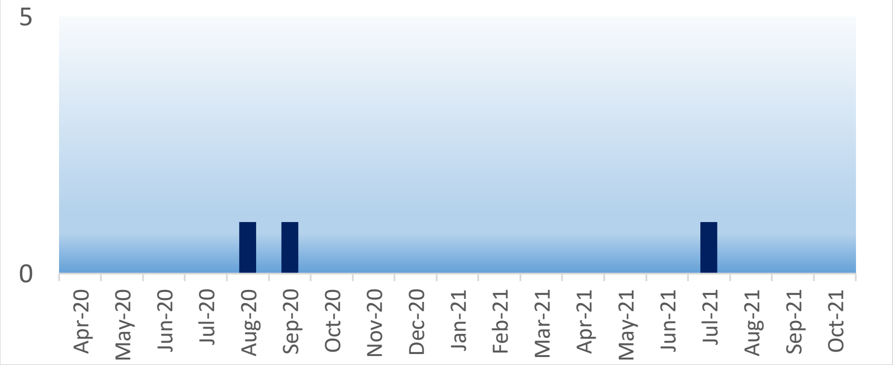
Improving position on number of inpatient falls; ward safety huddles and intensive support from Falls Lead prioritised over the month of October to improve on September's position. Numbers of patients who have had multiple falls also reducing. There has also been a renewed focus on enhanced care requests and the allocation of support workers to the patients with the greatest need. This is reviewed continually by the operational matrons and clinical site management team.

Indicator	**1.4 - Infection control - C.diff hospital acquired cases due to a lapse in care**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Oct-21
Value / RAG rating	0

Indicator description

The number of hospital acquired C.difficile cases where root cause analysis has identified a lapse in care. HDFT's C. difficile trajectory for 2021/22 is 19 cases. Cases where a lapse in care has been deemed to have occurred would count towards this.

Trend chart



Narrative

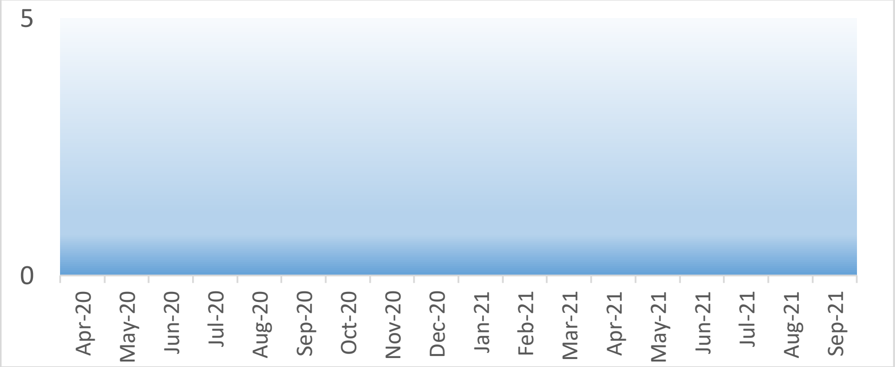
No hospital acquired C. Diff cases due to lapses in care have been reported for October 2021.

Indicator	**1.4 - Infection control - MRSA hospital acquired cases due to a lapse in care**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Oct-21
Value / RAG rating	0

Indicator description

The number of hospital acquired MRSA cases where root cause analysis has identified a lapse in care. HDFT's MRSA trajectory for 2021/22 is 0 cases. Cases where a lapse in care has been deemed to have occurred would count towards this.

Trend chart



Narrative

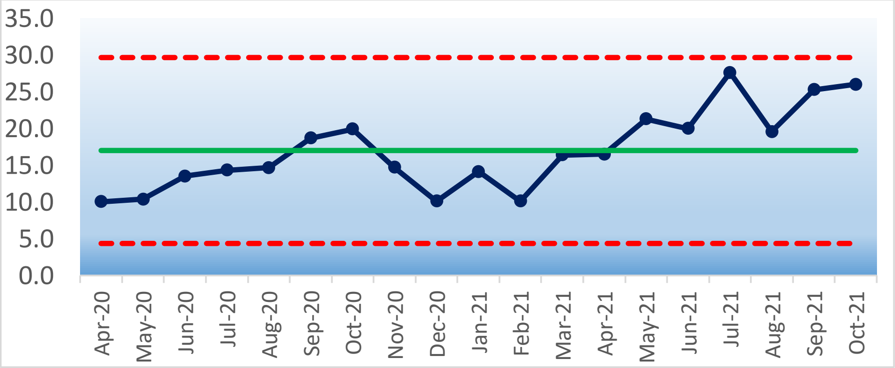
No hospital acquired MRSA cases due to lapses in care have been reported for October 2021.

Indicator	**1.6 - Incidents - ratio of low harm incidents**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Oct-21
Value / RAG rating	26.0

Indicator description

The number of incidents reported within the Trust each month. A large number of reported incidents but with a low proportion classified as causing significant harm is indicative of a good incident reporting culture.

SPC chart



Narrative

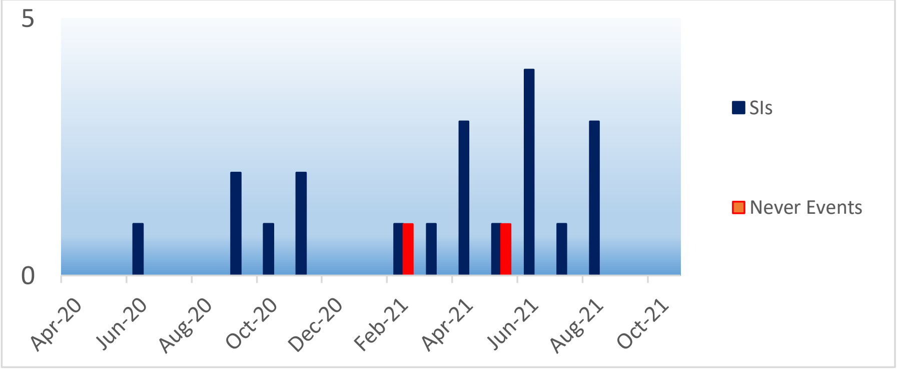
It is pleasing to report that the data has shown an upward trend with regards to the reporting of low harm and no harm incidents over the last two months, as this reflects an improving reporting culture across the organisation that is characterised by openness and transparency. Events reported where there is low harm and no harm helps to protect our patients from avoidable harm by increasing the opportunities to learn where things go wrong. The reporting of incidents is monitored week on week at directorate level and also at the trust weekly Quality Summit (QS). There was a marginal increase in reporting in month reflected by the site experiencing higher acuity; however this was not reflected in a rise in moderate or severe harms. Clinical teams are encouraged to report incidents and themes/trends are shared by the HoN's at QS.

Indicator	**1.7 - Incidents - comprehensive serious incidents (SI) and Never Events**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Oct-21
Value / RAG rating	0 (SI), 0 (Never Events)

Indicator description

The number of Serious Incidents (SI) and Never Events reported. The data includes hospital and community services. Only comprehensive SIRIs are included in this indicator, as concise SIRIs are reported within the pressure ulcer / falls indicators above.

Trend chart



Narrative

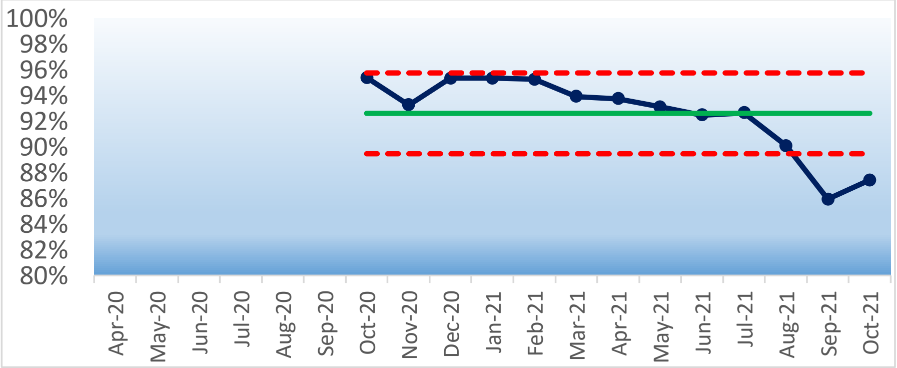
There have been no further serious incidents or never events declared in October 2021.

Indicator	**1.8.1 - Safer staffing - fill rate**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Oct-21
Value / RAG rating	87.4%

Indicator description

The chart shows the overall fill rate at HDFT for registered nurses/midwives (RN) and care support workers (CSW) for day and night shifts on inpatient wards. The fill rate is calculated by comparing planned staffing with actual levels achieved.

SPC chart



Narrative

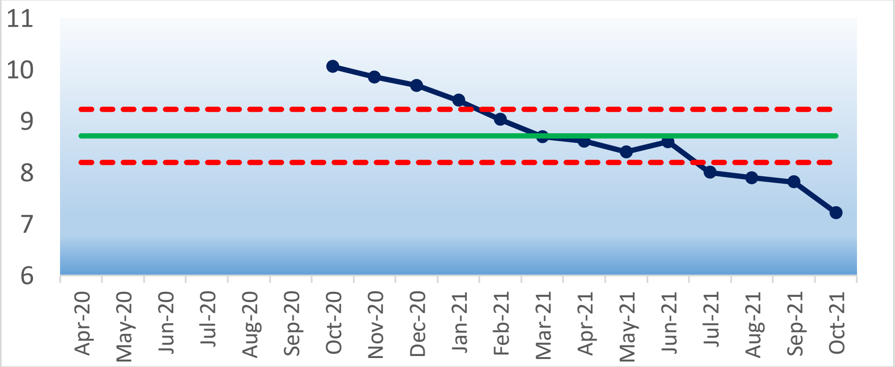
Although the overall fill rate has increased in month, staffing still remains a challenge due to a combination of increased short term sickness (including on day), maternity leave and covid related isolations. In order to help increase fill rate and mitigate gaps, the Trust has engaged with new nursing agencies and has put a bonus incentive scheme in place through its staff bank which has helped with some fill. As part of the Trust's daily operational response to staffing, heads of nursing and matrons (including CSM's) will risk assess and agree staff moves to help mitigate the areas of greatest risk.

Indicator	**1.8.2 - Safer staffing - care hours per patient per day (CHPPPD)**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Oct-21
Value / RAG rating	7.2

Indicator description

The chart shows the care hours per patient per day (CHPPPD). This is caclulated by comparing the total hours worked by reigstered and unregistered nurses and midwives and comparing these to the number of patients on the wards during the month.

SPC chart



Narrative

Acuity and demand remains high across most of the adult wards and therefore follows the same trend as the previous month. Enhanced cares have continued to be static at around the 30-40 cases per day. Nidderdale, Littondale, Wendsleydale, Jervaulx and Oakdale remain the areas of greatest demand from a patient perspective and those affected by short term sickness, which in turn has led to a further reduction in CHPPPD. Littondale still hosts the majority of gastro admissions and many patients are on complex IV regimes.

ITU has also been challenged with the staffing position this month - part sickness but also acuity. COVID LoS admissions are increasing (at level 3) and requiring more support which has at times come from theatres or general ward nurses which has an impact on these areas and therefore CHPPPD in these ward areas. NIV admissions have also risen and are being admitted into Farndale (where appropriate) and this further impacts on CHPPPD for other ward patients.

Indicator	**1.9 - Maternity - % women seen by a midwife (or healthcare professional) by 12w 6d**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Oct-21
Value / RAG rating	100%

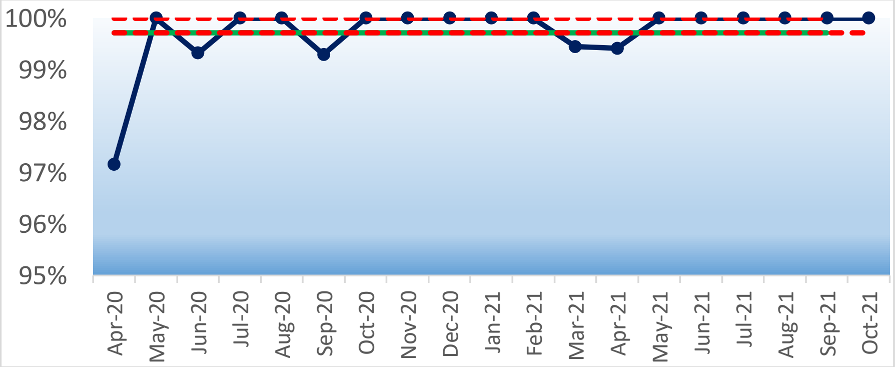
Indicator description

The % of pregnant women seen by a midwife (or healthcare professional) by 12 weeks 6 days gestation.

Narrative

100% standard met.

SPC chart



Indicator	**1.10 - Maternity - % women with Continuity of Care pathway**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	
Value / RAG rating	

Indicator description

This indicator is under development.

SPC chart

Narrative

Indicator	**1.11 - Maternity - % women smoking at time of delivery**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Oct-21
Value / RAG rating	3.0%

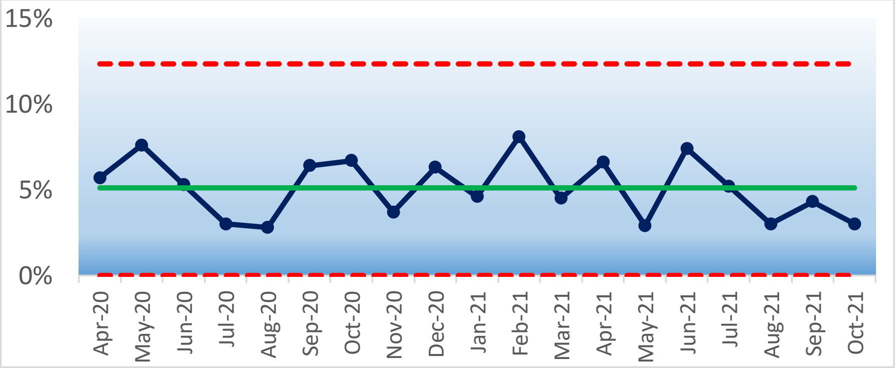
Indicator description

The % of pregnant women smoking at the time of delivery.

Narrative

Smoking rates of women at time of delivery remain lowest in the region.

SPC chart

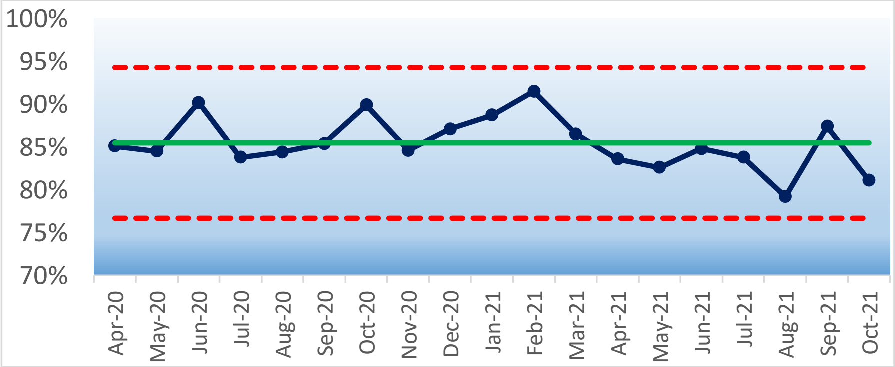


Indicator	**1.12 - Maternity - % women initiating breastfeeding**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Oct-21
Value / RAG rating	81.1%

Indicator description

The % of women initiating breastfeeding

SPC chart



Narrative

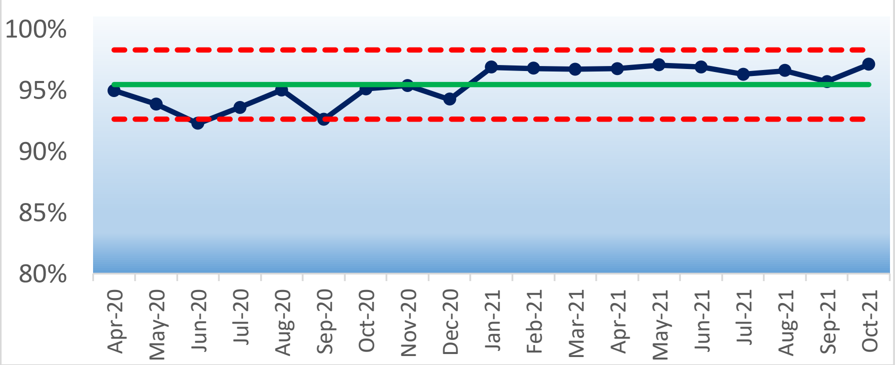
Breastfeeding initiation rates remain very high at 81.1% compared to a regional average of 69.0%.

Indicator	**1.13 - VTE risk assessment - inpatients**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Oct-21
Value / RAG rating	🟩 97.1%

Indicator description

The percentage of eligible adult inpatients who received a VTE risk assessment.

SPC chart



Narrative

GIRFT report and recommendations are currently informing the recruitment process for a VTE practitioner. This role will lead on the quality and governance of VTE risk assessments and management. Progress is being made in the compliance with risk assessment increasing.

Indicator	**1.14 - Sepsis screening - inpatient wards**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Oct-21
Value / RAG rating	🟩 91.5%

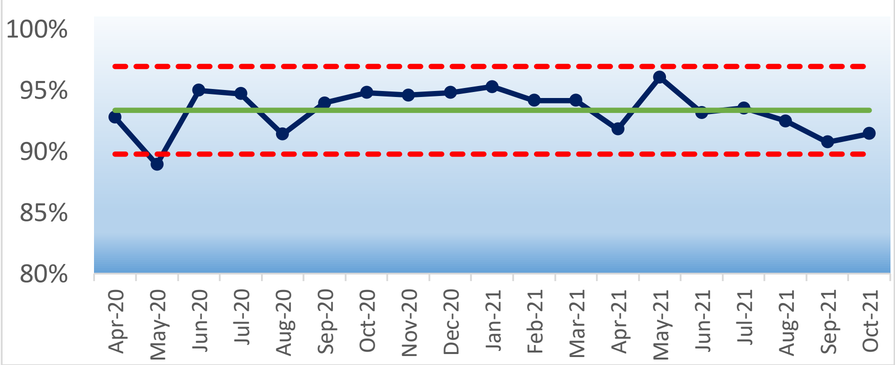
Indicator description

The percentage of eligible inpatients who were screened for sepsis.

Narrative

The % is within threshold for the month. On further analysis, there are a group of patients who may trigger a sepsis screening at the time of data collection; however the % will not include those patients who will later go on to have that screen.

SPC chart

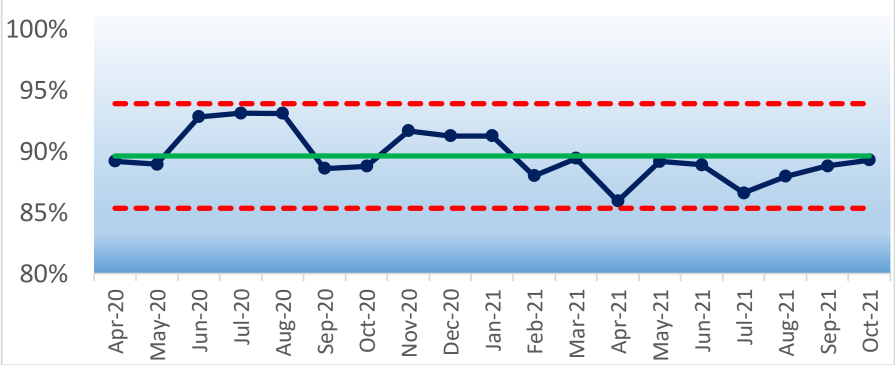


Indicator	**1.15 - Sepsis screening - Emergency department**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Oct-21
Value / RAG rating	🟥 89.3%

Indicator description

The percentage of eligible Emergency Department attendances who were screened for sepsis.

SPC chart



Narrative

As is the case with many areas across the Trust currently, ED remains under significant pressure day to day, which in turn is having an impact on the ability to consistently monitor and maintain sepsis screening, although the % is rising overall. However the Head of Nursing is working with the department leads to ensure there remains focus on the importance of this. Actions currently in place include adding a new message re: sepsis screening to the department huddle. A new regular one hour sessions on 'SEPSIS' has been added to our ED study days to further educate and highlight importance of SEPSIS. Emails have also been sent to staff with guidance on how to complete a sepsis screen and the performance of this metric forms part of directorate business meetings. The clinical educator for ED is also planning to train all flow coordinators to understand and know how to respond to the sepsis bleep. The department also plans to ensure the Patient Track system is always up on a screen next to main patient board as a further prompt.

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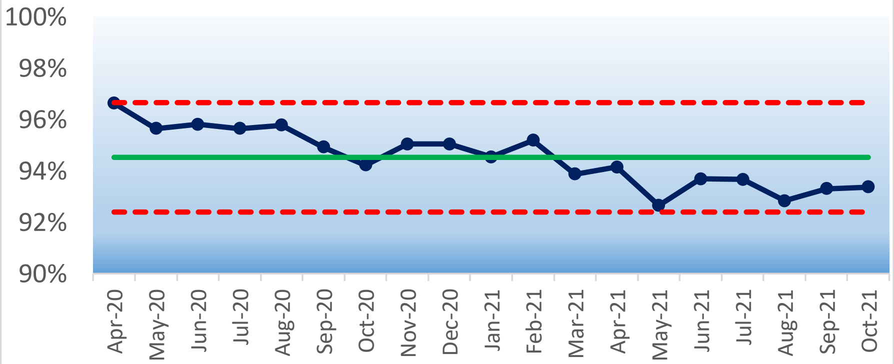
Domain 2 - Caring

Indicator	**2.1.1 - Friends & Family Test (FFT) - Patients**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Oct-21
Value / RAG rating	🟩 93.4%

Indicator description

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.

SPC chart



Narrative

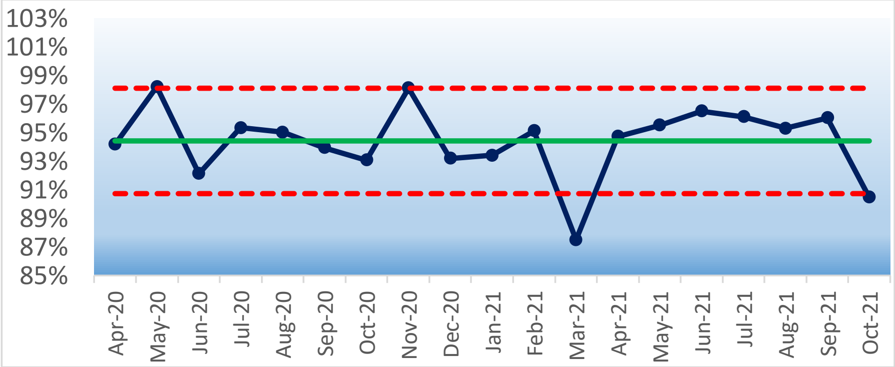
The Trust performs well in relation to FFT. Further work is underway through the Making Experiences Count Forum to capture patient experience more widely and in more real time, particularly linked to Healthwatch.

Indicator	**2.1.2 - Friends & Family Test (FFT) - Adult Community Services**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Oct-21
Value / RAG rating	🟩 90.5%

Indicator description

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.

SPC chart



Narrative

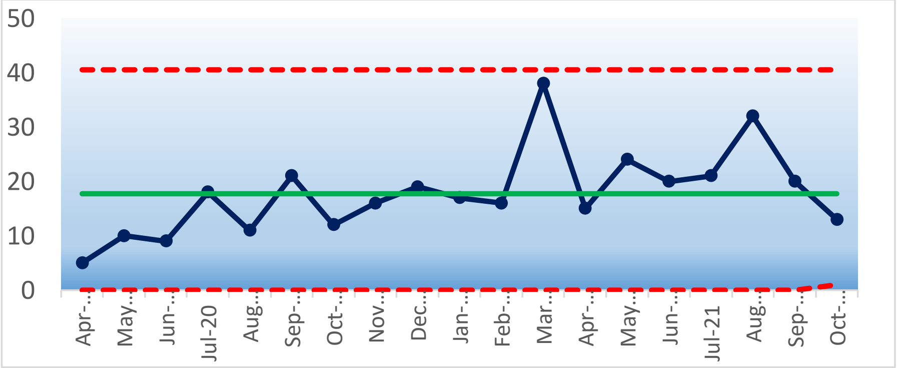
Community Services, as elsewhere in the Trust have been impacted by staff absences and staffing challenges. This is likely to have impacted on the promotion/awareness raising of FFT by those services which could explain the reduction in feedback for the month of October.

Indicator	**2.2.1 Complaints - numbers received**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Oct-21
Value / RAG rating	13

Indicator description

The number of complaints received by the Trust, shown by month of receipt of complaint. The data includes complaints relating to both hospital and community services.

SPC chart



Narrative

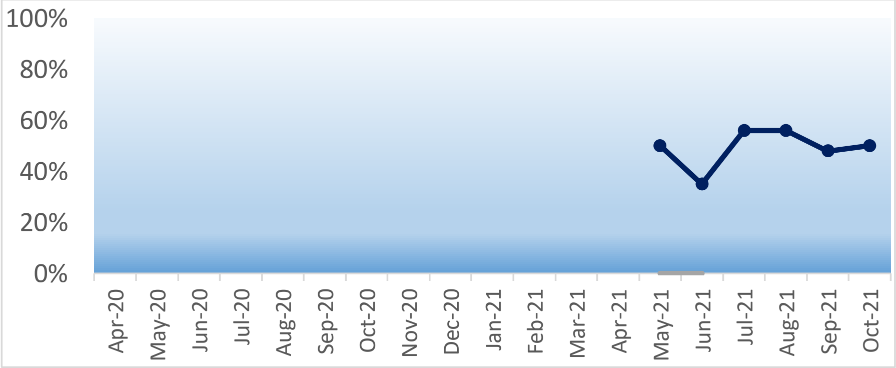
There were 13 complaints received during the month of October 2021. The split by directorate is as follows; Children and Community - 2, Planned and Surgical Care - 5, Long Term and Urgent Care - 6.

Indicator	**2.2.2 Complaints - % responded to within time**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Oct-21
Value / RAG rating	🟥 50%

Indicator description

The number of complaints responded to within 20 days. The Trust's improvement trajectory for 2021/22 is to respond to 95% of complaints on time by December 2021.

Trend chart



Narrative

Recovery work in relation to delivery of the complaints standard of 95% continues in earnest. Whilst it is disappointing not to have delivered the October position on the improvement trajectory of 85%, intensive work still continues across all three directorates to establish the robust systems and processes that are required to deliver timely responses. Elements of the complaints pathway still require further work to ensure that the end to end process is always reliable and efficient. the quality of complaints responses has improved, contributing to the overall improvement plan.

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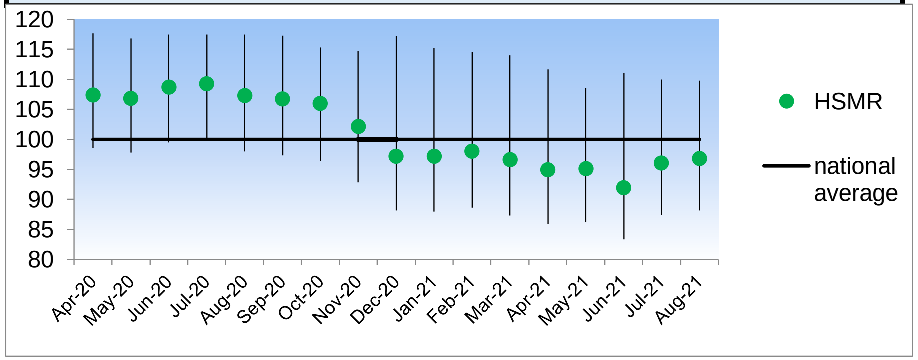
Domain 3 - Effective

Indicator	**3.1 - Hospital Standardised Mortality Ratio (HSMR)**
Executive lead	Jacqueline Andrews, Medical Director
Board Committee	Quality Committee
Reporting month	Aug-21
Value / RAG rating	96.84

Indicator description

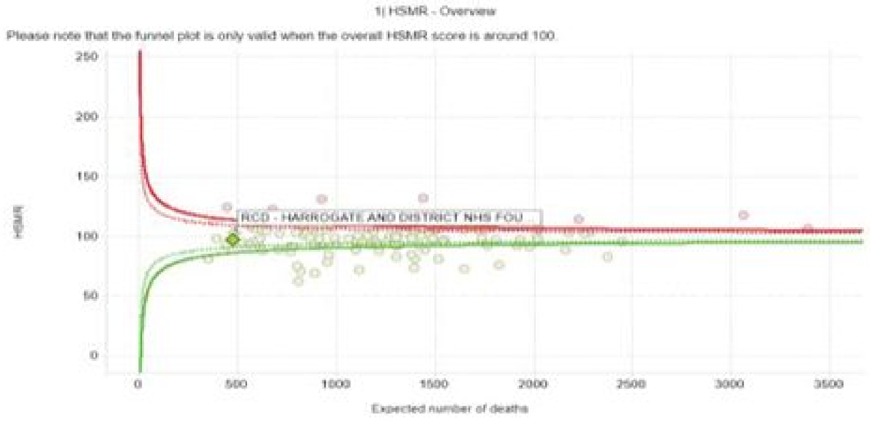
The HSMR looks at the mortality rates for 56 common diagnosis groups that account for around 80% of in-hospital deaths and standardises against various criteria including age, sex and comorbidities. The measure also makes an adjustment for palliative care.

Trend chart



Narrative

National average is 100. HDFT remains below average and within the expected range. The funnel plot below shows HDFT as the diamond compared to similar Trusts (shown as a cross) and all other Trusts.

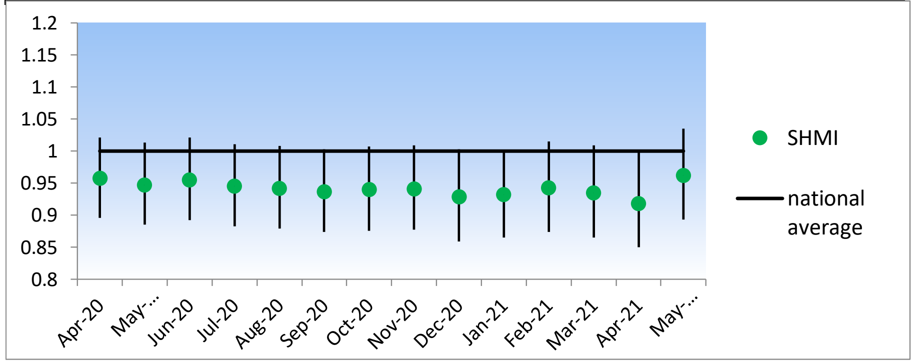


Indicator	**3.2 - Summary Hospital Mortality Index (SHMI)**
Executive lead	Jacqueline Andrews, Medical Director
Board Committee	Quality Committee
Reporting month	May-21
Value / RAG rating	0.96

Indicator description

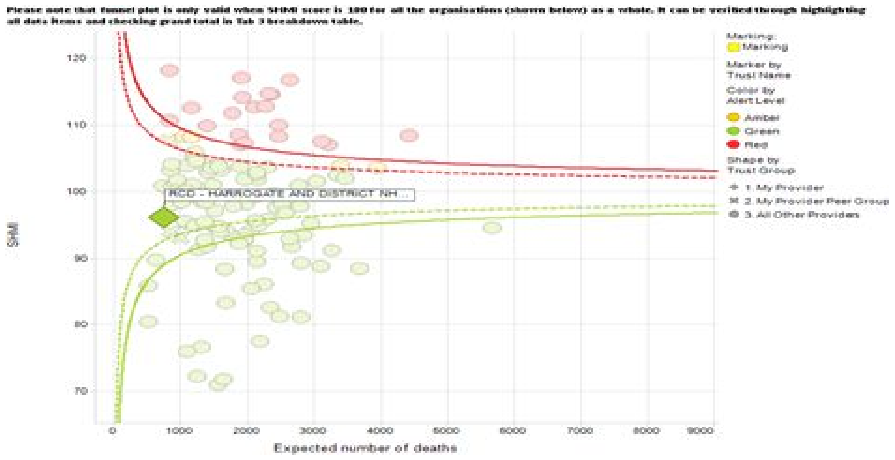
The SHMI looks at the mortality rates for all diagnoses and standardises against various criteria including age, sex and comorbidities. The measure does not make an adjustment for palliative care.

Trend chart



Narrative

National average is 1. HDFT remains below average and within the expected range. The funnel plot below shows HDFT as the diamond compared to similar Trusts (shown as a cross) and all other Trusts.

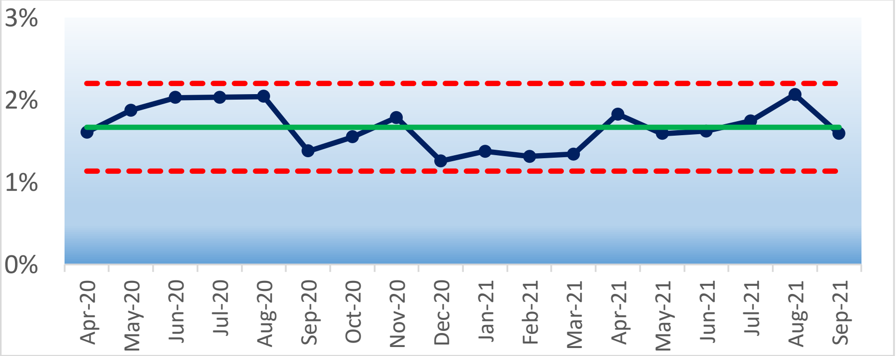

Please note that funnel plot is only valid when SHMI score is 100 for all the organisations (shown below) as a whole. It can be verified through highlighting all data items and checking grand total in Tab 3 breakdown table.

Indicator	**3.3.1 - Readmissions to the same specialty within 30 days - following elective admission**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Sep-21
Value / RAG rating	1.6%

Indicator description

The percentage of patients readmitted to the same specialty as an emergency within 30 days of discharge of an elective admission. This data is reported a month behind so that any recent readmissions are captured in the data.

SPC chart



Narrative

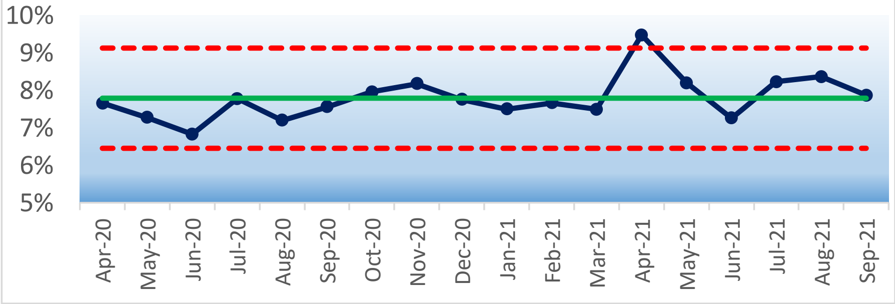
Readmissions following an elective admission decreased in September to 1.6%. This is within control limits and less than national average.

Indicator	**3.3.2 Readmissions to the same specialty within 30 days - following non-elective admission**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Sep-21
Value / RAG rating	7.9%

Indicator description

The number patients readmitted to the same specialty as an emergency within 30 days of discharge of an emergency admission. This data is reported a month behind so that any recent readmissions are captured in the data.

SPC chart



Narrative

Readmissions following a non-elective admission decreased in September to 7.9%. This is within the control limits and in line with national average.

Indicator	**3.4 - Returns to theatre**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	
Value / RAG rating	

Indicator description

This indicator is under development.

SPC chart

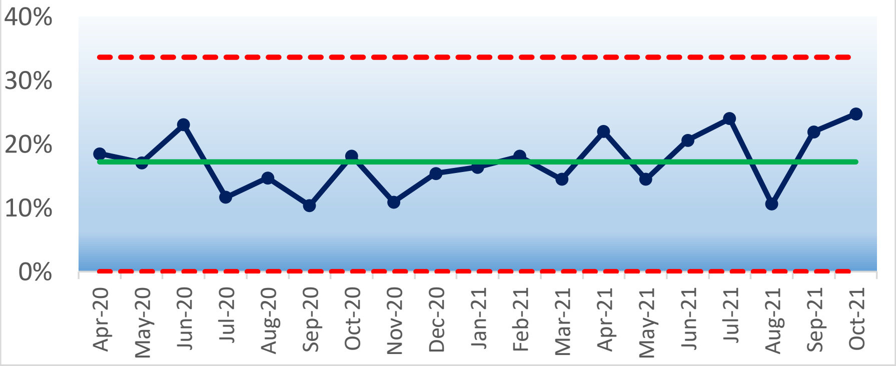
Narrative

Indicator	**3.5 - Delayed transfers of care**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Oct-21
Value / RAG rating	24.7%

Indicator description

The percentage of inpatients not meeting the criteria to reside as reported on the daily discharges sitrep.

SPC chart



Narrative

The Trust have now purchased a system using funding from NHSE that will allow the ward teams to electronically capture the criteria to reside of every patient. This will produce live data that will be available for the whole system to use to support discharge planning and reduced delays. A project manager has been appointed to oversee this roll out and a project group has been set up involving ward teams which will be meeting for the first time in October. The system integrates with the Trust's current patient systems and the plan is to commence roll out and training in December 2021.

This will enable real time viewing of delayed patients, however the major blockage with hospital outflow currently is the social care crisis.

Board of Directors (Public)
24th November 2021

Title:	Director of Nursing Update
Responsible Director:	Director of Nursing
Author:	Deputy Director of Nursing

Purpose of the report and summary of key issues:	For noting and information	
BAF Risk:	AIM 1: To be an outstanding place to work	
	BAF1.1 to be an outstanding place to work	x
	BAF1.2 To be an inclusive employer where diversity is celebrated and valued	
	AIM 2: To work with partners to deliver integrated care	
	BAF2.1 To improve population health and wellbeing, provide integrated care and to support primary care	x
	BAF2.2 To be an active partner in population health and the transformation of health inequalities	
	AIM 3: To deliver high quality care	
	BAF3.1 and 3.4 To provide outstanding care and outstanding patient experience	x
	BAF3.2 To provide a high quality service	x
	BAF3.3 To provide high quality care to children and young people in adults community services	
	BAF3.5 To provide high quality public health 0-19 services	
	AIM 4: To ensure clinical and financial sustainability	
	BAF4.1 To continually improve services we provide to our population in a way that are more efficient	x
	BAF4.2 and 4.3 To provide high quality care and to be a financially sustainable organisation	
	BAF4.4 To be financially stable to provide outstanding quality of care	
Corporate Risks	None	
Report History:	none	
Recommendation:	The Board of Directors to note and approve	

Trust Board

Report: Executive Director of Nursing, Midwifery and AHPs

Author: Emma Nunez

Harrogate and District
NHS Foundation Trust

Matters of concern & risks to escalate

- Nurse Staffing – (*IBR 1.8.1 & 1.8.2*) Staffing Fill Rates have seen a slight increase in October (87.4% from 85.9% in September) and reflects the ongoing management of safe staffing across the organisation. Care Hours Per Patient Day has seen a further decrease in October (7.2 from 7.8 in September) which despite the increasing fill rates reflects the increased acuity of patients and the increased activity and acuity of critical care.

- Complaints (*IBR 2.2.2*) – improvement trajectory of 85% for October not met, (50%) however improving position for November and overall improved quality of responses.

Major actions commissioned & work underway

- Fundamentals of Care programme review for CSWs – revised programme consultation and lead CSW appointed. New programme includes leadership development and clinical supervision for CSWs.

- Roles and responsibilities review completed for Matrons, Ward manager review will commence

Positive news & assurance

- Pressure Ulcers – overall reduction in hospital and community acquired (*IBR 1.1 & 1.2*). Improvement work in this area continues as remains a high safety priority for the Trust

- Falls – reduction in Falls during month of October (*IBR 1.3*). Intensive targeted support by Falls lead to high risk areas during month of October following increase identified in September. Ongoing work to sustain improved position.

- Incident Reporting (Low and No Harm) (*IBR 1.6*) – increasing rates of reporting demonstrating an improving positive patient safety culture.

- Serious Incidents (*IBR 1.7*) – No new serious incidents have been reported this month

- Deep Dive review into moderate harm incidents completed and assurance received of moderate harm rates of reporting.

- Safer Staffing Review Report completed, positive feedback from wards on the process of engagement and evidence base

Decisions made & decisions required of Board

- Support for the recommendations of the Safe Staffing Review

Board of Directors (Public)
24th November 2021

Title:	Corporate Nursing Adult Safeguarding Annual Report 2020-21
Responsible Director:	Director of Nursing
Author:	Jayne Upperton - Named Nurse - Adult Safeguarding, Janet Farnhill -Specialist Nurse - Adult Safeguarding

Purpose of the report and summary of key issues:	This report is the annual adult safeguarding report. This report details undertaken in 2020-21 with regard to Adult Safeguarding at HDFT. This report provides assurance that HDFT has appropriate Adult Safeguarding structures in place and that policies and procedures are fit for purpose. The report demonstrates compliance with external safeguarding standards. The report also provides an overview of the work of the Adult Safeguarding Team and information about safeguarding concerns raised both by and against the Trust.	
BAF Risk:	AIM 1: To be an outstanding place to work	
	BAF1.1 to be an outstanding place to work	x
	BAF1.2 To be an inclusive employer where diversity is celebrated and valued	
	AIM 2: To work with partners to deliver integrated care	
	BAF2.1 To improve population health and wellbeing, provide integrated care and to support primary care	x
	BAF2.2 To be an active partner in population health and the transformation of health inequalities	
	AIM 3: To deliver high quality care	
	BAF3.1 and 3.4 To provide outstanding care and outstanding patient experience	x
	BAF3.2 To provide a high quality service	x
	BAF3.3 To provide high quality care to children and young people in adults community services	
	BAF3.5 To provide high quality public health 0-19 services	
	AIM 4: To ensure clinical and financial sustainability	
	BAF4.1 To continually improve services we provide to our population in a way that are more efficient	x
	BAF4.2 and 4.3 To provide high quality care and to be a financially sustainable organisation	
	BAF4.4 To be financially stable to provide outstanding quality of care	
Corporate Risks	None	
Report History:	This report has been through internal governance systems for review prior to submission to Board.	
Recommendation:	The Board of Directors to note and approve the content of this report.	

Harrogate and District
NHS Foundation Trust

CORPORATE NURSING

ADULT SAFEGUARDING ANNUAL REPORT 2020/21

Author	Jayne Upperton - Named Nurse - Adult Safeguarding, Janet Farnhill -Specialist Nurse - Adult Safeguarding
Date	July 2021
Approval	Supporting Vulnerable People Steering Group

You matter most

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- Number of alerts raised against the Trust: 11

Future plans: **Error! Bookmark not defined.**

1. INTRODUCTION

The purpose of this report is to describe the work undertaken over the last year with regard to Adult Safeguarding at Harrogate and District NHS Foundation Trust (HDFT).

This report provides assurance that HDFT has appropriate Adult Safeguarding structures in place and that our Adult Safeguarding policies and procedures are fit for purpose, and demonstrate compliance with external safeguarding standards. It also provides an overview of the work of the Adult Safeguarding team and information about safeguarding concerns raised both by and against the Trust.

At HDFT we understand that safeguarding is everyone’s business and strive to support the Department of Health six principles of Safeguarding:

Empowerment People feel safe and in control, give consent to decisions and actions about them. They should be helped to manage risk of harm either to themselves.

Protection Support and help for those adults who are vulnerable and most at risk of harm

Prevention Working on the basis that it is better to take action before harm happens

Proportionality Responding in line with the risks and the minimum necessary to protect from harm or manage risks

Partnership Working together to prevent or respond to incidents of abuse

Accountability Focusing on transparency with regard to decision making.

Aims of HDFT Adult Safeguarding Service

The principle aims of the Adult Safeguarding Service are to:

- Ensure we keep our patients safe and protect them from harm.
- Provide expert opinion with regard to safeguarding
- Ensure staff are aware of their responsibilities with regard to adult safeguarding
- Ensure we have appropriate structures in place to manage and take forward the Adult Safeguarding agenda
- Provide assurance to external agencies that our safeguarding policies and procedures are robust and fit for purpose
- Ensure HDFT is represented at Adult Safeguarding multi-agency meetings and help to deliver our Safeguarding Adults Board’s (SAB) strategic plan
- Seek opportunities to raise the profile of safeguarding adults and ensure staff are aware of their responsibilities with regard to the safeguarding agenda;

- Continue to strengthen and align safeguarding processes and practice across hospital and community services
- Ensure appropriate training is available at all levels and monitor this. Seek opportunities to improve staff training and identify and address any gaps.
- Strengthen and support the adult safeguarding link worker network so it is used to its full advantage across all HDFT areas
- Support arrangements for working with Matrons and Managers to investigate incidents and support staff where a concern is raised about care provided by the Trust or where Trust staff have raised concerns about care in other parts of the care system or at home
- Use the safeguarding adults database to provide information from which we can monitor trends, learn lessons and share good practice
- Take forward work allied to Adult Safeguarding as required e.g. Prevent, Domestic Abuse
- Take forward any learning, as appropriate, from Safeguarding Adult Reviews (SAR) and Domestic Homicide Reviews (DHR)

Responsibilities of HDFT staff with regard to Safeguarding Adults

Each member of HDFT staff has a duty to ensure they;

- Work within the 6 key principles of Adult Safeguarding
- Are up to date with their safeguarding adults training commensurate with their position in the Trust
- Understand how to raise a concern within their area of work
- Know where to get help and support with a safeguarding issue
- Assist with safeguarding investigations as required
- Embrace a culture of learning from concerns

2. REPORT FOR 2020/21

The HDFT Adult Safeguarding Service

In November 2020 an additional member of staff, Jayne Upperton was recruited to the team. Jayne commenced as the Specialist Nurse 2 days a week. Janet Farnhill as Named Nurse retired and returned, in January 2021, and also works two days a week. Once a fortnight Jayne and Janet cross over their shifts to ensure good communication.

A detailed competencies action plan was signed off by the then Chief Nurse which supported Jayne taking over the role of Named Nurse from Janet on 1st April 2021.

The Adult Safeguarding team now consists of a Named Nurse for Adult Safeguarding who works 18.5 hours per week and a Specialist Nurse who works 15 hours per week (totalling 0.89wte)

The Acute Learning Disabilities/MCA Liaison Nurse works 34 hours per week (0.91wte) and is line managed by the Named Nurse.

The Adult Safeguarding Nurses and the Acute Learning Disability Liaison Nurse work individually but cross cover each other for days off and annual leave, where possible.

There is also a doctor with a Specific Interest in adult safeguarding (Dr Rebecca Watt, 0.5 PA/week).

The Named Nurse for Adult Safeguarding is professionally managed by the Head of Nursing for Long term and Unscheduled Care, although Adult Safeguarding itself sits within the Corporate Nursing function.

During the first Pandemic lockdown Janet worked clinically from April to June 2020 on a ward. The learning disabilities liaison nurse provided essential only cover for safeguarding during this period.

3. REMIT OF THE ROLES

Named Nurse

- Ensures Trust fulfils statutory duties with regard to Adult Safeguarding and Prevent (a request has been made for Prevent to sit within the Children’s safeguarding team)
- Develops policies and strategy for Adult Safeguarding, Prevent, Domestic Abuse
- Provides leadership for Adult Safeguarding agenda
- Represents HDFT at a number of the North Yorkshire Safeguarding Adults Board (NYSAB) sub-groups, local Prevent meetings, Regional Prevent attending meetings and providing data as required, also internally at the

previous Supporting Vulnerable People (SVP) meetings and Matrons meetings.

- Ensures the training program for all staff meets national requirements
- Plans audits etc.
- Line manages the Specialist Nurse and the LD/ MCA Liaison Nurse
- Ensures work of SG team is informed by current trends and emerging themes

Specialist Nurse

- Provides support and advice to staff
- Communicate with local authority regarding safeguarding cases and for SG enquiries, and provides information as required
- Attends individual safeguarding meetings and provide information for these
- Develop and deliver training for all levels of staff
- Chairs SG/LD link workers group and oversees their work plan
- Develop Domestic abuse champions including link worker group
- Maintain safeguarding database, extrapolate information as required
- Undertake audit as per program
- Develop SG/DA and Prevent pages on the Trust intranet
- Provide cover for LD/MCA Liaison Nurse
- Deputise for Named Nurse as required
- Responds to health record requests

Representation at external Adult Safeguarding meetings

The North Yorkshire Safeguarding Adults Board is attended by the Executive Director for Nursing, Midwifery and AHP's (who represents Health providers across North Yorkshire). The numerous sub-groups for the SAB are attended by the Named Nurse or the Specialist Nurse as her deputy.

These are;

- The Performance and Quality Improvement Group
- Learning and Review Group (From Safeguarding Adult Reviews)
- Health Partnership Group
- Policy and Practice and Learning Development Group
- Safeguarding Adults Reviews

Minutes for these meetings attended are stored on the team's shared drive.

Representation at individual safeguarding strategy and case conference meetings is by the Specialist Nurse Adult Safeguarding, relevant Matrons and clinical staff as appropriate.

4. Supporting Vulnerable People (SVP) Steering Group

The Named Nurse (or Specialist Nurse as her deputy) reports directly to the Supporting Vulnerable People Steering Group, and provides a report at the monthly meetings. This includes figures of safeguarding concerns and outcomes, feedback from relevant groups, training, the action plan and updates on the wider Adult Safeguarding arena.

The Supporting Vulnerable People Steering Group continues to ensure arrangements for safeguarding adults within HDFT are robust, fit for purpose and compliant with national and local standards.

The Chaperone policy has been update this year and signed off by the SVP. Compliance with the policy will be audited in 2021/22. This was postponed in 2020 because of the pandemic.

An audit of ‘Making Safeguarding Personal’ was carried out this year, and presented to the SVP group, with actions to improve compliance focusing on training and individual feedback.

Changes to the training requirements for adult safeguarding, as detailed in the ‘Adult Safeguarding Roles and Competencies for Healthcare Staff - Intercollegiate Document’ where agreed by the group to be implemented by Learning and Development.

This meeting is under review as part of the new Quality framework work being undertaken by the Trust.

5. Adult Safeguarding Advice

The nurses support and advise staff with regard to Adult Safeguarding across the whole of HDFT. This includes attending strategy meetings and case conferences to represent the Trust and support staff who attend as required. The Specialist Nurse also assists partner agencies with information gathering across HDFT for safeguarding incidents and investigations.

If a safeguarding concern is raised against HDFT the Matron/Manager for that area is involved in the safeguarding meetings whenever possible to ensure that staff are supported and this also ensures ownership is taken at a local level for any actions/learning that are identified as a result of a safeguarding incident/concern.

Information and details regarding each alert is stored on the safeguarding database and related notes/minutes of meetings are also kept for reference. Documentation includes referrer; if the alert has been raised by HDFT or against the HDFT, type of abuse, whether it is a pressure ulcer, whether it went through the safeguarding process and the outcome.

6. Safeguarding Adults/Learning Disabilities Link Workers

The Specialist Nurse oversees a link worker network which has representation from hospital and community areas.

With the challenges of the global pandemic meetings which previously took place quarterly have been suspended. During this time a quarterly newsletter for adult safeguarding and learning disabilities has been shared with the link workers. The meetings will resume once safe to do so.

The meetings are usually used to share good practice, discuss issues and offer support and guidance. Newsletters have included a range of topics, including domestic abuse, self-neglect and preventing radicalisation

7. Safeguarding and Governance

HDFT provides assurance and demonstrates compliance to NHS England and North Yorkshire Safeguarding Adults Board by completing the Adult Safeguarding self-assessment framework annually. This includes information with regard to policies and guidelines for safe recruitment, governance, and training. This was completed with the Children's Safeguarding Team and submitted in March 2021.

There is a clear process for ensuring safeguarding concerns are incorporated within the HDFT governance framework, which is detailed in the Adult Safeguarding Policy. This allows any safeguarding alerts raised against us to be monitored via the Datix system and provides assurance at a senior level that appropriate actions are taken to prevent reoccurrence.

Datix incident reports are also monitored for any safeguarding concerns and actions taken if required.

The risk management team identity's events which are externally reportable to the National Reporting and Learning System (NRLS) this data is accessible by the CQC as required

The team has a Quality meeting every 6 weeks using the KLOE as a template.

8. Training

Training is delivered at level 2 (3) face to face and at other levels by e-learning as specified in the Intercollegiate Document.

Training figures are produced by the workforce development team monthly and are reviewed and monitored at the Supporting Vulnerable People Steering Group. It should be noted that because of the global pandemic face to face training was severely affected this year. In previous years training has been aligned with the local authority levels but this year we have been working to the national levels as laid out in the Intercollegiate Document

Volunteers

Volunteers are required to undertake level 1 safeguarding and level 1 and 2 Prevent e-learning training. This is delivered through a national e-learning platform.

9. Audit

We carried out one audit this year on 'Making Safeguarding Personal' the results being shared with the Supporting Vulnerable People Group.

The planned audit for the chaperone policy has been deferred because of the pandemic.

10. Prevent Strategy

The 'Prevent' element of the Government's counter terrorism strategy remains within the safeguarding agenda and is overseen by the Supporting Vulnerable People Steering Group. The Named Nurse Adult Safeguarding is the Trust Prevent Lead.

Training has been rolled out as defined by the NHS England Prevent Training and Competencies Framework. The number of staff trained this year has continued to rise and we have therefore maintained our compliance with the national target of at least 85% for all staff groups.

The Named Nurse Adult Safeguarding continues to maintain links with the North Yorkshire Channel Panel and provides information as required, however the monthly meetings are now attended by a representative of the Safeguarding Children's team.

The Named Nurse continues to complete the quarterly Prevent return for NHS Digital and the CCG and attend the Local (Bronze) Prevent and NHS England Regional Prevent meetings. It should be noted that the majority of cases discussed at the Channel Panels are for people under the age of 18.

The team has requested that the lead for Prevent should sit within the Children's safeguarding team.

11. Domestic Abuse

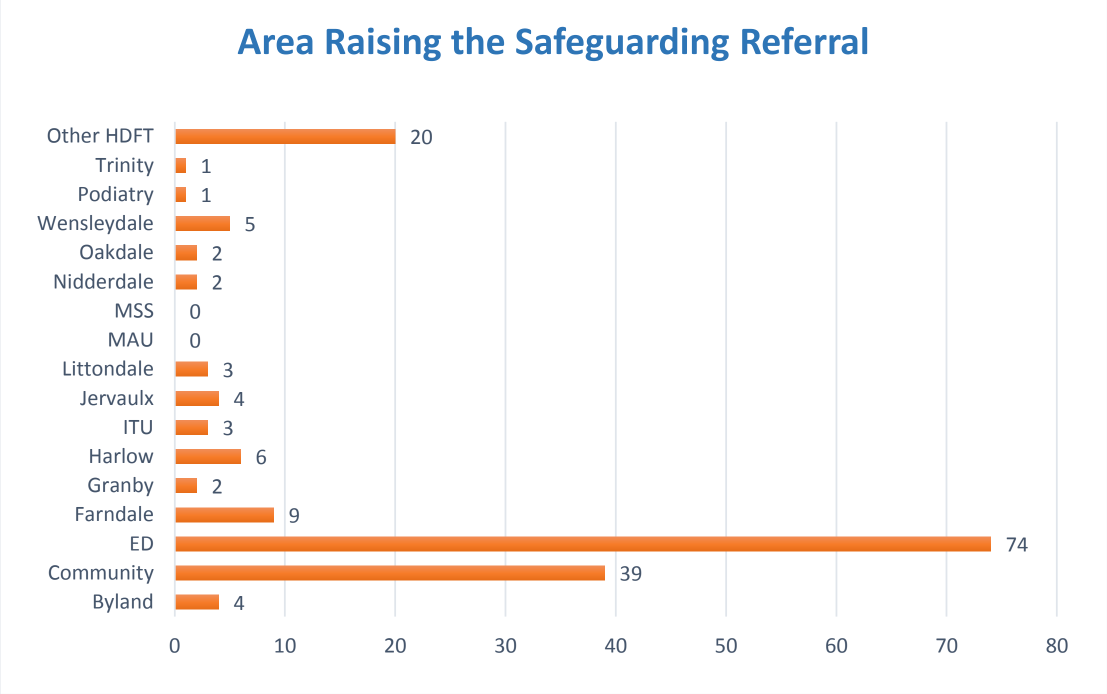
The role of HDFT staff continues to be to support and signpost patients/colleagues. The guidance is available on the intranet on the Domestic Abuse page which is under the umbrella of safeguarding. Guidance specific to Maternity is also available.

The Domestic Abuse webpage also has useful information including national and local helpline telephone numbers. Domestic abuse level 2 training is available via E Learning for all staff, but is not mandatory. The Domestic Abuse action plan sits with safeguarding children's services

12. ANALYSIS OF SAFEGUARDING CONCERNS FOR 2020/21

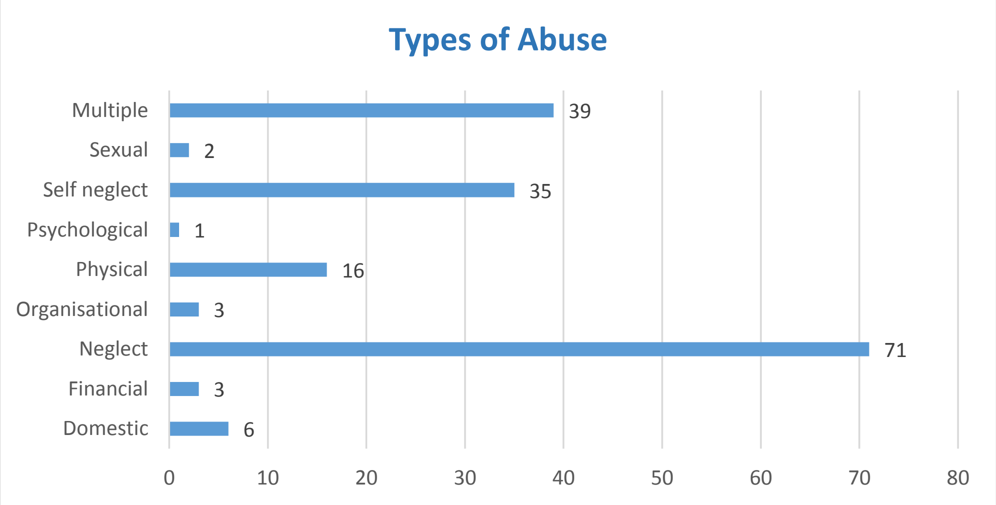
RAISED BY HDFT STAFF

The total number of concerns raised by HDFT staff this year (April 2020- March 2021) is 175. This was an increase on last year's figure of 126



As in previous years community areas and the Emergency Department (ED) are where most concerns are raised. This is because of the large numbers of vulnerable people seen in the community and the ED. The category 'Other HDFT' relates to HDFT services out of the acute hospital setting for example dentistry, Trinity ward at Ripon Community Hospital and Selby Urgent Treatment Centre.

Types of Abuse



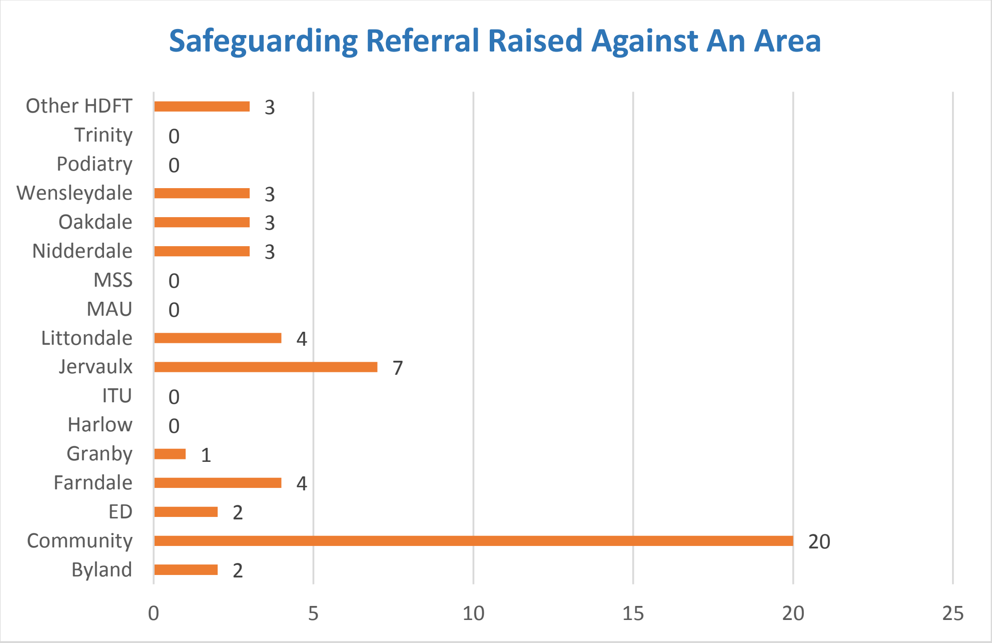
Allegations of neglect continue to be the main type of abuse reported. This is to be expected as neglect is the most obvious type of abuse in care settings, and many of our patients are in receipt of some type of care out of the hospital. A number of concerns cite more than one type of abuse, which falls under the 'multiple' heading. These cases are often linked to domestic abuse.

Outcomes

All safeguarding referrals are checked, logged, password protected and forwarded on to the appropriate local authority, who will investigate. We will liaise with the local authority as the case progresses.

RAISED AGAINST HDFT

The number of concerns raised against HDFT in 2020/21 is 52 compared to 48 in 2019/20.



Safeguarding concerns against the Trust reflects the practice of raising safeguarding concern against ourselves when a pressure ulcer grade 3, 4 or unstageable is identified ensuring we comply with safeguarding timescales.

Outcomes

Of these 52 concerns, 51 were for neglect and 1 for physical abuse.

37 of the neglect cases were for pressure ulcer development where omissions of care were identified at root cause analysis.

The physical abuse was reported to have been a male nurse hitting a patient (the patient subsequently retracted the statement).

The remaining 14 neglect cases were;

- Incorrect dietary advice on discharge
- Weight loss in hospital
- Fall with dislocation
- 2 falls with fractures
- Patient absconded (found at home)
- Patient with an eating disorder - incorrect management
- 3 Poor discharge advice
- Patient wasn't referred to a dietitian
- Patient transferred in an unkempt state
- Fracture not picked up on first x-ray
- Poor discharge following suicide attempt

13. Future Plans for the service

- We are working with Risk Management to ensure a safeguarding referral is sent, if required, in a timely manner for any Serious Incident Investigations.
- We are working with the County Durham 18-25 team to include processes for this group within adult safeguarding.
- We have asked to be involved in Pressure Ulcer panels going forward.
- We continue to raise the profile of adult safeguarding and will undertake a review of the service, benchmarked against other Trusts and the Children's Safeguarding Team structure
- We hope to identify a research project for the future
- Work more closely with the emergency department – examining the role of the children's specialist nurse in ED
- Working with the Children's safeguarding team, HR and occupational health develop a policy to support staff suffering domestic abuse
- Expand the size of the team to reflect the service
- Raise the profile of Adult Safeguarding across the Trust

14. Ongoing risks

- Size of the team – 0.89wte – 4 days a week cover – no succession planning at present. Business case being developed for additional staff due to increased workload both internally and externally
- The Prevent Agenda – requesting this moves to the Children's safeguarding team – paper prepared
- The impact of Liberty Protection Safeguards and where they sit, as a legal process, within the Trust

- The volume of information gathering and action planning required for the local authority leading up to or following Safeguarding Adult Reviews

Jayne Upperton RN MA

Named Nurse – Adult Safeguarding

April 2021

Trust Board (Public)
24th November 2021

Title:	**Strengthening Midwifery and Neonatal Safety Report**
Responsible Director:	Emma Nunez, Executive Director of Nursing, Midwifery & AHP's
Author:	Alison Pedlingham (HOM), Andy Brown (Risk management Midwife), Danielle Bhanvra (Matron, Maternity), Kat Johnson (Clinical Director), Julie Walker (Matron Paediatrics)

Purpose of the report and summary of key issues:	The purpose of this report is to provide a summary and update on the board level measures for the month of October as set out in the Perinatal Quality Surveillance model.	
BAF Risk:	AIM 1: To be an outstanding place to work	
	BAF1.1 to be an outstanding place to work	✓
	BAF1.2 To be an inclusive employer where diversity is celebrated and valued	
	AIM 2: To work with partners to deliver integrated care	
	BAF2.1 To improve population health and wellbeing, provide integrated care and to support primary care	✓
	BAF2.2 To be an active partner in population health and the transformation of health inequalities	✓
	AIM 3: To deliver high quality care	
	BAF3.1 and 3.4 To provide outstanding care and outstanding patient experience	✓
	BAF3.2 To provide a high quality service	✓
	BAF3.3 To provide high quality care to children and young people in adults community services	
	BAF3.5 To provide high quality public health 0-19 services	
	AIM 4: To ensure clinical and financial sustainability	
	BAF4.1 To continually improve services we provide to our population in a way that are more efficient	✓
	BAF4.2 and 4.3 To provide high quality care and to be a financially sustainable organisation	
	BAF4.4 To be financially stable to provide outstanding quality of care	
Report History:	Maternity Services Forum Maternity Safety Champions Meeting SMT	
Recommendation:	Board is asked to note the updated information provided in the report and for further discussion.	

STRENGTHENING MATERNITY AND NEONATAL SAFETY REPORT

1.0 Summary

This paper provides a summary and update of the detail on the board level measures for the month of October as set out in the Perinatal Quality Surveillance model.

1.0 Introduction

The new quality surveillance model seeks to provide consistent and methodical oversight of all services, including maternity. Strengthening trust-level oversight for quality and safety includes a focus on leadership, strong governance processes and pathways for information and escalation from floor to Board. The model includes five principles for improving oversight for effective perinatal clinical quality to ensure a positive experience for women and their families. To aid implementation there are local, regional and national elements of this model.

At local level, the model includes a monthly review of maternity and neonatal safety and quality reported to the trust board.

2.0 Proposal

2.1 The report covers the provider Board level measures required as part of the perinatal surveillance model. This month, the report includes additional neonatal measures.

2.2 Trust Board is asked to note the information provided in the report which provides a local update on progress.

3.0 Quality Implications and Clinical Input

3.1 The report provides a narrative on the key measures set out in the Perinatal Quality Surveillance model and has been analysed and presented by members of the maternity midwifery and obstetric teams.

4.0 Equality Analysis

5.1 An equality analysis has not been undertaken

5.0 Risks and Mitigating Actions

6.1 The middle grade staffing numbers have improved since the new doctors' started in August. However, the three new starters do not have sufficient entrustability to work without on-site supervision from a senior colleague. Although the new appointments have improved the in-week daytime staffing, out of hours cover remains a challenge. A further challenge is anticipated from February 2022 as a senior trainee has been accepted for an interdeanery transfer and will leave the trust. The department has received notification that the post will not be filled by the Deanery until August 2022.

A staffing review is required and preliminary discussions have taken place. Current mitigations include consultants remaining resident until 20:00h in week and the use of internal and external locums to cover some of the night shifts. No change to this risk since the October report.

6.2 Midwifery staffing levels have continued to be a challenge with significant gaps in the roster due to short-term staff sickness and waiting for new staff recruited to start in post.

6.3 Low compliance levels for safeguarding children are predominantly due to reduced midwifery staffing levels and no safeguarding level 3 training dates available. A decision was made to support midwives to complete the safeguarding children's e-workbooks to ensure compliance until further training dates are available. Clinical safeguarding supervision sessions have started to take place.

7.0 Recommendation

7.1 Trust Board is asked to note the updated information provided in the report and for further discussion.

Narrative in support of the Provider Board Level Measures – October 2021 data

Introduction

The revised perinatal surveillance model sets out six requirements to strengthen and optimise board level oversight for maternity and neonatal safety. Requirements include

- A monthly review of maternity and neonatal safety and quality is undertaken by the trust board,
- All maternity Serious Incidents (SIs) are shared with trust boards (in addition to reporting as required to HSIB) and
- To use a locally agreed dashboard to include a minimum set of measures drawing on locally collected intelligence to monitor maternity and neonatal safety at board meetings.

Obstetric cover on the delivery suite, gaps in rotas

The maternity unit has been staffed to minimum safe staffing standards at all times despite the gaps in the establishment and risks detailed below. There is no change to obstetric staffing since the last report in September.

Staffing Gaps and Contingencies			
Grade of doctor	**Staffing gaps**	**Contingency**	**Risks**
First on call rota FY2/ GPVTS/ ST1/2	None	Internal cover for short term sickness as required	None identified
Second on call rota ST3-7/ specialty doctor	Three doctors working on the middle grade rota are unable to work without on-site senior supervision. ST6 doctor will be leaving on an inter-deanery transfer February 2022 and will not be replaced by the deanery until August 2022.	Internal cover prioritising labour ward cover Internal cover for short term sickness as required Consultants covering shortfall Urgent recruitment to the vacant post required	Risk of fatigue in doctors on second on call tier Risk of cancelling elective activity to protect Delivery Suite cover Added to risk register March 2021
Consultant	No gaps		

Midwifery safe staffing, vacancies and recruitment update

Midwifery and maternity support worker levels have continued to be a challenge during the month of October.

The bi-annual staffing report has not been discussed within maternity forums and will be available for the meeting in December.

Sickness

Delivery Suite	**Midwives**	**MSW's**
Short Term	1 midwife (15 hours)	4 MSW (total of 46.5 hours)

Long Term	0	1 band 2 care assistant on long term sickness (99 hours)
Pannal ward		
Short Term	2 midwives (34 hours)	2 MSW (46 hours)
Long Term	1 midwife (75 hours)	0

Vacancies, retirements and resignations – in the month of October

Advert for 2.0 WTE band 6 midwives

Staff recruited/started in post and adverts

7 x Midwives started in post

2 x band 3 Maternity Support Workers started in post

Use of NHSP and agency for October

Pannal Ward - 8% of shifts covered by NHSP 20shifts

Delivery Suite - 6% of shifts covered by NHSP 18 shifts

Number of times the maternity unit was closed to further admissions/women diverted and action

Number of times the unit closed to further admissions and women diverted to other maternity units in the region in August:

	July	August	September	October
No. of times maternity unit closed to admissions	5	7	8	5
Reason				
Increased activity	5	5	8	3
Staffing below minimum levels	0	3	8	4
No. of women diverted to other maternity units	2	2	7	1

On review of these incidents, these occurred during the night and/or at the weekend when there are no team leaders and specialist midwives to offer support.

Actions taken

- Maternity escalation guideline has been reviewed and currently shared with senior members of the midwifery and medical teams
- WY&H LMS maternity escalation guidance in progress

October data – BR+ acuity tool

1:1 care in labour 98.2 % (September 96.3%)

Labour ward coordinator supernumerary 71 % (September 59%)

Percentage of specialist midwives in post – 7.2 WTE

Safer staffing – neonatal services

Gaps on roster

Short term sickness and covid absence has impacted on neonatal staffing as elsewhere in the Trust which has required some movement of staff and skill mix to mitigate gaps in the rota.

Reasons for gaps.

2 weeks Jury service, staff isolating 5 shifts needed covering, carers leave 2 shifts, sickness 3 shifts. Agency last minute cancellation.

Vacancy - nursing 01.84 wte, out to advert interviewing 8/11/21
Recruitment nursing - 0.61 wte starts 22/11/21

Essential training compliance for all staff groups in maternity related to the core competency framework and wider job essential training – (maternity and neonatal)

Prompt face-to-face training did recommence in October. A maximum of 12 members of staff attend due to need for social distancing.

Training compliance
Fetal surveillance (midwives 79% and obstetric staff 93%)
Neonatal life support (midwives 72%)

Level 3 safeguarding children's training - completion of the e-workbook is being supported due to no level 3 safeguarding introductory sessions available at the moment. We have requested the statistics for completion of the e-workbooks from Learning & Development.

Clinical safeguarding children's supervision sessions – have continued with new facilitators.

Safeguarding children level 3 training – no changes from the previous month, as no introductory sessions available.

SCBU

Overall %	92%
Safeguarding level 3	92%
Safeguarding supervision	100%

Risk and Safety

Risk register summary
No new risks added to the risk register, a directorate review of the maternity risk register is planned for later this month.

The number of incidents logged graded as moderate or above and what actions are being taken

In October 2021 there were 40 total incidents reported through Datix. Of these, there was one incident recorded as Moderate Harm.

- This incident related to a baby that developed seizures on the postnatal ward, 36 hours after a straightforward forceps delivery. CT/MRI has identified changes consistent with a neonatal stroke. A 48-hour report found that management was appropriate and there were no obvious precipitating factors, and the baby was born in good condition. The baby has been discharged home.

SCBU Incidents

5 Datix incidents reported:

- 3 no harm
- 2 low harm.
- 1 prescribing error not administered.
- 1 relating to staffing

Risk Register

- Delayed certification of Neonatal Advanced Life Support Training – 4
- Insufficient opportunity for senior medical staff to maintain skills for difficult procedures – 8
- Covid risk to staffing relating to isolation, pregnancy and household contacts - 6

Cot occupancy
Occupancy, steady throughout the month of October at full or near capacity.

ATAIN
In October 2 babies fitted the criteria for ATAIN; ‘fitting and grunting’

Babies transferred out (October)

Transfers out	0
Off pathway data	0

Findings of review of all perinatal deaths using the real time data-monitoring tool

Perinatal Monitoring Review Tool Report:

PMRT for premature delivery of twins at 22+6 weeks gestation. The panel found no issues with care – cause of death, extreme prematurity

Service User feedback

FFT - 45 responses received for Friends and Family (FFT) in October 2021. Of the 45 responses inputted for October 2021 100 %, responses reported as good or very good.

Regular positive feedback is received on a daily basis through the Social Media Facebook pages and shared (with permission) to the public and maternity team.

During October, we had no concerns requiring response and no formal complaints in progress.

Maternity Voice Partnership group – we are in the process of recruiting a new Chair for this group with the support of the current chair and a service user Rep from the NE & Yorkshire Regional Maternity Transformation Team. It has now been agreed this post will be remunerated (up to 4 days a month) by North Yorkshire CCG. The post is being advertised with an interview date 9th December.

Parents feedback received by SCBU

SCBU Quarter report

August to October 21 We asked - When you first saw your baby on SCBU did someone explain your baby's condition and the equipment supporting your baby?

You said: 93% "yes definitely"

Around this time did anyone discuss how you could help your baby by being there, talking and comfort holding?

You said: 86% "yes definitely" 7% "yes to some extent"

1 person said – "no", as baby was not on SCBU initially, but said that they were subsequently shown everything they could do and that it was encouraged.

Complaints / concerns to PET

No formal complaints.

Compliments

Parents of Sophia *"From the bottom of our hearts we would like to thank you for all the care and support you gave not just Sophia but all three of us"*

You said we did

The parent's room was very handy and I was extremely grateful I was able to stay so close to my baby. The cleaning cupboard was next to the parents' room and the cleaners were extremely loud very early in the morning.

I did feel vulnerable because of the number of people that had access and using bathroom, but I don't really have a solution due to the cleaning cupboard. The noise affected my sleep badly too. I appreciate the efforts made to make it as comfy and welcoming as you can

We have contacted the domestic supervisor and senior management to review the position of the cleaning cupboard; we hope to do a room swap.

Staff feedback to the Maternity Safety Champions

A concern was escalated to the executive and non-executive safety champions this month highlighting safety concerns due to reduced staffing levels on Pannal ward during times of escalation within the maternity department.

A midwife worked on their own on Pannal ward for most of a night shift because the other midwife on duty was required to work on delivery suite due to increased activity. There were no MSW's on duty for this shift (both sick). The situation was discussed with the site coordinator who was able to offer a CSW for a period of 2 hours only. The activity and acuity on Pannal ward was not suitable for one midwife to manage on their own.

Action taken

- HOM or Matron now attend the bed meeting – any issues with staffing are highlighted and discussed with potential solutions
- Close scrutiny of the daily staffing in the department is undertaken by the ward managers and any issues highlighted to discuss at the bed meeting if required
- Risk assessment by the coordinator of the current workload and the acuity on Pannal Ward and if required two members of staff to work on Pannal ward,preferably two midwives but a midwife and a MSW is acceptable in times of extremis where this has been appropriately risk assessed against the acuity and dependency of women and babies
- Once the additional midwives (as part of Ockenden monies) are recruited, we aim to increase the number of midwives working on the night shift. This is posing a challenge at the moment – some band 5's recruited do not complete their training until early next year due to the impact of the pandemic.

Coroner Reg 28 made directly to Trust

No Regulation 28 notifications have been received in October 2021.

Request for action from external bodies – NHS Resolution, HSIB,

In October 2021:

No new cases notified in this period

Action plans from previous cases are being progressed with monitoring of the action plans through MRMG. There are no open HSIB cases.

Maternity incentive scheme – year 4 (NHS Resolution)

The new safety standards for year 4 of the incentive scheme were received in September and some of the safety standards have been revised in October 2021. There are no changes to four of the safety actions and subtle changes to the remaining six.

National priorities

- **Continuity of carer (CofC) update**

Recent update from NHSE/I – October 2021

While the Health and Social Care Committee provided clear support in its July report for the importance of Midwifery CofC, and the strength of its evidence base, it highlighted longstanding challenges in local implementation, and the need for sufficient resources and support for LMS to deliver it. In individual submissions to the committee, several stakeholders highlighted the need to ensure that the transition to MCoC does not put undue pressure on midwives or compromise safe staffing levels across any part of the wider maternity service. To respond to these challenges, a national roundtable event was held in July to review evidence and progress to date, and to listen to the concerns of a broad range of stakeholders. Three broad themes emerged:

- Safe staffing levels - skill mix and training
- Engaging midwives and obstetricians – opportunity to share the vision
- Resources – estate and equipment.

Plans must cover how the rollout of additional MCoC teams will be phased alongside the fulfilment of required staffing levels. The NHS Operational Planning Guidance for 2021/22 requires that MCoC is established as the default model of midwifery care and offered to all women by March 2023.

While many maternity units will be able to achieve this by March 2023, alternative timescales will be accepted on a case-by-case basis, where it is clear that full staffing cannot be achieved by March 2023 and there is a credible linked recruitment plan. These revised timescales will be assessed and agreed through regional assurance visits.

From May 2021, we have declared 0% compliance, as we are not provided care in labour to women on a continuity of carer pathway. We continue to aim to achieve full midwifery establishment, including the additional 5.0WTE midwives identified in the Birthrate + report. New staff recruited to build the existing continuity teams and concentrate on providing continuity in the antenatal and postnatal periods.

Beth Fisher left the organisation at the end of September and we have recruited a band 7 midwife, Rachel Askey on secondment until May 2022 who has previously worked in the continuity model at Harrogate but recently worked in Bradford. Rachel commences in post on November 22nd.

Harrogate has a supportive meeting planned for January 2022 with the regional CofC midwifery leads and regional lead midwives to discuss the continuity of carer model, implementation, progress and plans for 2022/23. This date was postponed to allow Rachel time to settle into her role.

- **Ockenden action plan/evidence submitted**

Evidence feedback meeting arranged for 9th November to discuss the content of the evidence we submitted at the end of June. We were informed it was a strong submission that highlighted areas for further work that we were aware of and many of the ambers identified were similar across the region. Further information will be provided in the next Board report.

Update on local action plan

49 actions within the action plan and 18 actions not required at this time.

	September	**October**
Actions completed	18	18
Actions almost complete		3
Actions in progress	13	10

Clinical Indicators – Yorkshire and Humber Regional Dashboard and Local Dashboard

In summary for Quarter 2:

- Bookings less than 10 weeks are 72.5% and amongst the highest in the region. No Y&H Trust has met the 90% target, with the lowest Trust achieving 36.5%.
- 1:1 care in labour was 96.9%. Again, this compares very well against other Trusts (regional average 94.3%).
- Normal delivery rate is the lowest in the region (52.2%) against a regional average of 58.8%. Total Caesarean section rate was 34.1% (compared with the regional average of 31.4%). Of these, there were 16.6% elective Caesarean sections (compared with 13.2% regional average).
- Induction rate (29.1%) was lower than the Y&H average (34.1%)
- Significant PPH rate was lower in this quarter (4.4%), but marginally raised compared with the regional average (3.9%). This will reflect the higher Caesarean section rates.
- There were no stillbirths at HDFT in Q2. Rolling annual antenatal stillbirth rate is significantly lower (1.1 per 1000 births compared with the Y&H average of 3.5 per 1000)
- Breastfeeding initiation rates remain very high at 83.6% compared with the regional average of 69.0%, and are the highest in the region.
- Smoking rates at booking and time of birth are the lowest in the region (6.1% and 4.2% respectively)
- Carbon monoxide testing at booking and 36 weeks remains a challenge.

Local HDFT dashboard information (October)

For month of October:

- 164 mothers delivered (and 164 babies born)
- Elective Caesarean section rate 16.4% lower than previous month (18.4%).
- 16.4% emergency Caesarean section rate
- 52.4% normal delivery rate
- 33.5% induction rate
- 4.3% significant PPH ≥1500ml rate (7 patients, with 5 of these being delivered by Caesarean section)

- 1 x 3rd degree tear
- 80.6% breastfeeding rate at delivery
- 3% smoking rate at time of delivery.

Conclusion and recommendation

Please see the grid attached for concerns/risks to escalate and positive news and assurance.

Supporting information – applicable to some sections of the report

Further information will be added to this section to provide a narrative around the individual sections in the report.

Introduction – the revised Perinatal Surveillance model

The revised perinatal surveillance model sets out six requirements to strengthen and optimise board level oversight for maternity and neonatal safety. Requirements include

- A monthly review of maternity and neonatal safety and quality is undertaken by the trust board,
- All maternity Serious Incidents (SIs) are shared with trust boards (in addition to reporting as required to HSIB) and
- To use a locally agreed dashboard to include a minimum set of measures drawing on locally collected intelligence to monitor maternity and neonatal safety at board meetings.

Safer staffing – neonatal services

- Each shift had 2 registered nurses on duty one being Qualified in Speciality (QIS) meeting BAPM Professional guidance regarding optimal nurse staffing as described in the BAPM Service Standards for Hospitals providing Neonatal Care 2010 [2].
- The guidance states that the minimum nurse to baby ratio should be 1:1 for babies receiving intensive care (QIS nurses only), 1:2 for high dependency care (QIS nurses either directly delivering care or supervising registered nurses) and 1:4 for special care.

ATAIN

ATAIN (Avoiding Term Admission into Neonatal unit) is a national programme designed to reduce avoidable admissions of Term gestation babies, and reduce the harm caused by separation of mothers and their babies. The work focuses on quality improvement work in four main areas:

- respiratory conditions
- hypoglycaemia
- jaundice
- asphyxia (perinatal hypoxia-ischaemia)

To aid this, all Term admissions to SCBU are reviewed against a standardised proforma through a monthly multidisciplinary panel (midwifery, obstetric and paediatric/neonatal) to determine whether the admission could have been avoided and whether there is any learning or practice changes that could be embedded.

Data for Term admissions is captured through an ATAIN dashboard, submitted through the WY&H LMS, together with an action plan of learning points.

Coroner Reg 28 made directly to Trust

A Coroner has the power to make a report to prevent future deaths, provided under Regulation 28 of Coroner (Investigations) Regulations 2013.

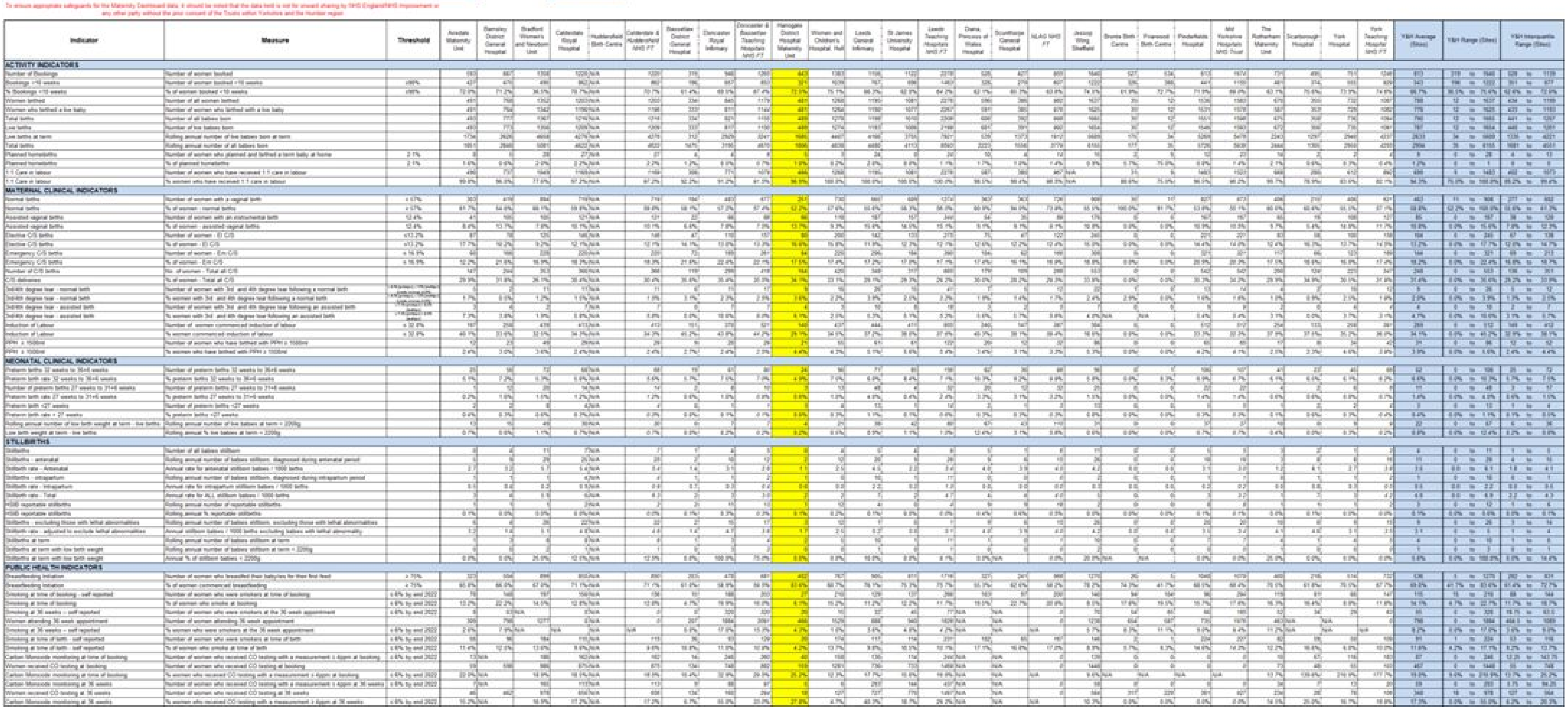
Clinical Indicators – Yorkshire and Humber Regional Dashboard and Local Dashboard (Appendix 1)

Comparative summary data from Trusts within with Yorkshire & Humber region is produced on a quarterly basis.

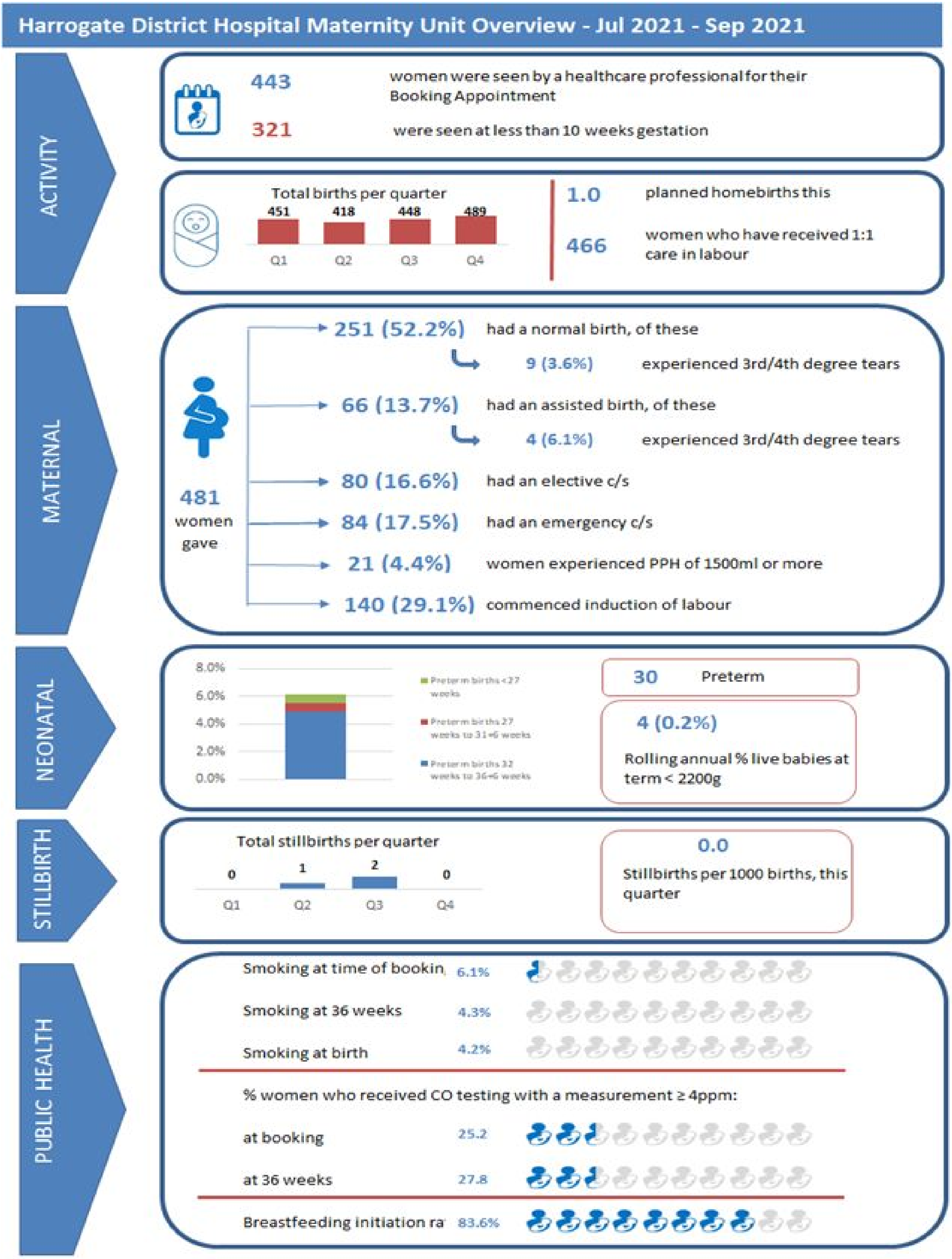
Appendix 1

YORKSHIRE & THE HUMBER MATERNITY DASHBOARD - CORE INDICATORS

Jul-Sep (Q2)
2021/22



Appendix 2



Harrogate District Hospital Maternity Unit Overview - Jul 2021 - Sep 2021

ACTIVITY

443 women were seen by a healthcare professional for their Booking Appointment

321 were seen at less than 10 weeks gestation

Total births per quarter

1.0 planned homebirths this

466 women who have received 1:1 care in labour

MATERNAL

481 women gave

251 (52.2%) had a normal birth, of these

9 (3.6%) experienced 3rd/4th degree tears

66 (13.7%) had an assisted birth, of these

4 (6.1%) experienced 3rd/4th degree tears

80 (16.6%) had an elective c/s

84 (17.5%) had an emergency c/s

21 (4.4%) women experienced PPH of 1500ml or more

140 (29.1%) commenced induction of labour

NEONATAL

8.0%
6.0%
4.0%
2.0%
0.0%
Preterm births <27 weeks
Preterm births 27 weeks to 31+6 weeks
Preterm births 32 weeks to 36+6 weeks

30 Preterm

4 (0.2%)

Rolling annual % live babies at term < 2200g

STILLBIRTH

Total stillbirths per quarter

0
1
2
0
Q1
Q2
Q3
Q4

0.0

Stillbirths per 1000 births, this quarter

PUBLIC HEALTH

Smoking at time of bookin	6.1%
Smoking at 36 weeks	4.3%
Smoking at birth	4.2%

% women who received CO testing with a measurement ≥ 4ppm:

at booking	25.2
at 36 weeks	27.8

Breastfeeding initiation ra	83.6%

Trust Board (Public)
24th November 2021

Title:	Safer Nursing Care Tool 2021 Review
Responsible Director:	Executive Director of Nursing, Midwifery & AHPs
Author:	Deputy Director of Nursing, Midwifery & AHPs Clinical Quality Matron Head of Nursing, LTUC

Purpose of the report and summary of key issues:	The Trust undertook a safer staffing review using a recognised tool that was carried out for a 4 week period earlier this year. Senior colleagues are asked to note the content of the report and support proposed recommendations.	
BAF Risk:	AIM 1: To be an outstanding place to work	
	BAF1.1 to be an outstanding place to work	
	BAF1.2 To be an inclusive employer where diversity is celebrated and valued	
	AIM 2: To work with partners to deliver integrated care	
	BAF2.1 To improve population health and wellbeing, provide integrated care and to support primary care	
	BAF2.2 To be an active partner in population health and the transformation of health inequalities	
	AIM 3: To deliver high quality care	
	BAF3.1 and 3.4 To provide outstanding care and outstanding patient experience	X
	BAF3.2 To provide a high quality service	X
	BAF3.3 To provide high quality care to children and young people in adults community services	X
	BAF3.5 To provide high quality public health 0-19 services	X
	AIM 4: To ensure clinical and financial sustainability	
	BAF4.1 To continually improve services we provide to our population in a way that are more efficient	x
	BAF4.2 and 4.3 To provide high quality care and to be a financially sustainable organisation	x
	BAF4.4 To be financially stable to provide outstanding quality of care	x
Corporate Risks	No Change	
Report History:	Executive Team Professional Practice Forum. SMT	
Recommendation:	Board is asked to note and discuss the contents of this report.	

Safer Nursing Care Tool (SNCT)

Date: November 2021

Authors: Charly Gill (Clinical Quality Matron), Kath Banfield (Head of Nursing) & Simon Riley-Fuller (Deputy Director of Nursing)

Situation

The Trust undertook a safer staffing review using a recognised tool that was carried out for a 4 week period earlier this year. Senior colleagues are asked to note the content of the report and support proposed recommendations.

Background

As part of the work undertaken around the Caring at Our Best Programme; a review of nursing workforce establishments on the adult wards was requested by the Executive Director of Nursing, Midwifery & AHP's. . As part of CAOB and this review, the role of Matron for Clinical Quality was introduced and funding later agreed for a Matron for Workforce and Compliance.

The trust currently operates a 'winter and summer' establishment model that was previously agreed in order to reflect seasonal trends. Increasing staffing challenges has meant that this model has become harder to operate and nowadays the demand tends to be much the same all year around. The COVID19 pandemic has also meant that the trust has had to reconfigure how and where we provide care in some areas and this too has at times impacted on the ability to provide consistent safer staffing levels.

Acuity and dependency has also increased across the wards and teams are reporting increasing levels of enhanced care requirements on a daily basis. In recent months this number can exceed a total of 40 enhanced cares on site with some wards having as many as 20 patients at any one time; many of whom require direct or indirect supervision for events such as falls, absconding risks or dementia and delirium patients.

Although staffing levels have been agreed in recent years, an established licensed model has not been used. In May 2021 the trust purchased a license for the SNCT and external support was provided to help train teams in a consistent way. The four week data collection period ran from mid-June '21 to mid-July '21 across all adult inpatient wards at the trust.

The Safer Nursing Care Tool (SNCT) was used with a 60:40 ratio RN to CSW for all wards; however for the two assessment admission wards (Harlow and Farndale), a ratio of 70:30 was used to take into account the additional registered nurse input required when admitting acutely unwell patients, which is recommended by the tool with regards to assessment areas.

Over the data collection period, the hospital bed occupancy was at an average of 85% the data was collected at the same time each day (15:00hrs).

Assessment

With the restrictions on visiting it is imperative to acknowledge the additional pressures this currently has on the ward staff. Ward clerks are required to book visiting slots and often families and carers call the ward daily to arrange these. The ward staff are required to support visitors at the entrance of the ward with donning and doffing PPE, when the visitors are on the ward, as this is more infrequent, they require more support and information from the ward staff. Pre-pandemic visitors would be able to support their families with enhanced care needs, relieving ward staff. This may be providing some distraction or supervision of patients with delirium or dementia or supporting with ensuring the nutritional needs of their relative are met.

There has also been a significant reduction in the amount of volunteers within the hospital, who may also support with the nutritional needs of patients, providing activities and supporting ward staff.

Almost all wards have daily safety huddles where all staff, including medical and AHP colleagues come together on the ward at a set time to discuss any patient safety risks; for example patients who are risk of falls and consider preventative measures to be put in place.

A detailed description of each ward and specific staffing, agency and quality indicators are described in the additional information sections. As recommended by the SNCT; data collected must be used in triangulation with quality indicators and professional judgement before any changes to establishments are agreed.

The SNCT recommendation is to review the required staffing establishment for each ward on a minimum of three separate study periods. This is to ensure robust data and analysis over different data collection periods/times of the year.

Headroom for each ward is calculated at an overall 21% with the following breakdown:

- 14.96% Annual leave
- 1.92% Study leave
- 3.9% Sickness

During the SNCT collection period the total combined bank and agency spend was: **£202,700.95**. The 4 areas of greatest spend were:

1. Wensleydale
2. Nidderdale
3. Oakdale
4. Farndale

Additional workforce:	Total combined spend during SNCT collection period = **£202,700.95**
Bank	£63,768.67
Agency	£138,932.28

Within the overall combined spend, the cost of providing additional enhanced cares support is included and reflected in the top three highest spend areas, as these are where the highest daily EC requests came from. Farndale ward had also admitted COVID patients during this time and therefore the demand and deployment of staff was different to previous.

As part of the SNCT process, the Deputy Director of Nursing, Head of Nursing and Clinical Quality Matron met with each ward manager and matron to review the SNCT results and apply professional judgements. All ward managers and matrons agreed the process was useful in understanding better their establishments and budgetary requirements. There was an overall feeling that this process helped with providing a much tighter grip around staffing and demand for each ward.

All clinical areas recognised the challenges and understood the results. Where there were perceived anomalies, these were discussed and professional judgement applied. This was pertinent to some smaller wards and assessment areas and those that host Covid positive patients including those that require non-invasive ventilation (NIV) as not all patients requiring NIV are admitted to a critical care environment at HDFT.

Recommendations

1. To note the content of this report and support the proposal to run the SNCT bi-annually moving forwards.

2. As part of the SNCT bi-annual process; the Deputy Director of Nursing will meet with the relevant Head of Nursing, Matron and ward/unit manager meets to review staffing levels and triangulate with current quality and operational demands.

3. That the Heads of Nursing for LTUC and PSC continue to work in tandem with regards to staffing need and where appropriate redistribute Band 5 resource within existing budget to support areas of greatest need.

4. Ensure non clinical management time amongst Band 7 ward/unit managers is consistent across both directorates; it is recommended this consists of four x 7.5 hour working days.

5. Currently over weekends and night shift the wards generally are staffed with band 5 RNs. However, after review and discussion with the ward leaders, it is recommended that more senior (band 6) are rostered onto these shifts. This will provide clinical leadership and timely response to clinical incidents. It is also anticipate that it will aid patient flow more effectively and provide some clinical supervision for junior staff who are under pressure during times of extremis

6. It has been evident through the safer staffing review process that non clinical functions are being delivered by clinical staff (e.g.: CSW's working as ward clerks). Therefore a further piece of work is recommended to review the provision and need of these types of roles. The demand needs to be calculated and the appropriate function put in place.

7. It is recommended that a detailed piece of work around enhanced cares is carried to support the work into exploring the need for an increase in non-clinical support roles.

8. The safer nursing care tool advises caution in the interpretation of ward with a lower bed base. The wards that this is applicable to are Rowan and Trinity, at the time of the study. It is acknowledged that these wards have increased due to operational bed pressures. Note: the minimum number off staffing required to run these wards safely has been applied.

9. To ensure further governance of safer staffing and the daily safe deployment of staff and general roster oversight, it is recommended the trust procures the additional 'safe care' module of Allocate (rostering system).

10. It is recommended that there is one consistent ward budget rather than a mixed summer/winter establishment.

SNCT data information pack

(1) SNCT summary table

(2) Contents per ward:

- Ward description
- Current budgeted establishment
- Band and Agency fill rates
- Turnover and sickness
- Quality Indicators
- Bed occupancy

(3) Appendices:

- Floor plan and layout for each ward
- Breakdown of total ward spends for bank and agency

Ward (bed numbers)	Bed Occupancy %	RN Fill rate Days %		RN Fill Rate Nights %		CSW Fill Rate Days %		CSW Fill Rate Nights %		RN Agency fill rate %	CSW Agency fill rate %	Vacancy RN	Vacancy CSW	CHPPD June	CHPPD July	Pressure Ulcers	Falls	Medication Incident	Complaint	DATIX related to staffing	RN Current WTE	SNCT Recommendation WTE	Variation	CSW Current WTE	SNCT Recommendation WTE	Variation
		June	July	June	July	June	July	June	July																	
Nidderdale (30 open beds Nov 21)	95	82	92	101	98	98	99	115	131	75	73	0.9	5.69	6.4	5.9	0	1	1	1	3	**17.5 (24 beds)**	**20.49**	**↑2.99**	**16.72 (24 beds)**	**20.49**	**↑3.77**
Rowan (12)	92	97	97	100	100	85	85	103	100	96	43	1.16	1.29	10	8.7	1	1	0	0	0	**11.76**	**8.51**	**↓3.25**	**10.68**	**8.51**	**↓2.17**
Oakdale (30 open beds Nov 21)	93	92	88	99	101	98	100	83	88	63	59	0.72	3.37	6.4	6.6	1	4	1	0	8	**19.92**	**21.87**	**↑1.95**	**18.47 (24 beds)**	**23.63**	**↑5.16**
Trinity (18 open beds Nov 21)	81	93	95	100	100	90	88	100	100	100	59	1.97	2.39	8.8	7.3	0	1	2	0	0	**12.01**	**10.09**	**↓1.92**	**13.27**	**10.09**	**↓3.18**
Wensleydale (31)	93	95	96	74	75	88	90	142	141	74	71	3.64	+0.31	7.5	6.9	11	8	4	1	5	**20.9**	**25.14**	**↑4.24**	**21.69**	**20.99**	**↓0.7**
Granby (22)	98	106	109	100	100	116	115	102	100	67	62	0.94	3.69	7.1	6.2	5	2	1	0	7	**13.47 (16 beds)**	**16.43**	**↑2.96**	**12.51 (16 beds)**	**16.43**	**↑3.92**
Jervaulx (30 open beds Nov 21)) *	88	91	84	94	97	94	86	114	115	72	65	3.18	3.3	6.9	6.2	3	6	3	0	4	**17.81 (22 beds)**	**23.5**	**↑2.96**	**16.91 (22 beds)**	**15.7**	**↓1.21**
Byland (Bolton) (23+5 CCU)	67	96	94	96	96	91	87	132	133	84	46	5.9	1.18	7.5	7.4	3	4	7	1	1	**18.87 (22 beds)**	**15.74**	**↓3.13**	**12.91 (22 beds)**	**10.49**	**↓2.41**
Fountains Ward	49	91	89	98	96	83	76	90	58	72	69	3.18	+2.32	10.4	9.6	0	0	0	0	1	**23.21**	**14.75**	**↓8.46**	**11.51**	**7.92**	**↓3.59**
Harlow (25)	80	81	76	78	76	82	79	96	100	75	62	6.45	+1.29	10.7	9.6	0	0	1	0	1	**22.31**	**21.68**	**↓0.63**	**20.06**	**9.4**	**↓10.66**
Farndale (23)	83	83	84	81	83	91	90	113	104	62	62	4.85	+0.41	12.3	12	6	9	3	0	0	**28.33**	**19.21**	**↓9.09**	**18.92**	**8.2**	**↓10.72**
Littondale (32 open Nov 21)	89	99	96	100	100	103	101	105	105	73	43	+0.44	+0.61	5.5	5.6	1	6	1	1	0	**20.32**	**20.98**	**↑0.66**	**15.03**	**14.2**	**↓0.83**

*Jervaulx Ward – data collection below the minimum of 20 days therefore invalid. The nearest comparator is Wensleydale Ward.

NB: Since the study was carried out, the trust has agreed the baseline inpatient adult base number and also what constitutes ‘escalation’ beds. Some wards have now increased their overall ward capacity as a result (e.g.: Oakdale, Littondale) so where the tool is recommending a decrease to staffing this point needs to be noted and triangulated with subsequent studies.

Also to note; Fountains Ward is an elective surgical unit and operates according to elective demand which remains variable. Any ‘surplus’ staff on a Fountains shift are invariably moved to support another area on a daily basis. Farndale (assessment ward) also requires further SNCT study in order to better match staffing to admission times and NIV/Covid acuity as both remain a factor for this ward that would not have been known specifically by the tool.

Total RN increase WTE	**15.76**	**Total CSW Increase WTE**	**25.7**
Total RN Decrease WTE	**26.48**	**Total CSW Decrease WTE**	**35.47**

Nidderdale Ward

Nidderdale is a 30 bedded orthopaedic trauma ward. The ward is a "T" shaped ward. With four adjacent bays and six single rooms, all of which are not in sight of the main staff base. Single room 1 and 2 are opposite bay 3 and single rooms 27 and 28 are opposite bay 6. The two remaining single rooms are out of sight off the entry corridor. The bathrooms, staff base linen room, and storage room face the bays. Other rooms include the ward office, dirty utility room, ward kitchen, treatment room, doctors' office, quiet room, therapy storage and staff room, which are all located a distance away from the main patient areas along the entry corridor.

The ward is led by an experienced Ward Manager and Matron, there are also experienced Band 6 Ward Sisters. The budgetary allocation for the Ward Manager is three management days per week.

As this is an orthopaedic trauma ward, a significant number of patients are frail and elderly. They often experience a post operative delirium and have an increased risk of falls. Due to this there is a daily request for an additional CSW overnight and increasingly for the additional long day shift. The ward exits by single room 2 and single room 27 are swipe card activated to prevent at risk patients leaving the ward. At risk patients are cohorted in bay 5 and 6 as these bays are the closest to the staff base.

Patient care is allocated by splitting into three teams of ten. Each team consists of the single rooms and bays. For example: Team 1 includes single room 1 and 2 and B3 -B10.
It is reliant on the nurse in charge to allocate the patients based on acuity and the skill mix on shift. Reallocation of the teams is sometimes done to support junior nurses who require a less acute team. The nurse in charge overarches all the patients and provides support as needed. If there are 3 RN's on shift the nurse in charge overarches and cares for a team of 10 patients.

Over the data collection period the fill rates were:

Month	Day		Night	
	RN	CSW	RN	CSW
June 2021	82%	98%	101%	115%
July 2021	92%	99%	98%	131%

The current shift establishment is:

Day		Night	
RN	CSW	RN	CSW
4	3	3	2

The budgeted establishment is for 24 beds which covers 17.5 RNs and 14.32 CSW

Based on the current shift establishment the budgetary requirement for 30 beds is 20.32 RNs and 14.32 CSW

Therefore an additional 2.82 RNs is required for 30 beds

Contracted for the time of data collection was 16.6 RN and 13.63 CSW

Bank or Agency Fill:
RN Demand 623 hours (16.6wte)
Fill 466 hours (12.4wte)
75% fill

CSW Demand 946 hours (25.2wte)
Fill 694hours (18.5wte)
73% fill

Turnover %		Sickness %	
RN	CSW	RN	CSW
0	0	1.37	6.93

Quality indicators
1 x medication incident
1 x fall
1 x formal complaint
3 x DATIX re: staffing
0 Pressure Ulcers

As a summary of the SNCT study period

Bed occupancy was 95%

WTE RNs Actual 17.5

SNCT indicates the ward requires 20.49wte RN this gives a variance of 2.99wte. As above, according to the shift establishments an additional 2.82wte is required to staff 30 beds.

CSW 16.72wte in establishment, the SNCT indicates the requirement is 20.49wte, a variance of 3.77wte.

Current budget is for 24 beds, SNCT recommends additional RN and CSW which is commensurate to the additional staffing put in place for 30 beds.

Rowan Ward

Rowan Ward is a 12 bedded rehab ward. The staff also have additional skills to manage up to two patients who are at the end of their life and who can be cared for in a quieter environment than an acute ward.
Although on the main hospital site, it is in a separate wing to all other wards and has no neighbouring wards. The ward is a "L" shaped ward. With two four bedded bays and four single rooms. All bays and rooms are in the same area of the ward. Immediately adjacent linen room, patient toilets and staff room. There are no en-suites. The staff base is at the apex of "L" shape. Other supporting areas such as the ward office, dirty utility, assisted bathroom and storerooms are off the entry corridor; all of which are a distance from the patients. The ward also has a large rehabilitation therapy room, ward education room where a practice educator is based, outpatients clinic room often utilised over the weekends and the radiology department use the ward for access to a CT Scanner – this increases footfall on the ward and often requires ward staff to answer the door as appropriate. The ward has a dining room (of which half is used as a store room) and a quiet room and a small outdoor area for

patient use; this means that often patients are located in numerous places across the ward. During periods of increased demand, the ward take patients who are awaiting complex discharges and also has a 13th bed for escalation – however this reduces clinic capacity if this is used.

At the time of the study the ward was led by an experienced Ward Manager (who has since left the Trust) and Matron, there is one experienced Band 6 Ward Sister. The budgetary allocation for the Ward Manager is one management day per week.

The patients on the ward often require assistance of two (or more) to support with the delivery of their care needs; this might be due to mobility or end of life care needs. The patients at the end of their life often need additional intensive support, both physical and psychological for themselves and their families. As this is a rehabilitation ward, the intensity of rehab available to the ward has a direct impact on the length of stay on the ward.

Patient care is allocated by the nurse in charge. The nurse in charge will have oversight of all patients and will support the CSW with personal care requirements of the patients.

Professional judgement by the Matron of the ward is that the ward management days would be adequate at two days per week due to the lower staffing levels with regard to HR management and reduced patient numbers.

Over the data collection period the fill rates were:

Month	**Day**		**Night**	
	RN	CSW	RN	CSW
June 2021	97%	85%	100%	103%
July 2021	97%	86%	100%	100%

The current shift establishment is:

Day				**Night**	
Early		**Late**			
RN	CSW	RN	CSW	RN	CSW
2	3	2	2	2	1

The budgeted establishment is for 12 beds is 11.76 RNs and 10.68 CSW

Contracted for the time of data collection was 11.0 RN and 9.39 CSW

Bank or Agency Fill:
RN Demand 51 hours (1.36wte)
Fill 49 hours (1.3wte)

96% fill

CSW Demand 214 hours (5.7wte)
Fill 93hours (2.48wte)
43% fill

Turnover %		Sickness %	
RN	CSW	RN	CSW
0	0	1.65	15.05

Quality indicators
0 x medication incident
1 x fall
0 x formal complaint
0 x DATIX re: staffing
1 x Pressure Ulcer

As a summary of the SNCT study period

Bed occupancy was 91.6%

WTE RNs Actual 11.76 (including Ward Manager)

SNCT indicates the ward requires 8.51 RN this gives a variance of 2.25wte. Given that a minimum of two RN need to be on duty at each shift this reduction would not support patient safety or care.

CSW 10.68wte in establishment, the SNCT indicates the requirement is 8.51wte, a variance of 2.17wte.

SNCT recommendations should be used cautiously for small wards as at least 2 RN (which is at least 11.2 plus a ward manager) are required per shift and professional judgement should be used to inform staffing levels. Due to the patient profile, as above, the recommendation would be that the CSW and RN establishment remains the same.

Oakdale Ward

Oakdale ward is a 30 bedded stroke, rehab, acute oncology and medical ward. There are three six bedded bays, one four bedded bay and eight single rooms. The ward is not uniformly laid out. Bay 1, room 12 and the oncology single rooms are out of sight and distant from the main staff base. Room 1, day room, ward manager office, kitchen and staff room are distant to the remainder of the ward. The six bedded rooms (4 & 5) and two of the single rooms are located around the main staff base. There is a further staff base located within line of sight of the four bedded (room 12) and the four oncology single rooms. The six bedded bays (4 & 5) have en suite facilities and six single rooms have en suite facilities.

The ward is led by an experienced Ward Manager and Matron, there are also experienced Band 6 Ward Sisters. The budgetary allocation for the Ward Manager is one management days per week. On the advice of occupational health the Ward Manager and one Ward Sisters have been working non clinically.

A registered nurse holds the oncology emergency bleep 1800-0800 every evening and bank holiday (at the time of data collection this was also covered over a weekend) and from 1600 on a weekend. This is a helpline for patients to access and be assessed by a RN. Each call can take up to an hour. Advice will be given or the patient will be signposted appropriately.
When patients are on the ward receiving chemotherapy staffing numbers need to be maintained with the appropriate skill mix of staff, as this requires intensive periods of level 2 care. In circumstances when this is not maintained, patients have had to be transferred to neighbouring hospitals for their care.

More recently, there has been a requirement for the ward to take Gastroenterology patients due to the capacity on Littondale Ward. This brings additional challenges such as complex IV regimes, treatment and often, enhanced care needs.
The ward is required to manage the Botox Clinic which requires three RNs six hours each to do so, a total of eighteen hours per month. However for the data collection period this was reduced to two RNs. This requirement comes directly from the nurse establishment on the ward. Due to the additional requirement of chemotherapy on the ward, the RNs need to attend monthly specialist training.
The ward is a multi speciality ward and therefore the nurse in charge is required to attend multiple ward rounds and MDT discussions.
This ward often has a high level of patients who are confused, an absconding risk or require enhanced care. The patients on the ward usually require intense rehabilitation and this may need more than two members of staff to support with this.
The layout of the ward is a challenge with regards fall prevention, as often patients cannot be visualised. Due to this there is a daily request for an additional CSW overnight and sometimes for the additional long day shift.
Oakdale ward has it's own speciality allied health professionals; they support with the ward huddle daily.

The geographical location is next to Granby Ward, therefore mutual aid is often provided from each ward.

Patient care is allocated by:

Days:

Bay 1: 6 patients, usually the least dependent patients

1 x RN and 1 X CSW – normally during the day that nurse is the nurse in charge.

Single room 2 & 3 and bay 4 : 8 patients in total.

1 X RN and 1 X CSW

Single room 6 & 7 and bay 5: 8 patients in total.

1 RN and 1 CSW

Single rooms, 8, 9, 10 & 11 and bay 12: 8 patients in total

1 RN and 1 CSW

As a contingency during the day if there are 3 RNS or 3 CSWs the divide is:

Bay 1 and bay 4: 12 patients

Bay 5 and single room 2, 3, 6, 7: 10 patients nurse in charge

Bay 12 and singleroom 8, 9, 10, 11: 8 patients.

Nights:

2 RNS and 2 CSWS allocated to bay 1, bay 4, bay 5 and single rooms 2, 3, 6, 7

1 RN and 1 CSW allocated to bay 12 and single rooms 8, 9, 10, 11

It is reliant on the nurse in charge to allocate the patients based on acuity and the skill mix on shift. Reallocation of the teams is done to support junior nurses who require a less acute team.

Over the data collection period the fill rates were: (based on a shift establishment for 24 open beds)

Month	**Day**		**Night**	
	RN	CSW	RN	CSW
June 2021	92%	98%	99%	83%
July 2021	88%	100%	101%	88%

The current shift establishment is (for 24 beds):

Day				**Night**	
Early		**Late**			
RN	CSW	RN	CSW	RN	CSW
4	4	4	3	3	3

At the time of the study the bed occupancy was 93% and the ward was staffed for 30 beds which requires an additional CSW on the late shift.

Based on the current shift establishment the budgetary requirement for 30 beds is 19.92 RNs and 20.43 CSW, however the budget is only 18.67CSW.

Contracted for the time of data collection was 40wte with

Bank or Agency Fill:
RN Demand 561 hours (14.96wte)
Fill 354 hours (9.44wte)
63% fill

CSW Demand 832 hours (22.19wte)
Fill 487hours (12.99wte)
59% fill

Turnover %		Sickness %	
RN	CSW	RN	CSW

0	4	1.05	1.04

Quality indicators
1 x medication incident
4 x fall
0x formal complaint
8 x DATIX re: staffing
1 x Pressure Ulcer

It is important to note that the ward have a well established safety huddle which occurs every morning; this has had considerable impact on the rate of falls on the ward.
Oakdale is one of the wards with the highest Datix reports regarding staffing; this is in relation to the ward being budgeted for 24 beds.

As a summary of the SNCT study period

Bed occupancy was 93%

WTE RNs Actual 19.92 (budget)

SNCT indicates the ward requires 21.87wte RN this gives a variance of 1.95wte.

CSW 18.47wte in establishment, the SNCT indicates the requirement is 21.87wte, a variance of 3.4wte. But also require an additional 1.76 (for 30 beds) to total 5.16wte

There is a recommendation to increase the RN by 1.95wte, this is to be reviewed in future study results. The recommendation is that the budget to be set at 30 beds and a further increase in CSW as per SNCT recommendation.

Trinity Ward

Trinity ward is a 16 (funded) bedded rehab ward (there is space to increase to 20 beds however no staffing/funding to go with this), with two palliative care beds. The ward is based at Ripon Community Hospital and the only inpatient facility there.
The ward is “T” shaped. The ward managers office and ward kitchen are beyond the Minor Injury Unit (MIU) on the entrance corridor to the ward. On entering the ward there is the staff base with an adjoining clinical utility room. To the right of the ward is a four bedded female bay with a direct link through to a three bedded female bay, a female single room with no ensuite facility, leading to a two bedded female bay with ensuite. The supporting patient bathroom facilities and dirty utility are out of site of the ward.
On entering the ward to the left, there is a male single room with no ensuite, a male partitioned bed space leading directly to a six bedded male bay. The supporting patient bathroom facilities and dirty utility is out of sight at the end of the ward.

On entering the ward and straight ahead there is a link corridor to the two bedded palliative care room. This has collocated ensuite facilities. There is also a day room leading from the link corridor to the palliative care room.

At the time of the study the ward was led by an experienced Ward Manager and Matron, there are also experienced Band 6 Ward Sisters. Currently having interim support by a Matron until the replacement matron is in post. The budgetary allocation for the Ward Manager is one management day per week.

The layout of the ward is a challenge with regards fall prevention, as often patients cannot be visualised, this is taken into account when reviewing patients who are suitable for transfer and rehabilitation at Trinity Ward.
Clinical oversight of the patients is provided by local GPs and an elderly care physician and ACP are on site once a week. In an emergency, as there is no medical cover 24/7, 999 is used for medical support. The ward nursing staff closely work alongside therapy teams (physiotherapist, occupational therapist and therapy assistant) to maximise patient rehabilitation potential. There are weekly MDT meetings that the RN in charge is required to attend.

Between 18:00 and 08:00 the ward staff are the only staff in the building of Ripon Hospital. The ward manager also has the role of site manager for Ripon Community Hospital.

It is reliant on the nurse in charge to allocate the patients based on acuity and the skill mix on shift. Reallocation of the teams is done to support junior nurses who require a less acute team.

Over the data collection period the fill rates were:

Month	**Day**		**Night**	
	RN	CSW	RN	CSW
June 2021	93%	90%	100%	100%
July 2021	95%	88%	100%	100%

The current shift establishment is (for 24 beds):

Day				**Night**	
Early		**Late**			
RN	CSW	RN	CSW	RN	CSW
2	3	2	2	2	2

At the time of the study the bed occupancy was 81%

Based on the current shift establishment the budgetary requirement for is 12.01 RNs and 13.27 CSW.

Contracted for the time of data collection was 23.25wte. Vacancy at the time of the study was 2.0wte RN and 1.5wte CSW.

Bank or Agency Fill:

RN Demand 185 hours (4.9wte)
Fill 185 hours (4.9wte)
100% fill

CSW Demand 319 hours (8.5wte)
Fill 187 hours (4.98wte)
59% fill

Turnover %		Sickness %	
RN	CSW	RN	CSW
0	0	2.57	0

Quality indicators

2 x medication incident
1 x fall
0x formal complaint
0 x DATIX re: staffing
0 x Pressure Ulcers

Inpatient Ward Forecasting Database shows the vacancy at:
RN: 2.45
CSW: 1.59

As a summary of the SNCT study period

Bed occupancy was 81%

WTE RNs Actual 12.01

SNCT indicates the ward requires 10.09wte RN this gives a variance of 1.92wte.

CSW 13.27wte in establishment, the SNCT indicates the requirement is 10.09wte, a variance of 3.18wte.

SNCT recommendations should be used cautiously for small wards as at least 2 RN are required per shift and professional judgement should be used to inform staffing levels. It is also to note that due to fire regulations there needs to be at least four members of staff on site on each shift on the case of evacuation being required.

Wensleydale Ward

Wensleydale ward is a 31 bedded Elderly Care ward.
The ward is one single corridor with a centrally located work base. The ward kitchen and staff room are located at the entrance corridor to the ward out of sight of the patient areas. The top half of the ward comprises three four bedded bays, three single rooms, one of which has ensuite and a two bedded bay. There are patient bathroom facilities centralised opposite the bays. The bottom half of the ward has three four bedded bays and two single rooms. One single room has been temporarily converted into a ward manager's office and the bathroom facilities are located opposite the bays. Behind the central staff base is a dirty utility, an MDT room and a clean utility.

There is a fire escape leading to concrete steps at the bottom of the ward, the fire doors do not lock but do alarm if opened. Only one patient in one single room is visible from the central staff base, no other patients are visible from the staff base. No bays have a base for staff.
Off the centre of the ward are storage areas.
Refurbishment of the ward is planned for 2022 and is overdue. There are no bed head light facility and the call bell, if unanswered within three minutes, converts to an emergency (crash alarm) bell. The door to bay 1 does not have a window.

The ward layout is compounded due to the high number of elderly care patients with dementia and delirium, the risk of falls, pressure ulcers and absconding patients is high. The ward request a daily CSW to support with the enhanced care needs of patients, Wensleydale Ward are the highest requested for enhanced care needs for patients throughout the Trust.

At the time of the study the ward was led by a recently appointed, highly committed Ward Manager and experienced Matron, who has since left, whilst an interim Matron arrangement is in place the replacement Matron will commence in November. There are also experienced Band 6 Ward Sisters. The budgetary allocation for the Ward Manager is one management day per week.

Patient care is allocated by: (Currently at 31 beds)

Bay 1 and 2 and annex (10 patients) 1 nurse

Bay 3 and 4 single rooms 1, 2, 3 (11 patients) 1 nurse

Bay 5 and 6 single room4, 5 (10 patients) 1 nurse

The 4th nurse is the nurse in charge and supports RNs and with all of the complex discharges that are required daily.

It is reliant on the nurse in charge to allocate the patients based on acuity and the skill mix on shift. Reallocation of the teams is done to support junior nurses who require a less acute team.

Over the data collection period the fill rates were:

Month	**Day**		**Night**	
	RN	CSW	RN	CSW
June 2021	95%	88%	74%	142%
July 2021	96%	90%	75%	141%

Due to our own vacancies the manager rosters three RNs on a night and four CSWs to offset the RN gap wherever possible.

The current shift establishment is:

Day				**Night**	
Early		**Late**			
RN	CSW	RN	CSW	RN	CSW
4	4	4	4	4	3

At the time of the study the bed occupancy was 93%

Based on the current shift establishment the budgetary requirement for is 22.9 RNs and 21.69 CSW.

Contracted for the time of data collection was 42.27wte
ESR data 3.owte RN, 1wte CSW

Bank or Agency Fill:
RN Demand 424 hours (11.3wte)
Fill 312 hours (8.3wte)
73.5% fill

CSW Demand 1280 hours (34wte)
Fill 914 hours (24.4wte)
71% fill

Turnover %		Sickness %	
RN	CSW	RN	CSW
0	0	0.88	12.03

The CSW long term sickness was primarily due to post Covid stress and anxiety, two of these members of staff remain absent from work.

Quality indicators
4 x medication incident
8 x fall
1 x formal complaint
5 x DATIX re: staffing
11 x Pressure Ulcers

The increased levels of pressure ulcers impact on the ongoing care required to prevent further deterioration. It is important to note that some, not all of these were acquired on Wensleydale Ward but were identified after transfer.

As a summary of the SNCT study period

Bed occupancy was 93%

WTE RNs Actual 20.9

SNCT indicates the ward requires 25.14wte RN this gives a variance of 2.24wte.

CSW 21.69 in establishment, the SNCT indicates the requirement is 20.99wte, a variance of 0.7wte.

The SNCT suggests an increase in RN based on a 60:40 ratio, recommendation is to consider the ratio with potential increase CSW to support with the care needs of the patients which is reflected in the CHPPD and increased levels of harms. The current establishment is to have 4 x RN on a night, however this is usually not filled and the ward manage with 3. The ward manager has the professional judgement view that due to the demographic of the patient, there should be consideration of increased CSW establishment; this is that 3 x RN are sufficient for the night shift, but with an increase of 5 x CSW for the day and night shift.

The ward currently do not have a full time nutritional support assistant or discharge support worker, the recommendation is that these posts are appointed to which will support with the additional pressures on the ward.

Granby Ward

Granby ward is budgeted as a 16 bedded respiratory/endocrine ward. There are also six escalation beds which takes the ward up to 22 beds.
The ward is a "Z" shaped ward. There are three six bedded bays, and four single rooms, two of which are ensuite. Two of the bays have toilet facilities. Upon entering the ward immediately on the left is the six bedded escalation bay which is out of sight of the remainder of the ward. Therefore, care is taken when assigning patients to that bay. The entry corridors to the main area of the ward have a therapy kitchen, patient shower facilities, staff kitchen, linen cupboard, dirty utility, and ward manager's office. The main area of the ward has a central staff base surrounded by the two bays and four single rooms. The visibility of patients, with the exception of the escalation bay, is good. Granby Ward request one to one enhanced care in exceptional circumstances.
The ward has a high turnover of patients who are either transferred or discharged directly from the ward, there are also occasional direct admissions.
Due to the high levels of patients requiring oxygen, there is often the requirement of a RN to escort a patient for any scans, X-Rays or appointments; this directly affects the capacity of the ward.
The ward is a multi-speciality ward and therefore the nurse in charge is required to attend multiple ward rounds and MDT discussions.
Anecdotally there are frequently complex discharges required of the ward. The ward frequently transfers patients to neighbouring hospitals which requires a RN escort, who can then be absent from the ward for the majority of the shift. The ward often cares for patients with Learning Disabilities; this often requires complex discharge planning and additional care requirements.

The geographical location is next to Oakdale Ward, therefore mutual aid is often provided from each ward.

The ward is led by an experienced Ward Manager and Matron, there are also experienced Band 6 Ward Sisters and Charge Nurse. The budgetary allocation for the Ward Manager is one management day per week.

Patient care is allocated by:

1 Bay and 2 single rooms – 1 RN

1 Bay and 2 single rooms – 1 - RN

Bay 1 to the Nurse in Charge as these patients are usually the least dependant.

It is reliant on the nurse in charge to allocate the patients based on acuity and the skill mix on shift. Reallocation of the teams is done to support junior nurses who require a less acute team.

Over the SNCT study period the ward was fully escalated at 22 beds

Over the data collection period the fill rates were:
This data is based on 16 beds – not 22 where additional staff are in the establishment.

Month	Day	Night

	RN	CSW	RN	CSW
June 2021	106%	116%	100%	102%
July 2021	109%	115%	100%	100%

The current shift establishment is:

	Day				**Night**	
	Early		**Late**			
	RN	CSW	RN	CSW	RN	CSW
16 beds	3	2	2	2	2	2
22 beds	3	3	3	3	2	2

At the time of the study the ward had 22 beds open 98%

Based on the current shift establishment the budgetary requirement for 22 beds is 15.23 RNs and 14.32 CSW. For 16 beds which is their budgeted establishment 13.47RN and 11.51CSW

Contracted for the time of data collection was 34.32wte

Bank or Agency Fill:
RN Demand 332hours (8.85wte)
Fill 224 hours (5.96wte)
67% fill

CSW Demand 520 hours (13.86wte)
Fill 323 hours (8.61wte)
62% fill

Turnover %		Sickness %	
RN	CSW	RN	CSW
6.25	0	4.67	3.98

Quality indicators
1 x medication incident
2 x fall
0 x formal complaint
7 x DATIX re: staffing
5 x Pressure Ulcers
As a summary of the SNCT study period

Bed occupancy was 98%

WTE RNs Actual 13.47

SNCT indicates the ward requires 16.43wte RN this gives a variance of 2.96wte. The staffing establishment for 22 beds requires an additional 1.76 RN.

CSW 12.51wte in establishment, the SNCT indicates the requirement is 16.43wte, a variance of 3.92wte. For 22 beds the ward requires 2.82wte additional CSW for the shift establishment for 22 beds.

Current budget is for 16 beds, SNCT recommends additional RN and CSW which is commensurate to the additional staffing put in place for 22 beds. The recommendation is that the budgetary funding is in line with 22 beds.

Fountains Ward (ESU)

Fountains ward is an elective surgery ward with 28 beds. There are three bays of six, a four bedded high observation bay (HOB) and six single rooms, two of which are ensuite.
The ward is an "L" shaped ward. Along the entry corridor is the ward office, clean utility, 2 single rooms out of sight of the main staff base and around the corner from the main ward area.
The staff base is at the apex of the "L" and the dirty utility and kitchen are immediately adjacent. There is some visibility of bay 1 and one single room from the staff base but the remaining bays, HOB and three single rooms have no visibility.
None of the bays have patient bathroom facilities, shared facilities are located opposite each bay.
There are dedicated orthopaedic beds which are required to be separated from the general surgery beds for infection control reasons.

The ward is led by an experienced Ward Manager and Matron, there are also experienced Band 6 Ward Sisters. The ward manager has budgeted management days three days per week.

Patient care is allocated by:

1 x Nurse in Charge

1 X RN & CSW for orthopaedic patients

1 x RN & CSW for general surgery patients

If there is a patient in the HOB an additional RN is required.

It is reliant on the nurse in charge to allocate the patients based on acuity and the skill mix on shift. Reallocation of the teams is done to support junior nurses who require a less acute team.

Over the data collection period the fill rates were:

Month	**Day**		**Night**	
	RN	CSW	RN	CSW
June 2021	91%	83%	98%	90%
July 2021	89%	76%	96%	58%

The reduced overnight CSW fill rate is due to the CSW's being moved to other wards to support when the bed occupancy is reduced, at the time of the study there was also increased CSW absence.
At the time of the study, three full time RNs were on maternity leave which is not taken out of the establishment.

The current shift establishment is:

Day				**Night**	
Early		**Late**			
RN	CSW	RN	CSW	RN	CSW
4	2	4	2	3	2

Bed occupancy varies dependant on the number of patients requiring an inpatient bed following elective surgery

Based on the current shift establishment the budgetary requirement is 23.21RNs and 11.51CSW

Contracted for the time of data collection was 35.43wte

The ward has been over established on CSW; this has been to support other wards. As well as this the ward is a "Green" ward and therefore staff have been allocated to the ward as part of redeployment recommendations from occupational health.

Bank or Agency Fill:
RN Demand 260 hours (6.9wte)
Fill 187 hours (5wte)
72% fill

CSW Demand 58 hours (1.6wte)
Fill 40 hours (1.06wte)
69% fill

Turnover %		Sickness %	
RN	CSW	RN	CSW
0	0	1.1	4

Quality indicators
0x medication incident
0x fall
0x formal complaint

1x DATIX re: staffing
0x Pressure Ulcers

Inpatient Ward Forecasting Database shows the vacancy at:
RN: 1.18
CSW: **over by 2.0**

As a summary of the SNCT study period

WTE RNs Actual 23.21

SNCT indicates the ward requires 14.75wte RN this gives a variance of 8.46wte. When post-surgical patients require care in the HOB, 1 RN is assigned to a maximum of 4 patients. This SNCT study does not take this in to account. The HOB has never had its own establishment and therefore the RN is taken from the existing ward establishment.

CSW 11.51wte in establishment, the SNCT indicates the requirement is 7.92wte, a variance of 3.59wte.

Harlow Ward

Harlow ward is a 25 bedded surgical admissions ward. Harlow Ward was formerly a 10 roomed private patient unit, leading directly onto a 15 bedded escalation ward. It is an “L” shaped ward with the ward kitchen, one single room on the approaching corridor. The remainder of the ward is in a singular corridor with the two staff bases. The former private end of the ward there are 10 single rooms each with en suite facilities, all have limited or zero visibility from staff bases. There is a dirty and clean utility opposite the first staff base and behind the second staff base. The former escalation ward area provides three bays of four beds and three single rooms. None of which have en suite facilities. Patient bathroom facilities are either opposite the bays or in the link corridor to the neighbouring ward; which is out of sight of the ward. The ward manager’s office is it at the entry to the ward away from the main staff base (s).

The ward is led by an experienced Ward Manager and Matron, there are also experienced Band 6 Ward Sisters. The ward manager has a budgetary allocation of three management days per week.

Patient care is allocated by:

It is reliant on the nurse in charge to allocate the patients based on acuity and the skill mix on shift. Reallocation of the teams is done to support junior nurses who require a less acute team.

Although there should be four RNs on each day shift, there are often only three and therefore work is allocated as follows. Each shift the nurse in charge coordinates the admissions and transfers, the remaining two nurses take half of the ward each.

Over the data collection period the fill rates were:

Month	Day		Night	
	RN	CSW	RN	CSW
June 2021	81%	82%	78%	96%
July 2021	76%	79%	76%	100%

The current shift establishment is:

Day				Night	
Early		Late			
RN	CSW	RN	CSW	RN	CSW
4	4	4	4	3 (+ 1 twilight)	3

The bed occupancy was 80% during the time of the study

Based on the current shift establishment the budgetary requirement is 22.31RNs and 20.06CSW

Contracted for the time of data collection was 36.49

Bank or Agency Fill:
RN Demand 491 hours (13.1wte)
Fill 367 hours (9.8wte)
75% fill

CSW Demand 287 hours (7.7wte)
Fill 179 hours (4.8wte)
62% fill

Turnover %		Sickness %	
RN	CSW	RN	CSW
0	0	4.56	14.19

Quality indicators
1x medication incident
0x fall
0x formal complaint
1x DATIX re: staffing
0x Pressure Ulcers

As a summary of the SNCT study period – based on the SNCT for acute admission units and based on 70:30 ratio

Bed occupancy was 80%

WTE RNs Actual 22.31

SNCT indicates the ward requires 21.68wte RN this gives a variance of 0.63wte

CSW 20.06 in establishment, the SNCT indicates the requirement is 9.31wte, a variance of 10.75wte.

The ward is currently a red ward as Covid numbers have exceeded 15 Trust wide, there is also a high number of single rooms and the additional demands of donning and doffing PPE. A supernumerary nurse in charge is required for the long day as the ward is an admission ward and there are increased demands with admission, transfer and discharge. The recommendation is that the study is repeated during winter months with a view of reducing the care support establishment on the ward, but maintaining the registered nurse establishment. The ward also has ward attenders every day who require an RN to support with their treatment.

Farndale Ward

Farndale ward is a 23 bedded medical admissions and Covid ward. There are two three bedded bays with ensuite facilities and 17 ensuite single rooms.
The ward is "L" shaped leading off the short entry corridor is the staff room and store room. There are three staff bases spread across the ward. Behind the central staff base is a fire exit corridor where the ward kitchen is located. Opposite the central staff base are the two three bedded bays which provide limited visibility. The remaining single rooms have very limited or zero visibility from any staff base. Store rooms, linen cupboard and ward managers office are located along the main corridor of the ward.

The ward is led by a recently appointed Ward Manager (0.78wte) and experienced Matron, there are experienced Band 6 Ward Sisters. The ward manager has a budgetary allocation of two management days per week which are not always able to be taken.

The patients that are admitted to the ward are usually acutely unwell and require enhanced nursing intervention in the first instance until the patient is stabilised. Throughout the pandemic there are patients who require Non-Invasive Ventilation (NIV) and as well as the nursing intervention that is required with this there are also the additional requirement of donning and doffing of PPE. There are also additional requirements for the monitoring and observations of these patients. As mentioned, the ward is primarily single rooms, which creates challenges with the visibility of these patients.

Patient care is allocated:

Ideally the patients are split into four teams however when there are only four RNs on duty they are split into three to allow a Nurse in Charge.

Team 1 consists of single room 1,2,3,4,5,6,23

Team 2 consists of Bay 1 (3 BEDS) Bay 2 (3 BEDS) and single rooms 13,14

Team 3 consists of single rooms 15,16,17,18,19,20,21,22

It is reliant on the nurse in charge to allocate the patients based on acuity and the skill mix on shift. Reallocation of the teams is done to support junior nurses who require a less acute team.

Over the data collection period the fill rates were:

Month	**Day**		**Night**	
	RN	CSW	RN	CSW
June 2021	83%	91%	81%	113%
July 2021	84%	90%	83%	104%

The current shift establishment is:

Day				**Night**	
Early		**Late**			
RN	CSW	RN	CSW	RN	CSW
5	4	5	4	5	3

The bed occupancy was 82.6% during the time of the study

Based on the current shift establishment the budgetary requirement is 28.33RNs and 18.92CSW

Contracted for the time of data collection was 44.36

Bank or Agency Fill:
RN Demand 870 hours (23.2wte)
Fill 536 hours (14.3wte)
62% fill

CSW Demand 326 hours (8.7wte)
Fill 201 hours (5.4wte)
62% fill

Turnover %		Sickness %	
RN	CSW	RN	CSW
0	0	5.6	3.8

Quality indicators
3x medication incident
9x fall
0x formal complaint
0x DATIX re: staffing
6x Pressure Ulcers

It is important to note that all six pressure ulcers were present on admission and did not occur on the ward

As a summary of the SNCT study period using the SNCT for acute admission units and based on a 70:30 ratio

Bed occupancy was 82.6%

WTE RNs Actual 28.33

SNCT indicates the ward requires 19.21wte RN this gives a variance of 9.12wte.

CSW 18.92 in establishment, the SNCT indicates the requirement is 8.22wte, a variance of 10.7wte.

The recommendation is that there is a requirement for a supernumerary nurse in charge for the long day into the twilight shift (until 23:00) to support with the patient flow and transfers required from an admissions unit. Apart from when there are additional patients requiring NIV, the establishment of the fifth RN on the nightshift could be reduced to a twilight shift.

Although the SNCT recommends a significant reduction in CSW establishment, the professional judgement of the Matron is that there is a requirement for the current CSW for supporting with ward transfers, preparing bed spaces, personal care of patients and support the registered nurses who are caring for acutely unwell patients.

On occasion, if the ED is busy; the CSW and RN's from Farndale ward in-reach into the department to support with patient flow, this is also reversed when the ED have capacity within their workforce to support.

Littondale Ward

Littondale is a 32 bedded surgical ward. The ward cares for mixed sex (previously all male) surgical, gastroenterology, urology and gynaecology and breast patients. The ward rarely takes direct admissions, the majority are admitted via surgical or medical admission wards.

The ward is a "T" shaped ward. With four adjacent bays and one double side room and six single rooms, all of which are not in sight of the main staff base. Single room 1 and 2 are opposite bay 3 and 4 and single room 8 and 9 are opposite bay 6. Room 5 is opposite the central staff base but visibility is still limited. The double side room is adjacent to room 6 at the far end of the ward. Two single rooms one with ensuite are on the entry corridor to the main ward. The bathrooms, staff base, linen room, and storage room face the bays. Other rooms include the ward office, dirty utility room, ward kitchen, treatment room, doctors' office, quiet room, therapy storage and staff room, which are all located a distance away from the main patient areas along the entry corridor.

The ward is led by an experienced Ward Manager and Matron, there are also experienced Band 6 Ward Sisters. The budgetary allocation for the Ward Manager is three management days per week, however this is often not the case and the ward manager is counted within the staffing numbers.

Whilst this is a surgical ward there are mainly gastroenterology patients who can present with delirium and confusion and can be challenging to manage and require one to one enhanced care. These patient are often on very complex intravenous treatment courses which require two nurses to check and administer. Frequently patients require a nurse escort to neighbouring hospitals for treatments. The ward is the only ward in the Trust with the skills to administer TPN and this adds an additional pressure to the ward.
At risk patients are cohorted in bay 5 wherever possible as this is the closest to the staff base.

Patient care is allocated by:
The ward is split into three, each having an RN and CSW
2 x 6 bedded bays
1 x 6 bedded bay and four single rooms
1 x 6 bedded bay, double side room and two single rooms
.

Over the data collection period the fill rates were:

Month	**Day**		**Night**	
	RN	CSW	RN	CSW
June 2021	99%	103%	100%	105%
July 2021	96%	101%	100%	105%

The current shift establishment is:

Day		**Night**	
RN	CSW	RN	CSW
4	3	3	2

The budgeted establishment is 20.32RN and 15.03CSW

Contracted for the time of data collection was:
RN 20.76wte
CSW 15.64wte

Bank or Agency Fill:
RN Demand 445 hours (11.9wte)
Fill 323 hours (8.6wte)
73% fill

CSW Demand 183 hours (4.9wte)
Fill 78 hours (2.1wte)
43% fill

Turnover %		Sickness %	
RN	CSW	RN	CSW
0	0	0.66	3.92

Quality indicators
1 x medication incident
6 x fall
1x formal complaint
0 x DATIX re: staffing
1 x Pressure Ulcers

As a summary of the SNCT study period

Bed occupancy was 89%

WTE RNs Actual 20.32

SNCT indicates the ward requires 20.98wte RN this gives a variance of 0.66wte

CSW 15.03wte in establishment, the SNCT indicates the requirement is 14.2, a variance of 0.83wte

The recommendation is to repeat the study and to consider the impact of the quality indicators and CHPPD have on the ward. At the time of the study the bed occupancy was lower than in recent months and the acuity of patients feels to have increased. The allocated budget for this ward is for 24 beds, however the ward does not run at 24 beds. The recommendation is that the ward is budgeted for the appropriate amount of beds.

Jervaulx Ward

Jervaulx ward is a 30 bedded elderly care ward. There are four bays of six and six single rooms, three of which are ensuite.
The ward is an "L" shaped ward. Along the entry corridor is the ward office, kitchen, linen room, staff room, treatment room and two single rooms out of sight of the main staff base and around the corner from the main ward area.

The staff base is at the apex of the "L" and the dirty utility is immediately adjacent. There is some visibility of bay 1 and limited visibility of one single room from the staff base but the remaining bays and single rooms have no visibility.
None of the bays have patient bathroom facilities, shared facilities are located opposite each bay.

The ward is led by an experienced Ward Manager and Matron, there are also experienced Band 6 Ward Sisters. The budgetary allocation of management days for the ward manager is one per week.

The ward is current supporting many staff with development training; some of this includes Nursing Associate Training and Return to Practice. This is to support with the recruitment and retention strategies on the ward.

Due to the high number of elderly care patients with dementia and delirium, the risk of falls, pressure ulcers and absconding patients is high. The ward request a daily CSW to support with the enhanced care needs of patients. Due to the pandemic there has been a rise in deconditioning of patients and their risk of falls is exacerbated by this. As well as this the ward RNs are often required to escort the patients to scans, X-rays and appointments.

Patient care is allocated by:

Team 1- bay 1 (6 patients and single-rooms 1,2,3) = 9 patients

1 RN allocated to this team and for 9 patients, CSW allocated to the bay due to support with the enhanced care needs of patients

Team 2- bay 2 (6 patients and single-rooms 4,5,6) = 9 patients

1 RN allocated to this team and for 9 patients, CSW allocated to the bay to support with enhanced care needs

Team 3- bay 3 and 4= 12 patients

1 RN and 1 CSW allocated to this team

The 4th CSW is allocated the 6 single-rooms and support team 3

The 4th RN on duty who acts as the coordinator will also help support nurse in team 3 with 12 patients.

It is reliant on the nurse in charge to allocate the patients based on acuity and the skill mix on shift. Reallocation of the teams is done to support junior nurses who require a less acute team.

The SNCT data cannot be used effectively as there was an invalid amount of data reported for the month; only 11 days could be reported on.

Over the data collection period the fill rates were: (Based on establishment for 30 beds)

Month	**Day**		**Night**	
	RN	CSW	RN	CSW
June 2021	91%	94%	94%	114%
July 2021	84%	86%	97%	115%

The budget is only for 22 beds but the ward is continuously open at 30 beds

The current shift establishment is:

Day				**Night**	
Early		**Late**			
RN	CSW	RN	CSW	RN	CSW
4	4	4	4	3	3

The bed occupancy 88%

The budgetary requirement (22 beds) is 17.81RNs and 16.91CSW for 30 beds 20.63RN and 19.72CSW

Bank or Agency Fill:
RN Demand 680 hours (18.1wte)
Fill 489 hours (13wte)
72% fill

CSW Demand 538 hours (14.3wte)
Fill 351 hours (9.4wte)
65% fill

Turnover %		Sickness %	
RN	CSW	RN	CSW
0	4.35	3.79	3.69

Quality indicators
3 x medication incident
6 x fall
0 x formal complaint
4 x DATIX re: staffing
3 x Pressure Ulcers

As a summary of the SNCT study period

Bed occupancy was 88%

WTE RNs Actual for 22 beds 17.81

For 30 beds 20.63

SNCT indicates the ward requires 23.5 RN this gives a variance of 5.69wte for 22 beds. For 30 beds the variance is 2.87wte

CSW 16.91wte in establishment for 22 beds, the SNCT indicates the requirement is 15.7wte, a variance of 1.21wte. For 30 beds the CSW is 19.72wte therefore the variance is 4.02wte

The nutritional assistant and discharge assistant are taken from the CSW establishment however do not get rostered within the CSW numbers.

However, the data for Jervaulx is invalid as the data was collected for less than 20 days. Therefore the recommendation is that this is repeated. The nearest comparator to Jervaulx is Wensleydale Ward.

Bolton Ward (previously Byland)

Bolton ward is a Medical Short Stay and Coronary Care Unit with 28 beds. There are three bays of six, CCU is a four bedded bay and a single room and there are five further single rooms.

The ward is a “L” shaped ward. Along the entry corridor is the day room, ward office, linen room, staff room, Doctors office, treatment room and two single rooms out of sight of the main staff base and around the corner from the main ward area. The kitchen is just to the side of the apex opposite bay 1.

The staff base is at the apex of the “L” and the dirty utility is immediately adjacent. There is some visibility of bay 1 and bay 2 and limited visibility of one single room from the staff base but the remaining bays and side rooms have no visibility.

None of the bays have patient bathroom facilities, shared facilities are located opposite each bay. Two of the side rooms have ensuite.

The CCU is in bay 3 where an RN is designated to work. That nurse also cares for the patient in the CCU single room which is across the corridor from CCU and also monitors up to four more patients on telemetry.

The ward also takes patients who require NIV, and therefore there is an increase in time spent providing intense care and the time spent donning and doffing of PPE.

The ward has significant turnover of patients; in the study period there were:

78 direct admissions

116 transfers in

52 transfers out

127 discharges

6 deaths

There is also often a requirement for an RN to escort a patient to neighbouring hospital for cardiac MRI, this often means the RN is out for the entire day.

The RN working on the ward is required to support the CCU nurse with double checking medication, break relief and infusion preparations.

The ward is led by an experienced Ward Manager and Matron, there are also experienced Band 6 Ward Sisters. The budgetary allocation of management days for the ward manager is one per week.

Patient care is allocated by:

Bay 1 and single room 1 – 1 RN

Bay 2 and single room 2 & 3 – 1 RN

Bay 3 (CCU) and single room 4 – 1 RN

Bay 4 and single room 5 & 6 – 1 RN

On the Early shift there is a nurse in charge (NIC) to direct flow, plan and complete discharges and support CCU.

It is reliant on the nurse in charge to allocate the patients based on acuity and the skill mix on shift. Reallocation of the teams is done to support junior nurses who require a less acute team.

Over the data collection period the fill rates were:

Month	**Day**		**Night**	
	RN	CSW	RN	CSW
June 2021	96%	91%	96%	132%
July 2021	94%	87%	96%	133%

The current shift establishment is: (for 29 beds)

Day				**Night**	
Early		**Late**			
RN	CSW	RN	CSW	RN	CSW
5	3	4	4	4	1 + twilight

The bed occupancy 67%

The budgetary requirement is 24.27RNs and 14.68CSW for 29 but the budget is for only 22 beds therefore 18.87RN and 12.91CSW

Bank or Agency Fill:
RN Demand 930 hours (24.8wte)

Fill 778 hours (20.7wte)
84% fill

CSW Demand 323 hours (8.6wte)
Fill 150 hours (4wte)
46% fill

It is important to note that sometimes shifts are put to agency to cover wards other than Byland/Bolton; as to where the need is required.

Turnover %		Sickness %	
RN	CSW	RN	CSW
4.76	0	3.03	0.43

Quality indicators
7 x medication incident
4 x fall
1 x formal complaint
5 x DATIX re: staffing
3 x Pressure Ulcers

As a summary of the SNCT study period

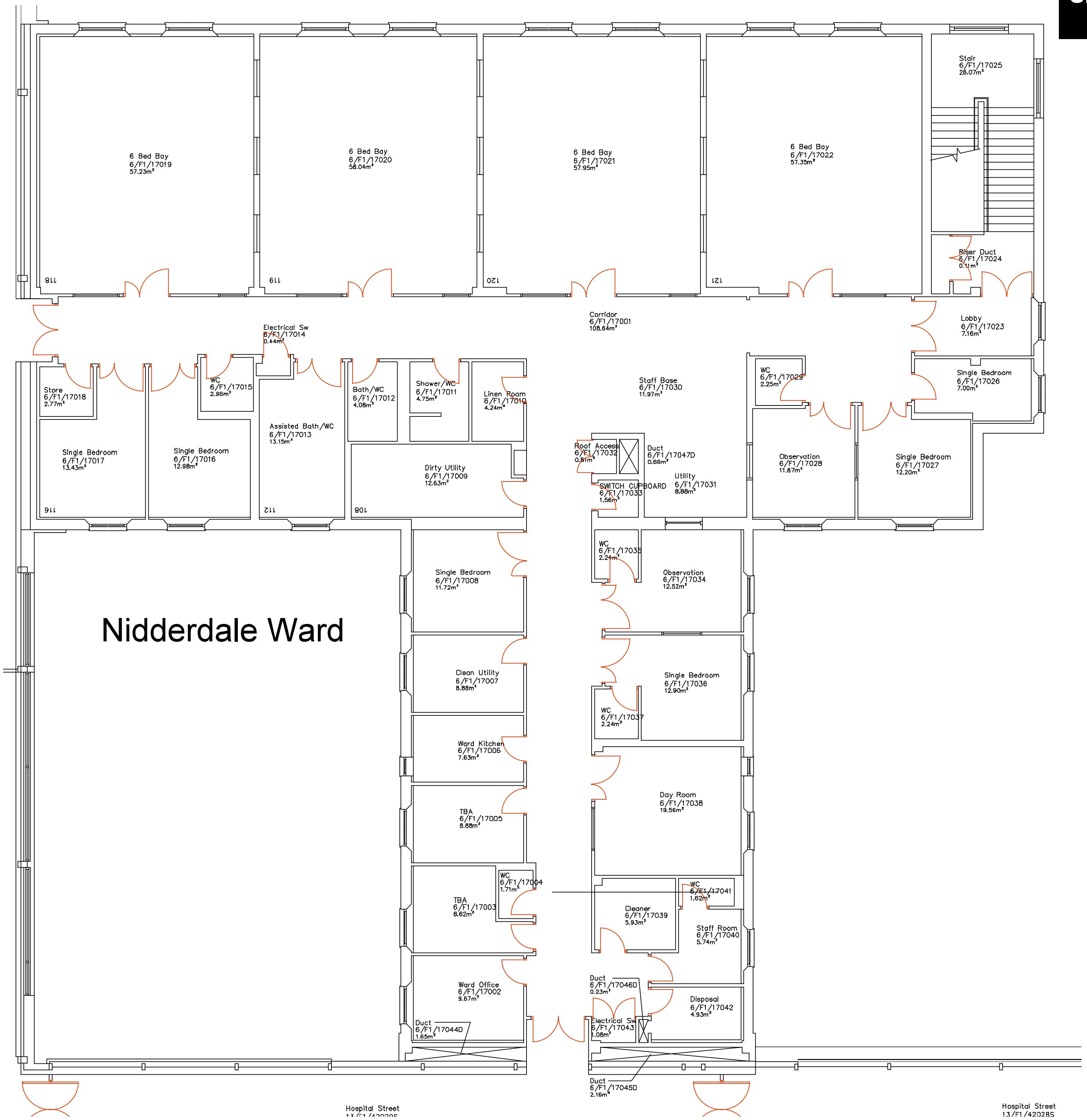
Bed occupancy was 67%

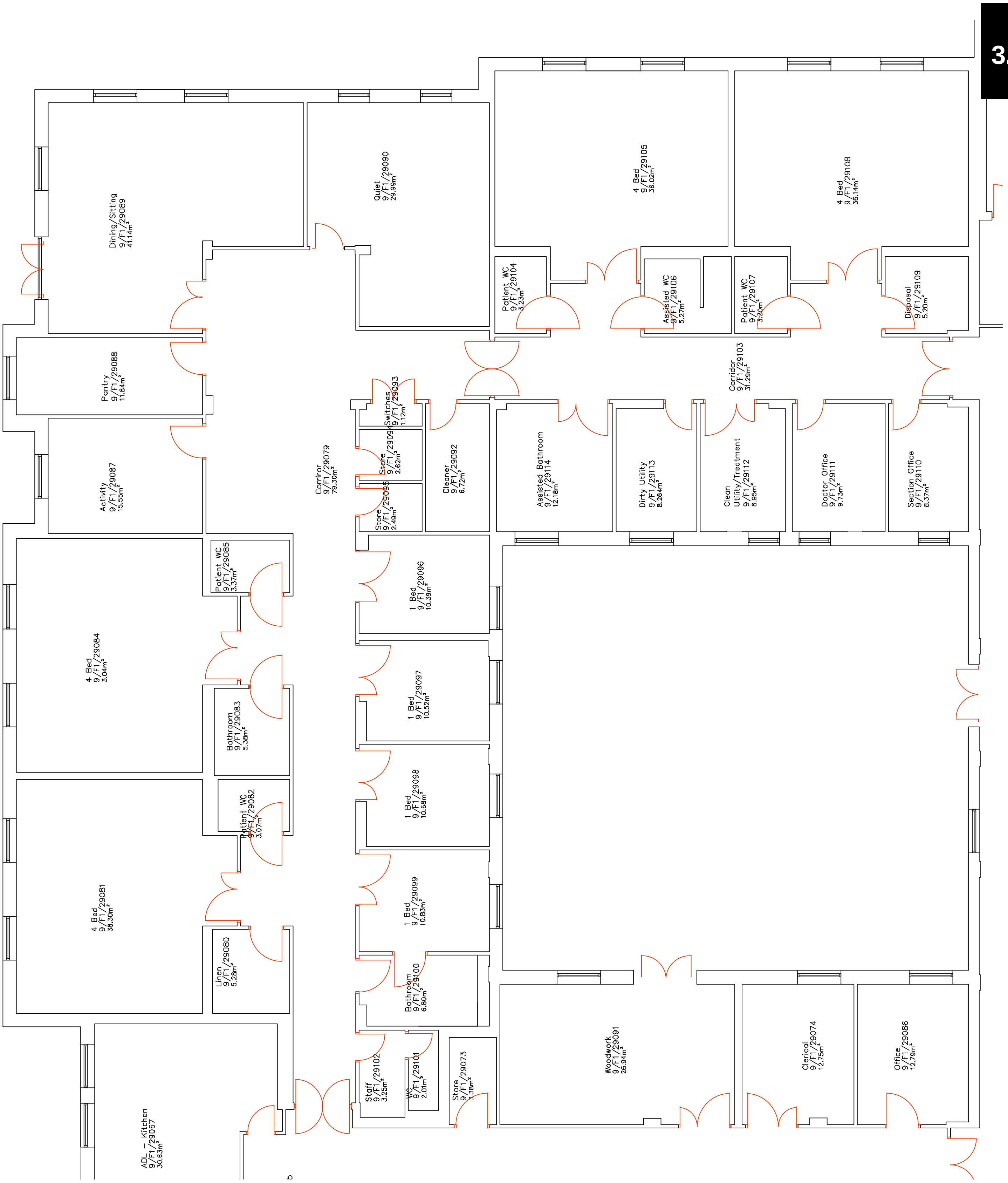
WTE RNs Actual 18.87 for 22 beds, 24.27 for 29 beds

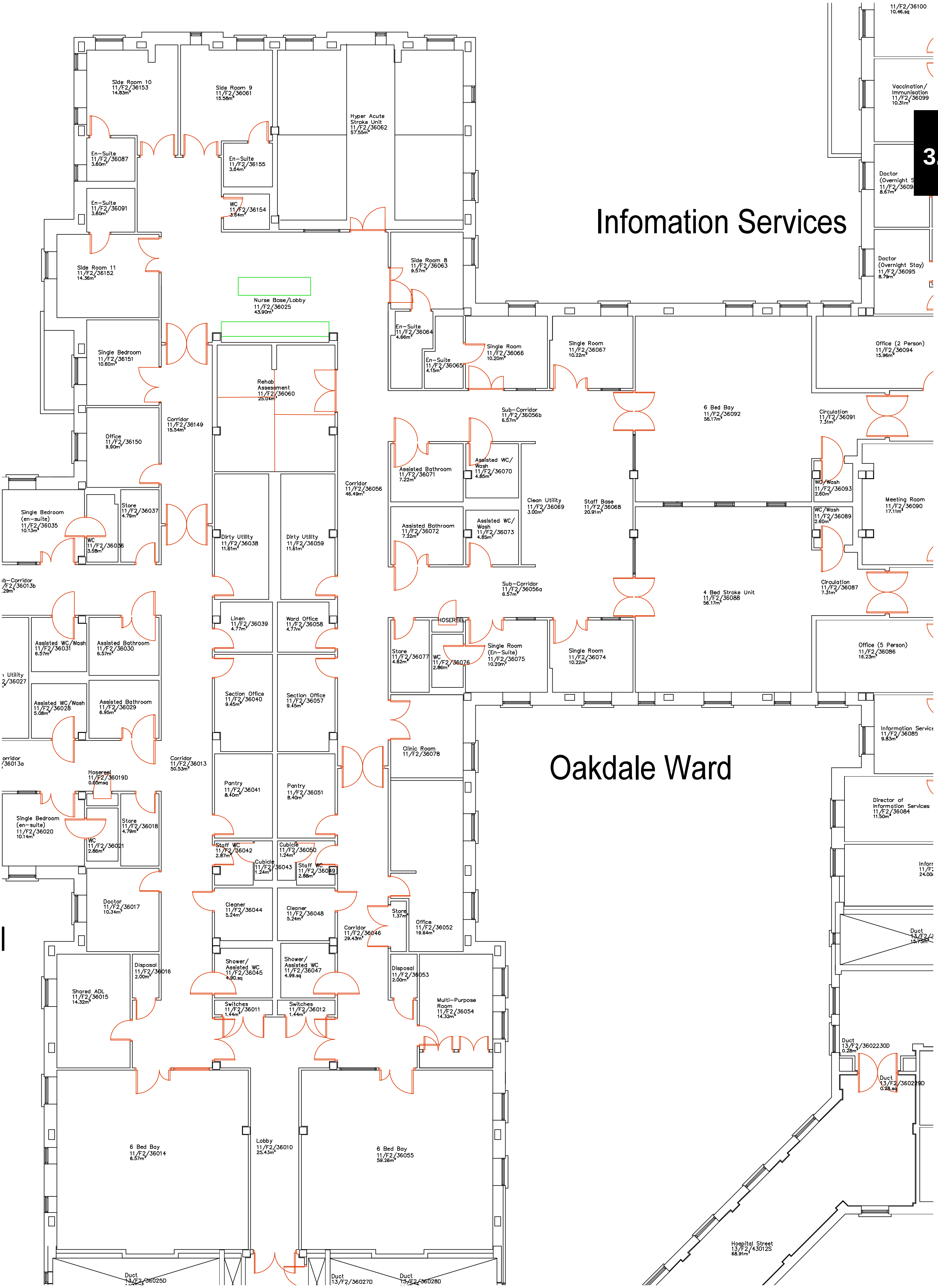
SNCT indicates the ward requires 15.74wte RN this gives a variance for 22 beds is 3.52wte.. The variance does not account for the requirement of 1 RN allocated to the 5 x CCU patients 24/7 or the requirement for a nurse in charge on the early shift due to patient assessment and discharge planning.

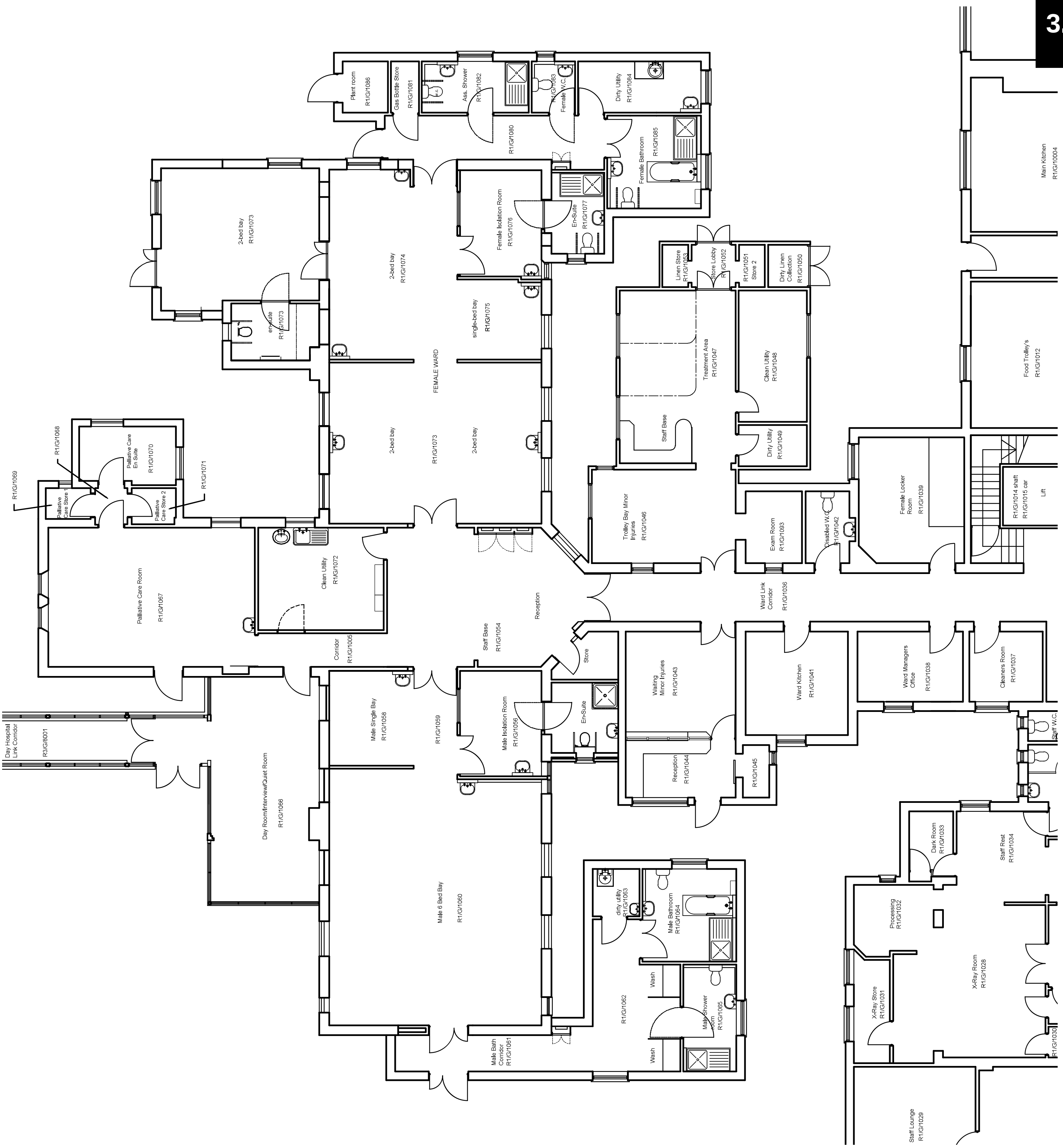
CSW 12.91wte in establishment for 22 beds, the SNCT indicates the requirement is 10.49wte, a variance of 2.42wte for 29 beds.

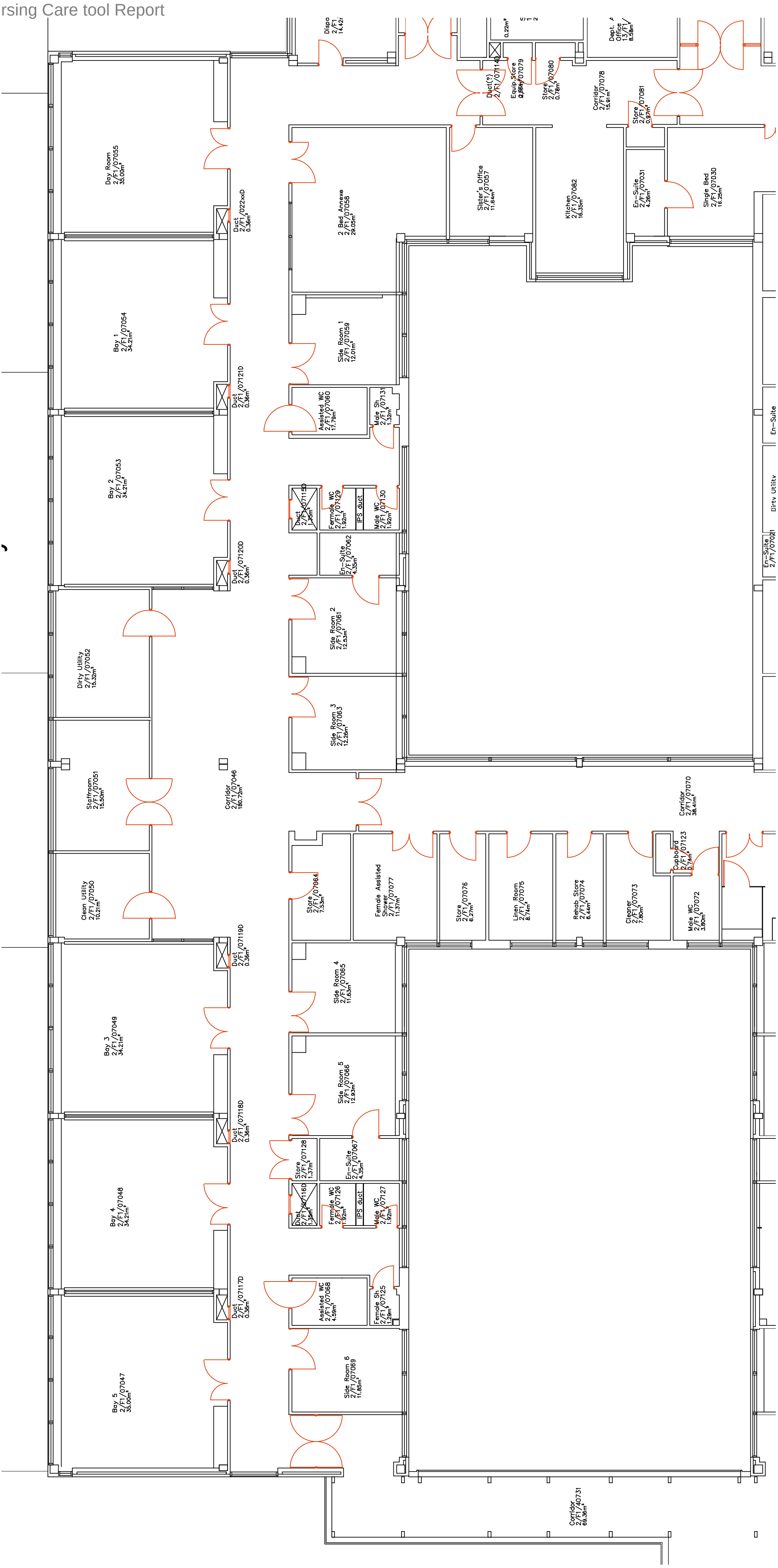
The recommendation is that this is reviewed following future studies. It is also important to note that the bed occupancy is much lower than currently.

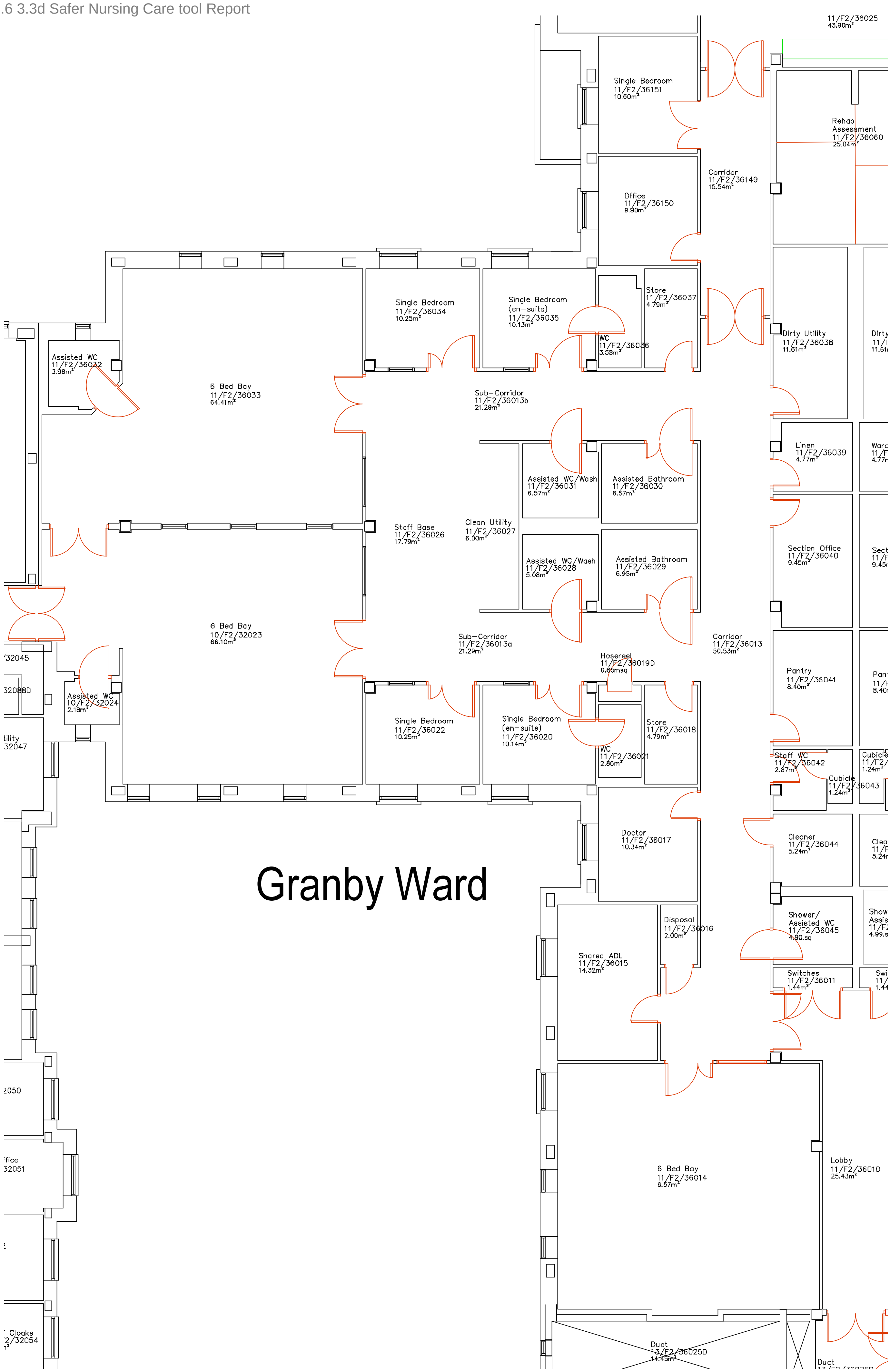

Nidderdale Ward
6 Bed Bay
6/F1/17019
57.23m²
6 Bed Bay
6/F1/17020
58.04m²
6 Bed Bay
6/F1/17021
57.95m²
6 Bed Bay
6/F1/17022
57.35m²
Stair
6/F1/17025
26.07m²
Riser Duct
6/F1/17024
0.11m²
118
119
120
121
Corridor
6/F1/17001
108.64m²
Lobby
6/F1/17023
7.16m²
Electrical Sw
6/F1/17014
0.44m²
Store
6/F1/17018
2.77m²
WC
6/F1/17015
2.96m²
Bath/WC
6/F1/17012
4.08m²
Shower/WC
6/F1/17011
4.75m²
Linen Room
6/F1/17010
4.24m²
Assisted Bath/WC
6/F1/17013
13.15m²
Single Bedroom
6/F1/17017
13.43m²
Single Bedroom
6/F1/17016
12.98m²
Dirty Utility
6/F1/17009
12.63m²
116
112
108
Staff Base
6/F1/17030
11.97m²
WC
6/F1/17029
2.25m²
Single Bedroom
6/F1/17026
7.00m²
Roof Access
6/F1/17032
0.81m²
Duct
6/F1/17047D
0.66m²
Utility
6/F1/17031
8.88m²
SWITCH CUPBOARD
6/F1/17033
1.56m²
Observation
6/F1/17028
11.67m²
Single Bedroom
6/F1/17027
12.20m²
Single Bedroom
6/F1/17008
11.72m²
WC
6/F1/17035
2.24m²
Observation
6/F1/17034
12.52m²
Clean Utility
6/F1/17007
8.88m²
Single Bedroom
6/F1/17036
12.90m²
WC
6/F1/17037
2.24m²
Ward Kitchen
6/F1/17006
7.63m²
TBA
6/F1/17005
8.88m²
Day Room
6/F1/17038
19.56m²
WC
6/F1/17004
1.71m²
TBA
6/F1/17003
8.62m²
WC
6/F1/17041
1.62m²
Cleaner
6/F1/17039
5.93m²
Staff Room
6/F1/17040
5.74m²
Ward Office
6/F1/17002
9.67m²
Duct
6/F1/17046D
0.23m²
Disposal
6/F1/17042
4.93m²
Electrical Sw
6/F1/17043
1.08m²
Duct
6/F1/17044D
1.65m²
Duct
6/F1/17045D
2.16m²
Hospital Street
Hospital Street
13/F1/42028S


Dining/Sitting 9/F1/29089 41.14m²
Quiet 9/F1/29090 29.99m²
4 Bed 9/F1/29105 36.02m²
4 Bed 9/F1/29108 36.14m²
Patient WC 9/F1/29104 3.23m²
Assisted WC 9/F1/29106 5.27m²
Patient WC 9/F1/29107 3.30m²
Disposal 9/F1/29109 5.20m²
Pantry 9/F1/29088 11.84m²
Carridor 9/F1/29103 31.29m²
Switches 9/F1/29093 1.12m²
Store 9/F1/29094 2.62m²
Store 9/F1/29095 2.49m²
Cleaner 9/F1/29092 6.72m²
Assisted Bathroom 9/F1/29114 12.18m²
Dirty Utility 9/F1/29113 8.264m²
Clean Utility/Treatment 9/F1/29112 8.95m²
Doctor Office 9/F1/29111 9.73m²
Section Office 9/F1/29110 8.37m²
Activity 9/F1/29087 15.55m²
Corriror 9/F1/290079 79.30m²
Patient WC 9/F1/29085 3.37m²
1 Bed 9/F1/29096 10.39m²
4 Bed 9/F1/29084 3.04m²
1 Bed 9/F1/29097 10.52m²
Bathroom 9/F1/29083 5.38m²
1 Bed 9/F1/29098 10.68m²
Patient WC 9/F1/29082 3.07m²
4 Bed 9/F1/29081 38.30m²
1 Bed 9/F1/29099 10.83m²
Linen 9/F1/29080 5.28m²
Bathroom 9/F1/29100 6.80m²
Woodwork 9/F1/29091 26.94m²
Clerical 9/F1/29074 12.75m²
Office 9/F1/29086 12.79m²
Staff 9/F1/29102 3.25m²
WC 9/F1/29101 2.01m²
Store 9/F1/29073 1.38m²
ADL – Kitchen 9/F1/29067 30.63m²
5

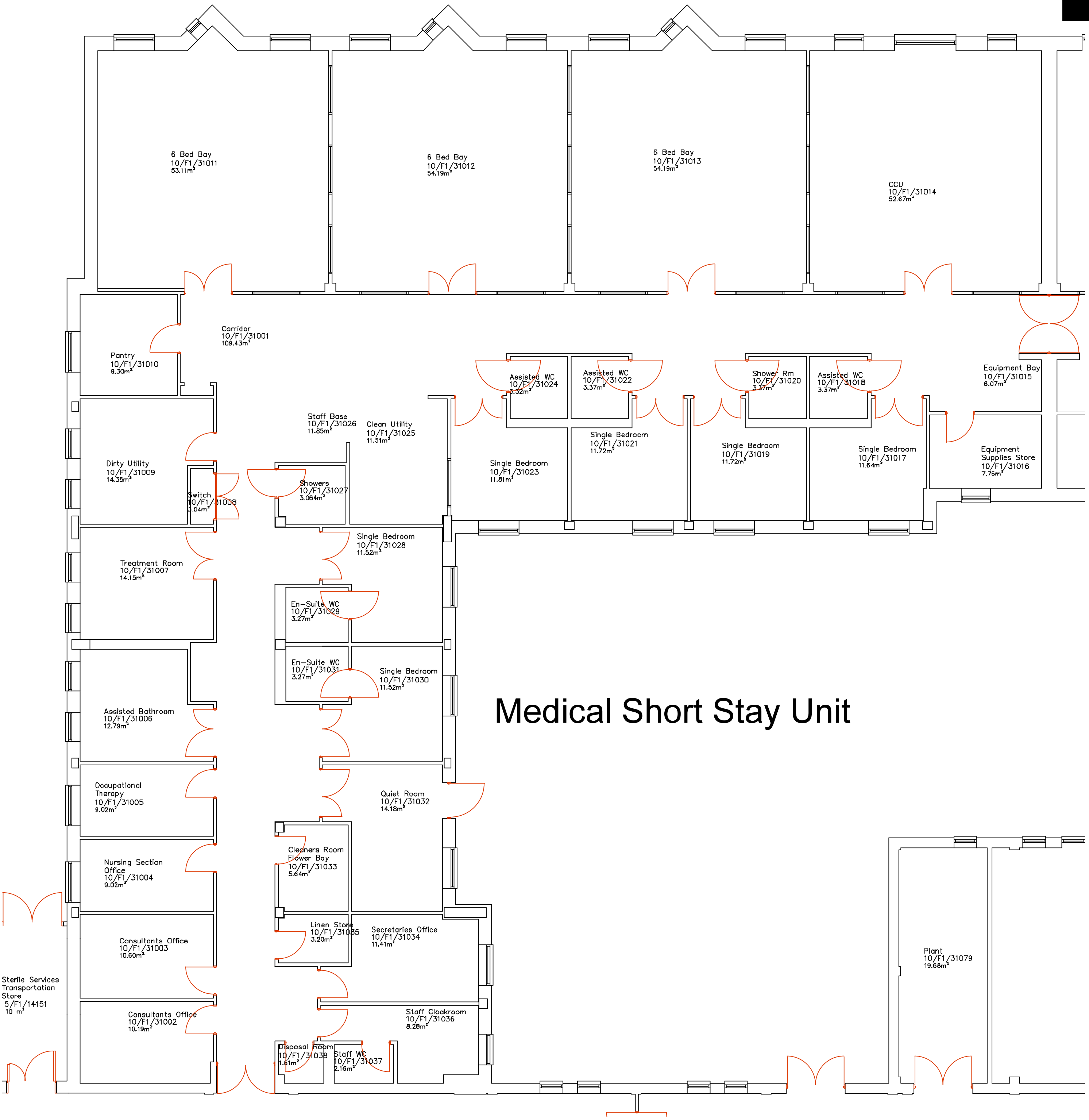

Infomation Services
Oakdale Ward
Side Room 10 11/F2/36153 14.83m²
Side Room 9 11/F2/36061 15.58m²
Hyper Acute Stroke Unit 11/F2/36062 57.55m²
11/F2/36100 10.46.sq
Vaccination/ Immunisation 11/F2/36099 10.31m²
En-Suite 11/F2/36087 3.60m²
En-Suite 11/F2/36155 3.64m²
En-Suite 11/F2/36091 3.60m²
WC 11/F2/36154 3.64m²
Side Room 11 11/F2/36152 14.36m²
Side Room 8 11/F2/36063 9.57m²
Nurse Base/Lobby 11/F2/36025 43.90m²
En-Suite 11/F2/36064 4.66m²
En-Suite 11/F2/36065 4.15m²
Single Room 11/F2/36066 10.20m²
Single Room 11/F2/36067 10.22m²
Office (2 Person) 11/F2/36094 15.96m²
Single Bedroom 11/F2/36151 10.60m²
Rehab Assessment 11/F2/36060 25.04m²
Corridor 11/F2/36149 15.54m²
Sub-Corridor 11/F2/36056b 6.57m²
6 Bed Bay 11/F2/36092 56.17m²
Circulation 11/F2/36091 7.31m²
Office 11/F2/36150 9.90m²
Corridor 11/F2/36056 46.49m²
Assisted Bathroom 11/F2/36071 7.22m²
Assisted WC/ Wash 11/F2/36070 4.85m²
WC/Wash 11/F2/36093 2.60m²
Meeting Room 11/F2/36090 17.11m²
Single Bedroom (en-suite) 11/F2/36035 10.13m²
Store 11/F2/36037 4.79m²
WC 11/F2/36036 3.58m²
Dirty Utility 11/F2/36038 11.61m²
Dirty Utility 11/F2/36059 11.61m²
Clean Utility 11/F2/36069 3.00m²
Staff Base 11/F2/36068 20.91m²
Assisted Bathroom 11/F2/36072 7.22m²
Assisted WC/ Wash 11/F2/36073 4.85m²
WC/Wash 11/F2/36089 2.60m²
Sub-Corridor 11/F2/36013b 6.29m²
Sub-Corridor 11/F2/36056a 6.57m²
4 Bed Stroke Unit 11/F2/36088 56.17m²
Circulation 11/F2/36087 7.31m²
Linen 11/F2/36039 4.77m²
Ward Office 11/F2/36058 4.77m²
HOSEREEL
Assisted WC/Wash 11/F2/36031 6.57m²
Assisted Bathroom 11/F2/36030 6.57m²
Store 11/F2/36077 4.82m²
WC 11/F2/36076 2.86m²
Single Room (En-Suite) 11/F2/36075 10.20m²
Single Room 11/F2/36074 10.22m²
Office (5 Person) 11/F2/36086 18.23m²
Utility 2/36027
Section Office 11/F2/36040 9.45m²
Section Office 11/F2/36057 9.45m²
Assisted WC/Wash 11/F2/36028 5.08m²
Assisted Bathroom 11/F2/36029 6.95m²
Information Service 11/F2/36085 9.83m²
Clinic Room 11/F2/36078
Corridor 36013a
Corridor 11/F2/36013 50.53m²
Hosereel 11/F2/36019D 0.65msq
Pantry 11/F2/36041 8.40m²
Pantry 11/F2/36051 8.40m²
Director of Information Services 11/F2/36084 11.50m²
Single Bedroom (en-suite) 11/F2/36020 10.14m²
Store 11/F2/36018 4.79m²
WC 11/F2/36021 2.86m²
Staff WC 11/F2/36042 2.87m²
Cubicle 11/F2/36050 1.24m²
Cubicle 11/F2/36043 1.24m²
Staff WC 11/F2/36049 2.88m²
Infor 11/F2 24.00
Doctor 11/F2/36017 10.34m²
Cleaner 11/F2/36044 5.24m²
Cleaner 11/F2/36048 5.24m²
Store 1.37m²
Office 11/F2/36052 19.64m²
Corridor 11/F2/36046 29.43m²
Duct 13/F2/3 13.75m²
Disposal 11/F2/36016 2.00m²
Shower/ Assisted WC 11/F2/36045 4.90.sq
Shower/ Assisted WC 11/F2/36047 4.99.sq
Disposal 11/F2/36053 2.00m²
Shared ADL 11/F2/36015 14.32m²
Multi-Purpose Room 11/F2/36054 14.32m²
Switches 11/F2/36011 1.44m²
Switches 11/F2/36012 1.44m²
Duct 13/F2/3602230D 0.28m²
Duct 13/F2/360229D 0.28.sq
6 Bed Bay 11/F2/36014 6.57m²
Lobby 11/F2/36010 25.43m²
6 Bed Bay 11/F2/36055 59.26m²
Hospital Street 13/F2/43012S 68.91m²
Duct 13/F2/36025D
Duct 13/F2/36027D
Duct 13/F2/36028D
Doctor (Overnight S 11/F2/3609 8.67m²
Doctor (Overnight Stay) 11/F2/36095 8.79m²

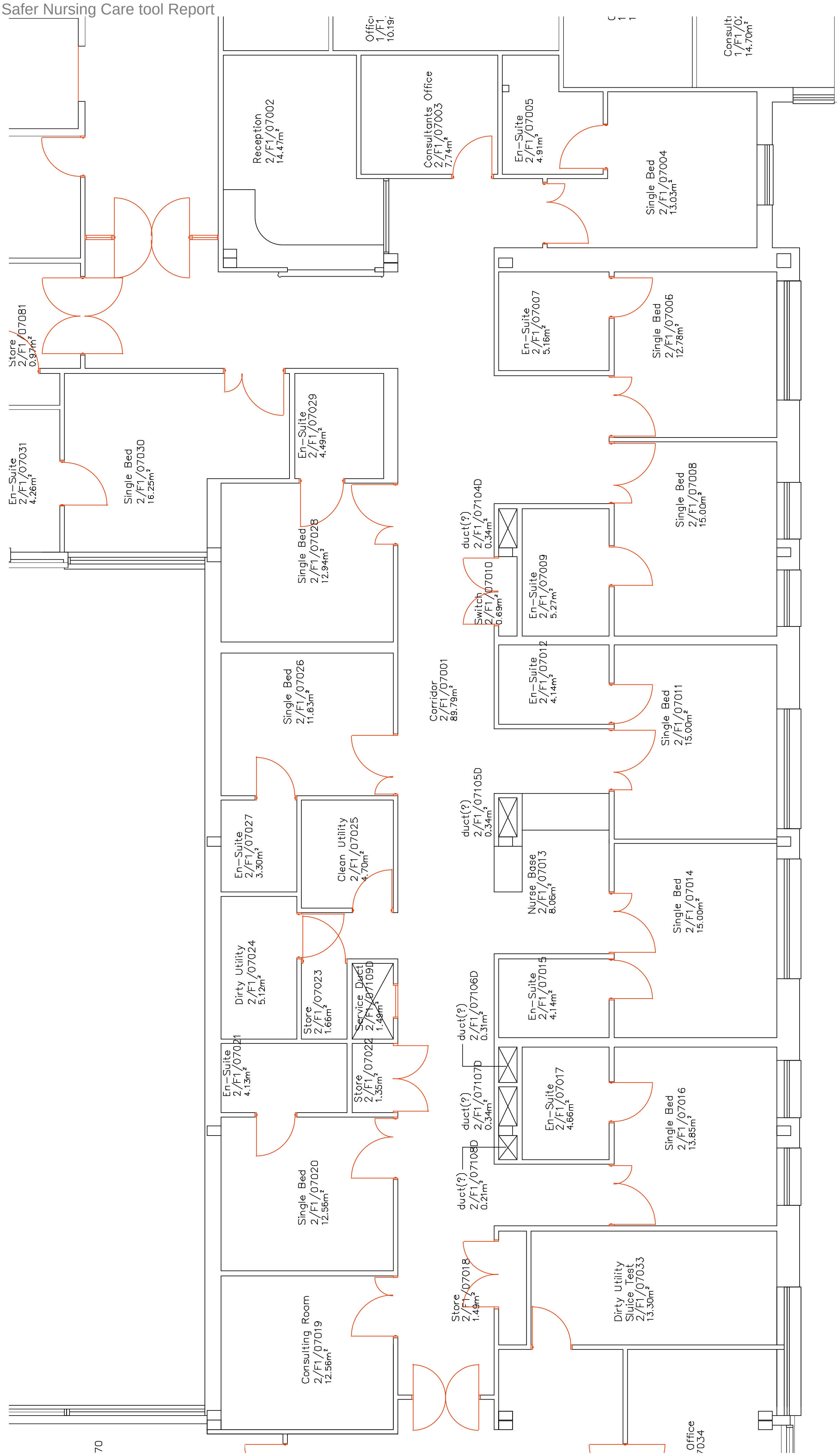

Plant room R1/G/1086
Gas Bottle Store R1/G/1081
Ass. Shower R1/G/1082
R1/G/1083 Female W.C.
Dirty Utility R1/G/1084
R1/G/1080
Female Bathroom R1/G/1085
Main Kitchen R1/G/10004
2-bed bay R1/G/1073
2-bed bay R1/G/1074
Female Isolation Room R1/G/1076
En-Suite R1/G/1077
en-suite R1/G/1073
single-bed bay R1/G/1075
FEMALE WARD
2-bed bay
R1/G/1073
2-bed bay
Linen Store R1/G/1053
Store Lobby R1/G/1052
R1/G/1051 Store 2
Dirty Linen Collection R1/G/1050
Treatment Area R1/G/1047
Clean Utility R1/G/1048
Staff Base
Dirty Utility R1/G/1049
Food Trolley's R1/G/1012
R1/G/1068
R1/G/1069
Palliative Care En Suite R1/G/1070
R1/G/1071
Palliative Care Store 1
Palliative Care Store 2
Trolley Bay Minor Injuries R1/G/1046
Exam Room R1/G/1093
Disabled W.C. R1/G/1042
Female Locker Room R1/G/1039
R1/G/1014 shaft R1/G/1015 car
Lift
Palliative Care Room R1/G/1067
Clean Utility R1/G/1072
Reception
Ward Link Corridor R1/G/1036
Corridor R1/G/1005
Staff Base R1/G/1054
Store
Waiting Minor Injuries R1/G/1043
Ward Kitchen R1/G/1041
Ward Managers Office R1/G/1038
Cleaners Room R1/G/1037
Day Hospital Link Corridor
R3/G/6001
Male Single Bay R1/G/1058
R1/G/1059
Male Isolation Room R1/G/1056
En-Suite
Reception R1/G/1044
R1/G/1045
Staff W.C.
Day Room/Interview/Quiet Room R1/G/1066
Dark Room R1/G/1033
Staff Rest R1/G/1034
dirty utility R1/G/1063
Male Bathroom R1/G/1064
Male 6 Bed Bay R1/G/1060
Processing R1/G/1032
Wash
R1/G/1062
Male Shower Room R1/G/1065
X-Ray Room R1/G/1028
X-Ray Store R1/G/1031
R1/G/1030
Wash
Male Bath Corridor R1/G/1061
Staff Lounge R1/G/1029

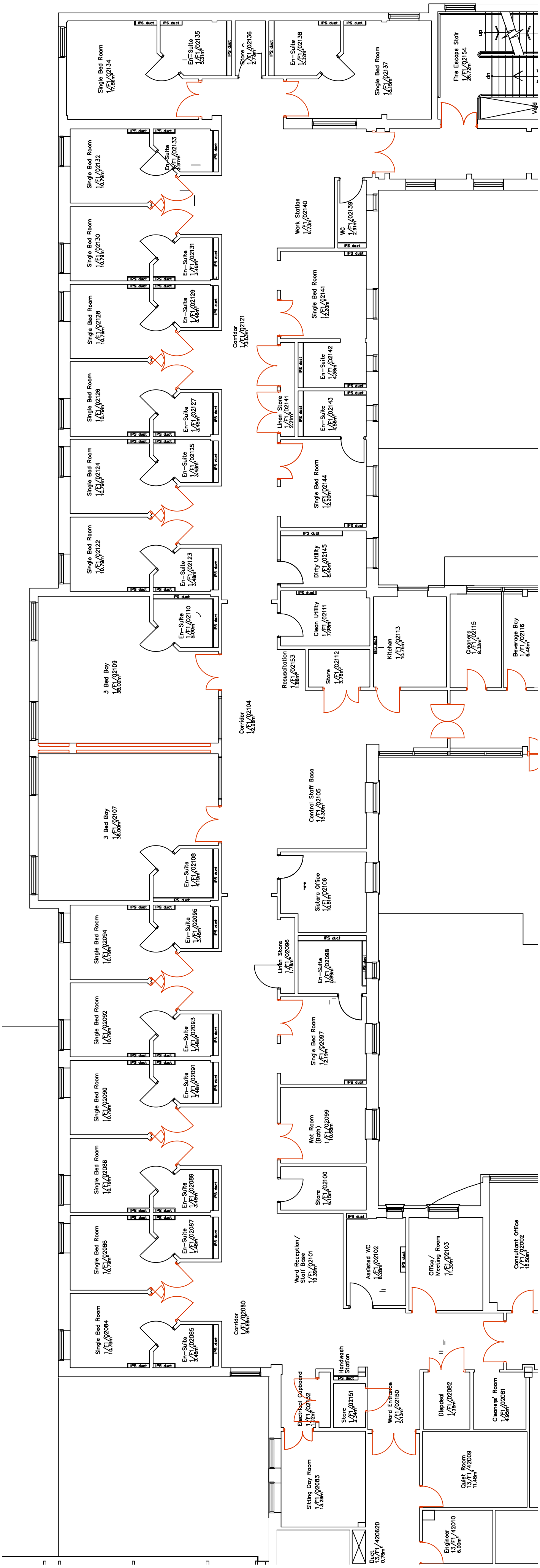

Day Room 2/F1/07055 35.00m²
Bay 1 2/F1/07054 34.21m²
Bay 2 2/F1/07053 34.21m²
Dirty Utility 2/F1/07052 15.32m²
Staffroom 2/F1/07051 15.50m²
Clean Utility 2/F1/07050 10.21m²
Bay 3 2/F1/07049 34.21m²
Bay 4 2/F1/07048 34.21m²
Bay 5 2/F1/07047 35.00m²
Corridor 2/F1/07046 180.72m²
2 Bed Annexe 2/F1/07058 29.05m²
Side Room 1 2/F1/07059 12.01m²
Assisted WC 2/F1/07060 1.78m²
Male Sh. 2/F1/07131 1.32m²
Female WC 2/F1/07129 1.82m²
IPS duct
Male WC 2/F1/07130 1.92m²
En-Suite 2/F1/07062 4.35m²
Side Room 2 2/F1/07061 12.53m²
Side Room 3 2/F1/07063 12.28m²
Store 2/F1/07064 7.53m²
Female Assisted Shower 2/F1/07077 11.57m²
Store 2/F1/07076 6.27m²
Linen Room 2/F1/07075 8.74m²
Rehab Store 2/F1/07074 6.44m²
Cleaner 2/F1/07073 7.80m²
Cupboard 2/F1/07123
Male WC 2/F1/07072 3.80m²
Corridor 2/F1/07070 38.41m²
Side Room 4 2/F1/07065 11.63m²
Side Room 5 2/F1/07066 12.93m²
Store 2/F1/07128 1.37m²
En-Suite 2/F1/07067 4.35m²
Female WC 2/F1/07126
IPS duct
Male WC 2/F1/07127 1.92m²
Assisted WC 2/F1/07068 4.59m²
Female Sh. 2/F1/07125 1.29m²
Side Room 6 2/F1/07069 11.85m²
Corridor 2/F1/40731 69.36m²
Sister's Office 2/F1/07057 11.64m²
Kitchen 2/F1/07082 16.35m²
En-Suite 2/F1/07031 4.26m²
Single Bed 2/F1/07030 16.25m²
Corridor 2/F1/07078 15.91m²
Store 2/F1/07081
Equip Store 2/F1/07079
Store 2/F1/07080 0.78m²
Duct 2/F1/07114D
Duct 2/F1/07115D 1.35m²
Duct 2/F1/07116D 1.35m²
Duct 2/F1/07117D 0.36m²
Duct 2/F1/07118D 0.36m²
Duct 2/F1/07119D 0.36m²
Duct 2/F1/07120D 0.36m²
Duct 2/F1/07121D 0.36m²
Duct 2/F1/0722xxD 0.36m²
Dept. Office 13/F1/ 8.59m²
Dispo 2/F1 14.42
En-Suite
Dirty Utility
En-Suite 2/F1/07021

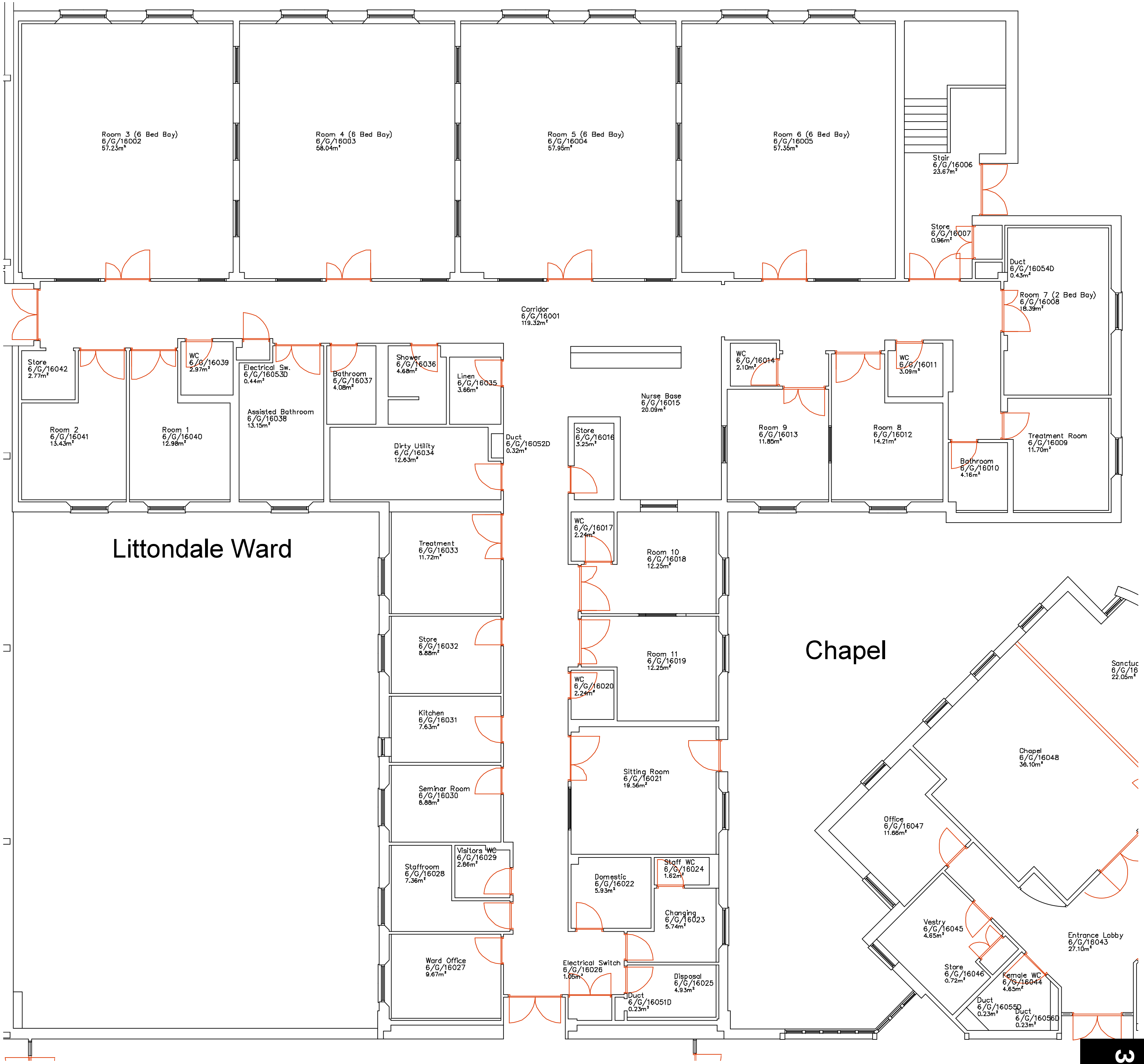

11/F2/36025
43.90m²
Single Bedroom
11/F2/36151
10.60m²
Rehab
Assessment
11/F2/36060
25.04m²
Corridor
11/F2/36149
15.54m²
Office
11/F2/36150
9.90m²
Single Bedroom
11/F2/36034
10.25m²
Single Bedroom
(en-suite)
11/F2/36035
10.13m²
Store
11/F2/36037
4.79m²
WC
11/F2/36036
3.58m²
Dirty Utility
11/F2/36038
11.61m²
Assisted WC
11/F2/36032
3.98m²
6 Bed Bay
11/F2/36033
64.41m²
Sub-Corridor
11/F2/36013b
21.29m²
Linen
11/F2/36039
4.77m²
Assisted WC/Wash
11/F2/36031
6.57m²
Assisted Bathroom
11/F2/36030
6.57m²
Staff Base
11/F2/36026
17.79m²
Clean Utility
11/F2/36027
6.00m²
Section Office
11/F2/36040
9.45m²
Assisted WC/Wash
11/F2/36028
5.08m²
Assisted Bathroom
11/F2/36029
6.95m²
6 Bed Bay
10/F2/32023
66.10m²
Sub-Corridor
11/F2/36013a
21.29m²
Corridor
11/F2/36013
50.53m²
/32045
32088D
Hosereel
11/F2/36019D
0.65msq
Pantry
11/F2/36041
8.40m²
Assisted WC
10/F2/32024
2.18m²
Single Bedroom
11/F2/36022
10.25m²
Single Bedroom
(en-suite)
11/F2/36020
10.14m²
Store
11/F2/36018
4.79m²
WC
11/F2/36021
2.86m²
Staff WC
11/F2/36042
2.87m²
Cubicle
11/F2/
1.24m²
Cubicle
11/F2/36043
1.24m²
Doctor
11/F2/36017
10.34m²
Cleaner
11/F2/36044
5.24m²
Disposal
11/F2/36016
2.00m²
Shared ADL
11/F2/36015
14.32m²
Shower/
Assisted WC
11/F2/36045
4.90.sq
Switches
11/F2/36011
1.44m²
6 Bed Bay
11/F2/36014
6.57m²
Lobby
11/F2/36010
25.43m²
Duct
13/F2/36025D
14.45m²
Duct

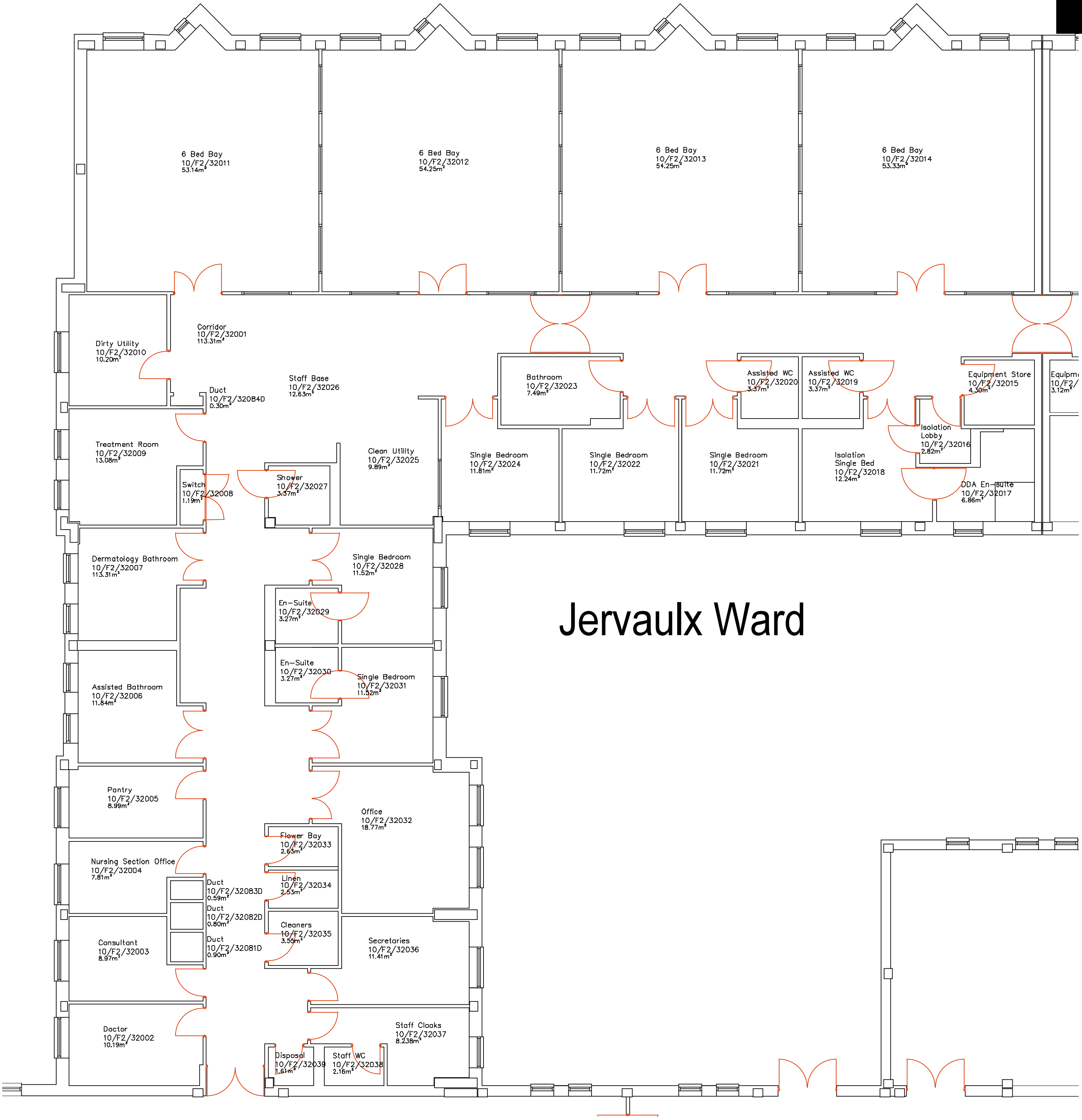
Granby Ward

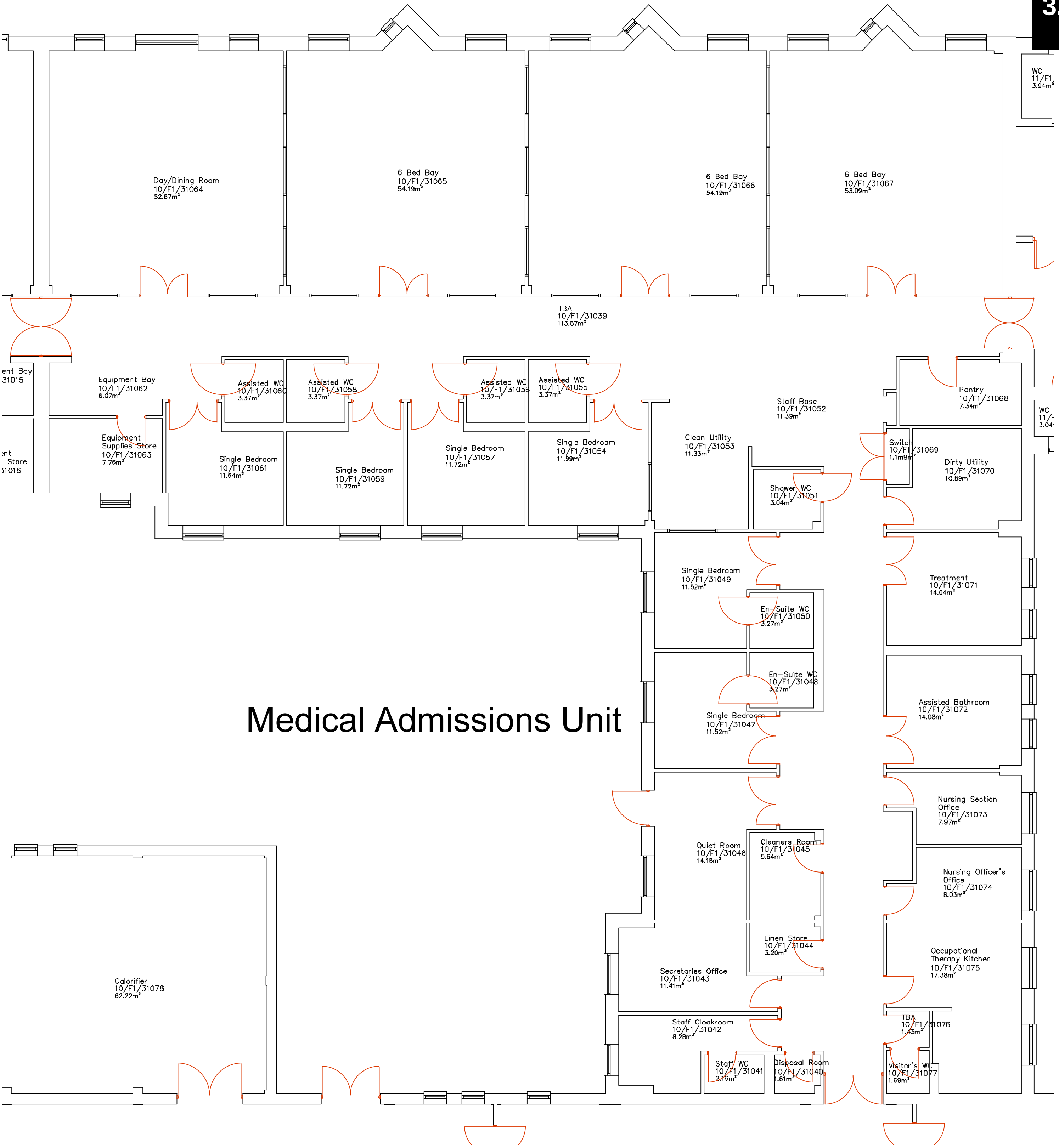

6 Bed Bay
10/F1/31011
53.11m²
6 Bed Bay
10/F1/31012
54.19m²
6 Bed Bay
10/F1/31013
54.19m²
CCU
10/F1/31014
52.67m²
Corridor
10/F1/31001
109.43m²
Pantry
10/F1/31010
9.30m²
Assisted WC
10/F1/31024
3.32m²
Assisted WC
10/F1/31022
3.37m²
Shower Rm
10/F1/31020
3.37m²
Assisted WC
10/F1/31018
3.37m²
Equipment Bay
10/F1/31015
8.07m²
Staff Base
10/F1/31026
11.85m²
Clean Utility
10/F1/31025
11.51m²
Single Bedroom
10/F1/31021
11.72m²
Single Bedroom
10/F1/31019
11.72m²
Single Bedroom
10/F1/31017
11.64m²
Equipment
Supplies Store
10/F1/31016
7.76m²
Dirty Utility
10/F1/31009
14.35m²
Showers
10/F1/31027
3.064m²
Single Bedroom
10/F1/31023
11.81m²
Switch
10/F1/31008
3.04m²
Single Bedroom
10/F1/31028
11.52m²
Treatment Room
10/F1/31007
14.15m²
En-Suite WC
10/F1/31029
3.27m²
En-Suite WC
10/F1/31031
3.27m²
Single Bedroom
10/F1/31030
11.52m²
Medical Short Stay Unit
Assisted Bathroom
10/F1/31006
12.79m²
Occupational
Therapy
10/F1/31005
9.02m²
Quiet Room
10/F1/31032
14.18m²
Cleaners Room
Flower Bay
10/F1/31033
5.64m²
Nursing Section
Office
10/F1/31004
9.02m²
Linen Store
10/F1/31035
3.20m²
Secretaries Office
10/F1/31034
11.41m²
Plant
10/F1/31079
19.68m²
Consultants Office
10/F1/31003
10.60m²
Sterile Services
Transportation
Store
5/F1/14151
10 m²
Consultants Office
10/F1/31002
10.19m²
Staff Cloakroom
10/F1/31036
8.28m²
Disposal Room
10/F1/31038
1.61m²
Staff WC
10/F1/31037
2.16m²


Offic
1/F1
10.19r
Consult
1/F1/0
14.70m²
Reception
2/F1/07002
14.47m²
Consultants Office
2/F1/07003
7.74m²
En–Suite
2/F1/07005
4.91m²
Single Bed
2/F1/07004
13.03m²
Store
2/F1/07081
0.97m²
En–Suite
2/F1/07007
5.16m²
Single Bed
2/F1/07006
12.78m²
En–Suite
2/F1/07031
4.26m²
Single Bed
2/F1/07030
16.25m²
En–Suite
2/F1/07029
4.49m²
Single Bed
2/F1/07028
12.94m²
duct(?)
2/F1/07104D
0.34m²
Switch
2/F1/07010
0.69m²
En–Suite
2/F1/07009
5.27m²
Single Bed
2/F1/07008
15.00m²
Single Bed
2/F1/07026
11.63m²
Corridor
2/F1/07001
89.79m²
En–Suite
2/F1/07012
4.14m²
Single Bed
2/F1/07011
15.00m²
En–Suite
2/F1/07027
3.30m²
Clean Utility
2/F1/07025
4.70m²
duct(?)
2/F1/07105D
0.34m²
Nurse Base
2/F1/07013
8.06m²
Single Bed
2/F1/07014
15.00m²
Dirty Utility
2/F1/07024
5.12m²
Store
2/F1/07023
1.66m²
Service Duct
2/F1/07109D
1.49m²
duct(?)
2/F1/07106D
0.31m²
En–Suite
2/F1/07015
4.14m²
En–Suite
2/F1/07021
4.13m²
Store
2/F1/07022
1.35m²
duct(?)
2/F1/07107D
0.34m²
En–Suite
2/F1/07017
4.66m²
Single Bed
2/F1/07016
13.85m²
Single Bed
2/F1/07020
12.56m²
duct(?)
2/F1/07108D
0.21m²
Store
2/F1/07018
1.49m²
Dirty Utility
Sluice Test
2/F1/07033
13.30m²
Consulting Room
2/F1/07019
12.56m²
70
Office
7034


Single Bed Room 1/F1/02134 17.86m^2
En-Suite 1/F1/02135 5.31m^2
Store 1/F1/02136 2.73m^2
En-Suite 1/F1/02138 5.32m^2
Single Bed Room 1/F1/02137 18.15m^2
Fire Escape Stair 1/F1/02154 26.72m^2
up
dn
Void
IPS duct
Single Bed Room 1/F1/02132 10.79m^2
En-Suite 1/F1/02133 3.97m^2
Work Station 1/F1/02140 6.73m^2
WC 1/F1/02139 2.91m^2
Single Bed Room 1/F1/02130 10.79m^2
En-Suite 1/F1/02131 3.48m^2
Single Bed Room 1/F1/02128 10.79m^2
En-Suite 1/F1/02129 3.48m^2
Corridor 1/F1/02121 73.53m^2
Single Bed Room 1/F1/02141 12.20m^2
En-Suite 1/F1/02142 4.56m^2
Single Bed Room 1/F1/02126 10.79m^2
En-Suite 1/F1/02127 3.48m^2
Linen Store 1/F1/02141 2.21m^2
En-Suite 1/F1/02143 4.56m^2
Single Bed Room 1/F1/02124 10.79m^2
En-Suite 1/F1/02125 3.48m^2
Single Bed Room 1/F1/02144 12.20m^2
Single Bed Room 1/F1/02122 10.79m^2
En-Suite 1/F1/02123 3.48m^2
Dirty Utility 1/F1/02145 8.45m^2
En-Suite 1/F1/02110 5.00m^2
Clean Utility 1/F1/02111 7.98m^2
Kitchen 1/F1/02113 10.76m^2
Cleaners 1/F1/02115 8.32m^2
Beverage Bay 1/F1/02116 6.46m^2
3 Bed Bay 1/F1/02109 38.00m^2
Resuscitation 1/F1/02153 1.86m^2
Store 1/F1/02112 3.78m^2
Corridor 1/F1/02104 42.28m^2
3 Bed Bay 1/F1/02107 38.00m^2
Central Staff Base 1/F1/02105 15.30m^2
En-Suite 1/F1/02108 4.19m^2
Sisters Office 1/F1/02106 10.81m^2
Single Bed Room 1/F1/02094 10.79m^2
En-Suite 1/F1/02095 3.48m^2
Linen Store 1/F1/02096 1.78m^2
En-Suite 1/F1/02098 5.89m^2
Single Bed Room 1/F1/02092 10.79m^2
En-Suite 1/F1/02093 3.48m^2
Single Bed Room 1/F1/02097 12.19m^2
Single Bed Room 1/F1/02090 10.79m^2
En-Suite 1/F1/02091 3.48m^2
Wet Room (Bath) 1/F1/02099 10.68m^2
Single Bed Room 1/F1/02088 10.79m^2
En-Suite 1/F1/02089 3.48m^2
Store 1/F1/02100 6.15m^2
Single Bed Room 1/F1/02086 10.79m^2
En-Suite 1/F1/02087 3.48m^2
Ward Reception/ Staff Base 1/F1/02101 10.39m^2
Assisted WC 1/F1/02102 8.28m^2
Office/ Meeting Room 1/F1/02103 11.30m^2
Consultant Office 1/F1/02002 15.50m^2
Single Bed Room 1/F1/02084 10.79m^2
En-Suite 1/F1/02085 3.48m^2
Corridor 1/F1/02080 84.88m^2
Handwash Station
Electrical Cupboard 1/F1/02152 1.02m^2
Store 1/F1/02151 2.34m^2
Ward Entrance 1/F1/02150 5.13m^2
Disposal 1/F1/02082 4.38m^2
Cleaners' Room 1/F1/02081 4.95m^2
Sitting Day Room 1/F1/02083 13.29m^2
Quiet Room 13/F1/42009 11.48m^2
Duct 13/F1/42062D 0.76m^2
Engineer 13/F1/42010 6.00m^2


Room 3 (6 Bed Bay)
6/G/16002
57.23m²
Room 4 (6 Bed Bay)
6/G/16003
58.04m²
Room 5 (6 Bed Bay)
6/G/16004
57.95m²
Room 6 (6 Bed Bay)
6/G/16005
57.35m²
Stair
6/G/16006
23.67m²
Store
6/G/16007
0.96m²
Duct
6/G/16054D
0.43m²
Room 7 (2 Bed Bay)
6/G/16008
18.39m²
Corridor
6/G/16001
119.32m²
Store
6/G/16042
2.77m²
WC
6/G/16039
2.97m²
Electrical Sw.
6/G/16053D
0.44m²
Bathroom
6/G/16037
4.08m²
Shower
6/G/16036
4.68m²
Linen
6/G/16035
3.66m²
Room 2
6/G/16041
13.43m²
Room 1
6/G/16040
12.98m²
Assisted Bathroom
6/G/16038
13.15m²
Dirty Utility
6/G/16034
12.63m²
Duct
6/G/16052D
0.32m²
Nurse Base
6/G/16015
20.09m²
Store
6/G/16016
3.25m²
WC
6/G/16014
2.10m²
Room 9
6/G/16013
11.85m²
WC
6/G/16011
3.09m²
Room 8
6/G/16012
14.21m²
Treatment Room
6/G/16009
11.70m²
Bathroom
6/G/16010
4.16m²
Littondale Ward
Treatment
6/G/16033
11.72m²
Store
6/G/16032
8.88m²
Kitchen
6/G/16031
7.63m²
Seminar Room
6/G/16030
8.88m²
Visitors WC
6/G/16029
2.86m²
Staffroom
6/G/16028
7.36m²
Ward Office
6/G/16027
9.67m²
WC
6/G/16017
2.24m²
Room 10
6/G/16018
12.25m²
Room 11
6/G/16019
12.25m²
WC
6/G/16020
2.24m²
Sitting Room
6/G/16021
19.56m²
Domestic
6/G/16022
5.93m²
Staff WC
6/G/16024
1.62m²
Changing
6/G/16023
5.74m²
Electrical Switch
6/G/16026
1.05m²
Disposal
6/G/16025
4.93m²
Duct
6/G/16051D
0.23m²
Chapel
Sanctuc
6/G/16
22.05m²
Chapel
6/G/16048
38.10m²
Office
6/G/16047
11.66m²
Vestry
6/G/16045
4.65m²
Store
6/G/16046
0.72m²
Female WC
6/G/16044
4.65m²
Duct
6/G/16055D
0.23m²
Duct
6/G/16056D
0.23m²
Entrance Lobby
6/G/16043
27.10m²


Jervaulx Ward
6 Bed Bay 10/F2/32011 53.14m²
6 Bed Bay 10/F2/32012 54.25m²
6 Bed Bay 10/F2/32013 54.25m²
6 Bed Bay 10/F2/32014 53.33m²
Corridor 10/F2/32001 113.31m²
Dirty Utility 10/F2/32010 10.20m²
Staff Base 10/F2/32026 12.63m²
Duct 10/F2/320B4D 0.30m²
Bathroom 10/F2/32023 7.49m²
Assisted WC 10/F2/32020 3.37m²
Assisted WC 10/F2/32019 3.37m²
Equipment Store 10/F2/32015 4.30m²
Equipm 10/F2/ 3.12m²
Treatment Room 10/F2/32009 13.08m²
Clean Utility 10/F2/32025 9.89m²
Single Bedroom 10/F2/32024 11.81m²
Single Bedroom 10/F2/32022 11.72m²
Single Bedroom 10/F2/32021 11.72m²
Isolation Single Bed 10/F2/32018 12.24m²
Isolation Lobby 10/F2/32016 2.82m²
DDA En-suite 10/F2/32017 6.86m²
Switch 10/F2/32008 1.19m²
Shower 10/F2/32027 3.37m²
Dermatology Bathroom 10/F2/32007 113.31m²
Single Bedroom 10/F2/32028 11.52m²
En-Suite 10/F2/32029 3.27m²
En-Suite 10/F2/32030 3.27m²
Single Bedroom 10/F2/32031 11.52m²
Assisted Bathroom 10/F2/32006 11.84m²
Pantry 10/F2/32005 8.99m²
Office 10/F2/32032 18.77m²
Flower Bay 10/F2/32033 2.63m²
Nursing Section Office 10/F2/32004 7.81m²
Duct 10/F2/32083D 0.59m²
Linen 10/F2/32034 2.53m²
Duct 10/F2/32082D 0.80m²
Cleaners 10/F2/32035 3.55m²
Duct 10/F2/32081D 0.90m²
Consultant 10/F2/32003 8.97m²
Secretaries 10/F2/32036 11.41m²
Staff Cloaks 10/F2/32037 8.238m²
Doctor 10/F2/32002 10.19m²
Disposal 10/F2/32039 1.81m²
Staff WC 10/F2/32038 2.16m²


Medical Admissions Unit
Day/Dining Room 10/F1/31064 52.67m²
6 Bed Bay 10/F1/31065 54.19m²
6 Bed Bay 10/F1/31066 54.19m²
6 Bed Bay 10/F1/31067 53.09m²
WC 11/F1 3.94m²
TBA 10/F1/31039 113.87m²
ent Bay 31015
Equipment Bay 10/F1/31062 6.07m²
Assisted WC 10/F1/31060 3.37m²
Assisted WC 10/F1/31058 3.37m²
Assisted WC 10/F1/31056 3.37m²
Assisted WC 10/F1/31055 3.37m²
Staff Base 10/F1/31052 11.39m²
Pantry 10/F1/31068 7.34m²
WC 11/F 3.04
Equipment Supplies Store 10/F1/31063 7.76m²
nt Store 1016
Single Bedroom 10/F1/31061 11.64m²
Single Bedroom 10/F1/31059 11.72m²
Single Bedroom 10/F1/31057 11.72m²
Single Bedroom 10/F1/31054 11.99m²
Clean Utility 10/F1/31053 11.33m²
Switch 10/F1/31069 1.1m9m²
Dirty Utility 10/F1/31070 10.89m²
Shower WC 10/F1/31051 3.04m²
Single Bedroom 10/F1/31049 11.52m²
En-Suite WC 10/F1/31050 3.27m²
Treatment 10/F1/31071 14.04m²
En-Suite WC 10/F1/31048 3.27m²
Single Bedroom 10/F1/31047 11.52m²
Assisted Bathroom 10/F1/31072 14.08m²
Nursing Section Office 10/F1/31073 7.97m²
Quiet Room 10/F1/31046 14.18m²
Cleaners Room 10/F1/31045 5.64m²
Nursing Officer's Office 10/F1/31074 8.03m²
Calorifier 10/F1/31078 62.22m²
Linen Store 10/F1/31044 3.20m²
Secretaries Office 10/F1/31043 11.41m²
Occupational Therapy Kitchen 10/F1/31075 17.38m²
Staff Cloakroom 10/F1/31042 8.28m²
TBA 10/F1/31076 1.43m²
Staff WC 10/F1/31041 2.16m²
Disposal Room 10/F1/31040 1.61m²
Visitor's WC 10/F1/31077 1.69m²

APPENDIX: SNCT FINANCE BREAKDOWN

SHIFT DATE	(Multiple Items)	Shift Dates 21/06/21 - 21/07/21

			Data		
WARD	ACCOUNT CODE (SUBJECTIVE CODE)	Shift Date2	Sum of ACTUAL TOTAL HOURS	Sum of TOTAL COST	
(ESU) Elective Surgical Unit			**189.5**	**5130.89**	
	809500		**134.5**	**3724.1**	Band 5
	809600		**30.5**	**926.27**	Band 6
	811200		**24.5**	**480.52**	Band 2
Bolton Ward			**23**	**698.31**	
	809500		**23**	**698.31**	Band 5
Farndale MAU			**664.5**	**16529.23**	
	809500		**300**	**8430.8**	Band 5
	809600		**47**	**1822.1**	Band 6
	810400		**107.25**	**2414.68**	Band 4
	811200		**210.25**	**3861.65**	Band 2
Granby			**448**	**10791.89**	
	809500		**181**	**4922.62**	Band 5
	809600		**46**	**1562.37**	Band 6
	811200		**221**	**4306.9**	Band 2
Harlow Suite			**498.5**	**12314.63**	
	809500		**265.75**	**7154.11**	Band 5
	809600		**35**	**1349.79**	Band 6
	810400		**7.5**	**126.77**	Band 4
	811200		**190.25**	**3683.96**	Band 2
Jervaulx			**491.5**	**13164.38**	
	809500		**297.5**	**8255.36**	Band 5
	809600		**70**	**2319.92**	Band 6
	810400		**11**	**270.72**	Band 4
	811200		**113**	**2318.38**	Band 2
Littondale			**263.99**	**7042.15**	
	809500		**146**	**4147.23**	Band 5
	809600		**50.99**	**1639.73**	Band 6
	811200		**67**	**1255.19**	Band 2
Nidderdale Trauma & Orthopaedics			**918.24**	**20841.09**	
	809500		**296.08**	**7331.38**	Band 5

809500	Band 5
809600	Band 6
811200	Band 2
810400	Band 4
809700	Band 7

Nidderdale Trauma & Orthopaedics	**809600**	**62.5**	**2347.85**	Band 6
	811200	**559.66**	**11161.86**	Band 2
Oakdale		**766.25**	**16928.8**	
	809500	**320.17**	**8625.01**	Band 5
	811200	**446.08**	**8303.79**	Band 2
Rowan Ward		**113.25**	**2437.58**	
	809500	**23**	**625.69**	Band 5
	809600	**20.25**	**527.45**	Band 6
	811200	**70**	**1284.44**	Band 2
Trinity ward		**481.79**	**11261.25**	
	809500	**177**	**5014.77**	Band 5
	809600	**7.75**	**259.13**	Band 6
	809700	**33**	**938.57**	Band 7
	811200	**264.04**	**5048.78**	Band 2
Wensleydale Elderly care		**1015.33**	**21792.08**	
	809500	**187.5**	**5427.86**	Band 5
	809600	**40.83**	**1153.97**	Band 6
	811200	**787**	**15210.25**	Band 2
Grand Total		**5873.85**	**138932.28**	

APPENDIX: SNCT FINANCE BREAKDOWN

SHIFT DATE (Multiple Items) Shift Dates 21/06/21 - 21/07/21

WARD	ACCOUNT CODE (SUBJECTIVE CODE)	SUPPLIER NAME	Data Sum of ACTUAL TOTAL HOURS	Sum of TOTAL COST (ex AGENCY VAT)
(ESU) Elective Surgical Unit	842200	Reed Specialist Rec	15.00	354.61
	842200 Total		**15.00**	**354.61**
	842500	D R C Locums	11.00	308.89
		Plan B Healthcare	22.00	1007.54
	842500 Total		**33.00**	**1316.43**
(ESU) Elective Surgical Unit Total			**48.00**	**1671.04**
Farndale MAU	842200	D R C Locums	22.00	465.28
	842200 Total		**22.00**	**465.28**
	842500	D R C Locums	11.00	308.89
		Direct Healthcare Plc	77.00	3266.4
		Hays	11.00	308.89
		Plan B Healthcare	78.00	3565.78
		Your World Recruitment	11.00	408.08
	842500 Total		**188.00**	**7858.04**
Farndale MAU Total			**210.00**	**8323.32**
Granby	842200	2 4 7 Recruitment	11.00	233.03
		D R C Locums	32.82	757.17
		Hays	33.00	602.76
		Reed Specialist Rec	48.50	1000.91
	842200 Total		**125.32**	**2593.87**
	842500	B N A	6.00	134.45
		Plan B Healthcare	24.00	1057.4
	842500 Total		**30.00**	**1191.85**
Granby Total			**155.32**	**3785.72**
Harlow Suite	842200	D R C Locums	11.00	213.07
	842200 Total		**11.00**	**213.07**
	842500	D R C Locums	11.00	339.31
		Direct Healthcare Plc	33.00	1378.14
		Plan B Healthcare	43.50	2106.52
	842500 Total		**87.50**	**3823.97**
Harlow Suite Total			**98.50**	**4037.04**

Key	
842500	Band 5
844200	Band 2

Jervaulx	842200	D R C Locums	132.00	2622.61
		Hays	22.00	410.45
		Reed Specialist Rec	95.50	1916.31
	842200 Total		**249.50**	**4949.37**
	842500	B N A	6.00	134.45
		D R C Locums	22.00	707.35
		Direct Healthcare Plc	44.00	1863.3
		Plan B Healthcare	99.00	4494.11
		Your World Recruitment	11.00	408.08
	842500 Total		**182.00**	**7607.29**
Jervaulx Total			**431.50**	**12556.66**
Littondale	842200	Reed Specialist Rec	11.00	213.07
	842200 Total		**11.00**	**213.07**
	842500	B N A	19.50	580.07
		Plan B Healthcare	108.00	4610.54
	842500 Total		**127.50**	**5190.61**
Littondale Total			**138.50**	**5403.68**
Nidderdale Trauma & Orthopaedic	842200	D R C Locums	142.85	2844.51
		Hays	55.00	1058.3
		Reed Specialist Rec	48.25	914.37
	842200 Total		**246.10**	**4817.18**
	842500	B N A	11.98	396.77
		Direct Healthcare Plc	33.00	1401.04
		Plan B Healthcare	105.00	4449.18
		Your World Recruitment	11.00	408.08
	842500 Total		**160.98**	**6655.07**
Nidderdale Trauma & Orthopaedics Total			**407.08**	**11472.25**
Oakdale	842200	D R C Locums	32.75	635.65
		Hays	44.00	837.72
		Reed Specialist Rec	46.50	934.85
	842200 Total		**123.25**	**2408.22**
	842500	B N A	12.00	268.9
		D R C Locums	11.00	368.04
		Plan B Healthcare	40.00	1745.86
	842500 Total		**63.00**	**2382.8**
Oakdale Total			**186.25**	**4791.02**
Rowan Ward	842200	D R C Locums	11.00	213.07
		Hays	11.00	209.53
		Reed Specialist Rec	7.50	200.78

Rowan Ward	**842200 Total**		**29.50**	**623.38**
	842500	B N A	6.48	145.17
	842500 Total		**6.48**	**145.17**
Rowan Ward Total			**35.98**	**768.55**
Trinity ward	842500	Plan B Healthcare	11.98	464.79
	842500 Total		**11.98**	**464.79**
Trinity ward Total			**11.98**	**464.79**
Wensleydale Elderly care	842200	2 4 7 Recruitment	6.00	134.64
		D R C Locums	154.00	3239.71
		Hays	77.00	1479.4
		Reed Specialist Rec	46.25	1036.13
	842200 Total		**283.25**	**5889.88**
	842500	D R C Locums	11.00	308.89
		Direct Healthcare Plc	11.00	485.16
		Plan B Healthcare	77.50	3428.44
		Your World Recruitment	11.00	382.23
	842500 Total		**110.50**	**4604.72**
Wensleydale Elderly care Total			**393.75**	**10494.6**
Grand Total			**2116.87**	**63768.67**

Board of Directors (Public)
24th November 2021

Title:	Medical Director Update
Responsible Director:	Medical Director
Author:	Medical Director

Purpose of the report and summary of key issues:	For noting and information	
BAF Risk:	AIM 1: To be an outstanding place to work	
	BAF1.1 to be an outstanding place to work	x
	BAF1.2 To be an inclusive employer where diversity is celebrated and valued	
	AIM 2: To work with partners to deliver integrated care	
	BAF2.1 To improve population health and wellbeing, provide integrated care and to support primary care	x
	BAF2.2 To be an active partner in population health and the transformation of health inequalities	
	AIM 3: To deliver high quality care	
	BAF3.1 and 3.4 To provide outstanding care and outstanding patient experience	x
	BAF3.2 To provide a high quality service	x
	BAF3.3 To provide high quality care to children and young people in adults community services	
	BAF3.5 To provide high quality public health 0-19 services	
	AIM 4: To ensure clinical and financial sustainability	
	BAF4.1 To continually improve services we provide to our population in a way that are more efficient	x
	BAF4.2 and 4.3 To provide high quality care and to be a financially sustainable organisation	
	BAF4.4 To be financially stable to provide outstanding quality of care	
Corporate Risks	none	
Report History:	none	
Recommendation:	The Board are asked to note and approve the information contained in this report	

Medical Director Report
Date: November 2021 Public Board

Harrogate and District
NHS Foundation Trust

Matters of concern & risks to escalate

- Ongoing effect of COVID pandemic on moral and wellbeing of all staff in the NHS- HDFT and system partners

Major actions commissioned & work underway

- Medical Leadership Forum- inaugural event later this month
- Clinical Strategy programme- advanced planning for launch by DoS & MD
- Pilot scheme to establish directorate oversight of Compliance reports and action plans following publication of National Standards now rolled out to Planned and Surgical and Children's and Community Services
- Review of oversight of clinical policies- training, QC, approval and ongoing management- Datix Cloud Policy Module being procured
- Acute Care at our Best – Surgical input identified and already proving effective. Day case acute surgery pathway enabled and tested. Review of surgical staffing structure of SDEC underway in order to further improve flow and reduce exception reports by trainees
- GIRFT – improving clinical engagement in reviewing national reports. 2 further deep dive visits planned (acute medicine and neurology)
- Quality improvement workshop on reducing time to bed allocation and occupation planed for 16 - 17 November
- Rapid Process Improvement Workshop on Multi-agency urgent response planned with HARA for week of 29 November

Positive news & assurance

- Interim PMO support secured for CAOB programme (Vicky Innocent)
- Senior interim support secured for clinical governance aspects of MD portfolio (Clinical Effectiveness and Audit, Mortality and Legal teams)- will also oversee 6th month review of new quality governance structure
- Rebecca Hill (Clinical effectiveness facilitator) team is finalist for a National "Local Clinical auditor of the Year" award. Winner announced at the Clinical Audit Leadership Summit 26th Nov.
- HEE CL Fellowship in Digital Innovation- closes 12th Nov, will align with digital exemplar ward programme
- NHSX Unified Tech Fund- Maternity funding bid submitted for £680k to support the implementation of a new Maternity EPR

Decisions made & decisions required of Public Board

- New monthly "Learning at our Best" forum being initiated to identify, discuss and share learning from claims/inquests/complaints/SIs plus also our Clinical Effectiveness and R&I programmes (HDFT continuous learning system)

teamHDFT
At our best

NHS
Harrogate and District
NHS Foundation Trust

Board of Directors (Public)
24th November 2021

Title:	Learning from Deaths Quarterly Report 2: July-September 2021
Responsible Director:	Executive Medical Director
Author:	Deputy Medical Director for Quality and Safety

Purpose of the report and summary of key issues:	The board is asked to note the surveillance of mortality indices across the trust. Trust mortality is in line with expected values. Details are provided in the report for areas where any concerns have been identified.	
BAF Risk:	AIM 1: To be an outstanding place to work	
	BAF1.1 to be an outstanding place to work	
	BAF1.2 To be an inclusive employer where diversity is celebrated and valued	
	AIM 2: To work with partners to deliver integrated care	
	BAF2.1 To improve population health and wellbeing, provide integrated care and to support primary care	X
	BAF2.2 To be an active partner in population health and the transformation of health inequalities	
	AIM 3: To deliver high quality care	
	BAF3.1 and 3.4 To provide outstanding care and outstanding patient experience	X
	BAF3.2 To provide a high quality service	X
	BAF3.3 To provide high quality care to children and young people in adults community services	
	BAF3.5 To provide high quality public health 0-19 services	
	AIM 4: To ensure clinical and financial sustainability	
	BAF4.1 To continually improve services we provide to our population in a way that are more efficient	
	BAF4.2 and 4.3 To provide high quality care and to be a financially sustainable organisation	
	BAF4.4 To be financially stable to provide outstanding quality of care	
Corporate Risks	N/A	
Report History:	No prior scrutiny before Board. Paper is also discussed at Patient Safety Forum	
Recommendation:	The board is asked to note the contents of the report, including the metrics and methodology used.	

Board Meeting Held in Public

24th November 2021

Learning from Deaths Quarterly Report 2

Executive Medical Director

1.0 Executive Summary

Crude mortality rates for the trust continue to track the national trends.

Standardised mortality rates continue to be within the expected range.

16 structured judgement reviews have been undertaken since the last report. All cases had overall care described as “good”.

There have been 9 in hospital Covid-19 deaths in this quarter.

A review into deaths of patients with a diagnosis of pneumonia was undertaken following a previous HSMR alert. This did not find any significant lapses in care.

The HDFT Medical Examiner team is performing well when benchmarked against regional data.

2.0 Introduction

Mortality data in Q2 continues in a similar manner to Q1, with a return to more normal levels than that seen during previous Covid waves. However crude mortality in August did not drop as seen in most previous years, and it is now apparent that Covid is still a significant cause of mortality in our patient group.

3.0 Findings

3.1 Crude Mortality Data

The crude mortality rate for admissions gives a long-term view of trust mortality rates. In total, 179 deaths were recorded in Q2, up from 144 in Q1. This data is not risk-adjusted so takes no account of the unique characteristics of the admissions. Comparison with the national mortality rate is also shown where data is available (shown in the darker blue line in Figures 1 and 2). This demonstrates that the peaks and troughs we see in HDFT are often mirrored at the national level. Figure 2 gives a "zoomed in" view of data from the last 2 years. In previous years, Q2 is our period of lowest mortality, but that has not been seen this year. This triangulates with higher levels of acute activity seen in HDFT and across the NHS acute sector nationally.

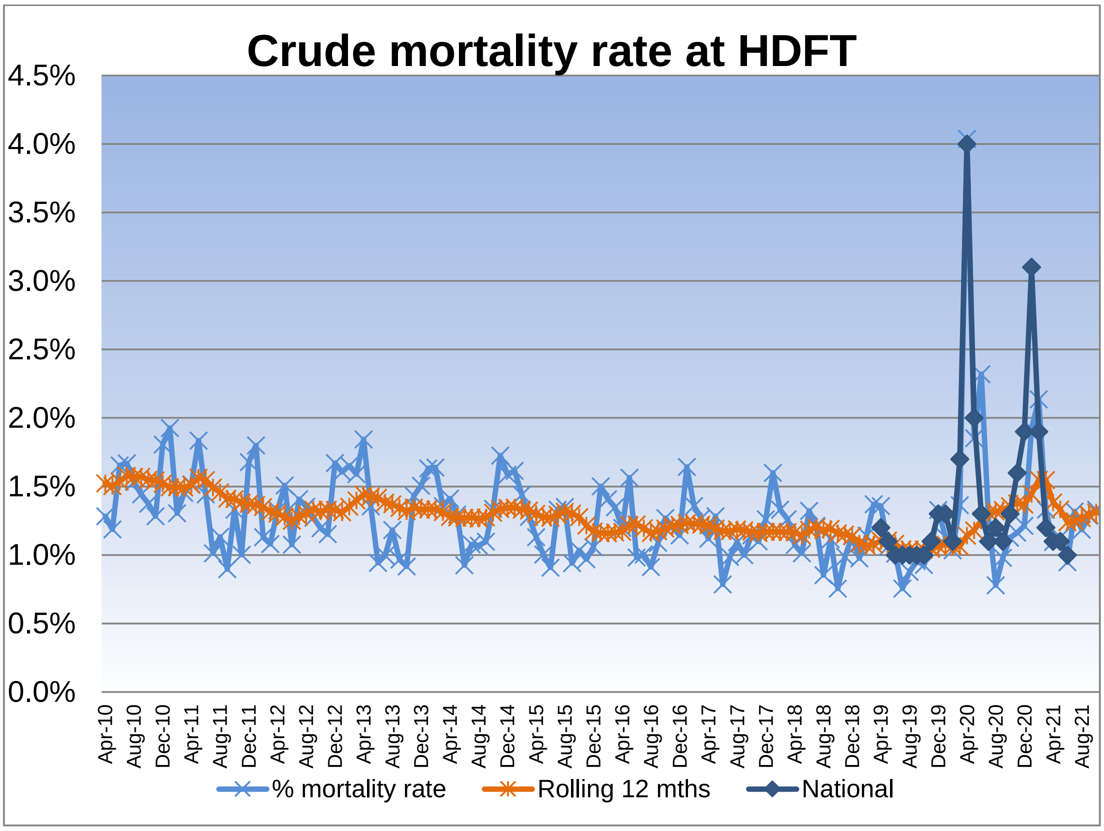


Figure 1: Crude mortality rates over the last 11 years (%deaths per qualifying admission activity)

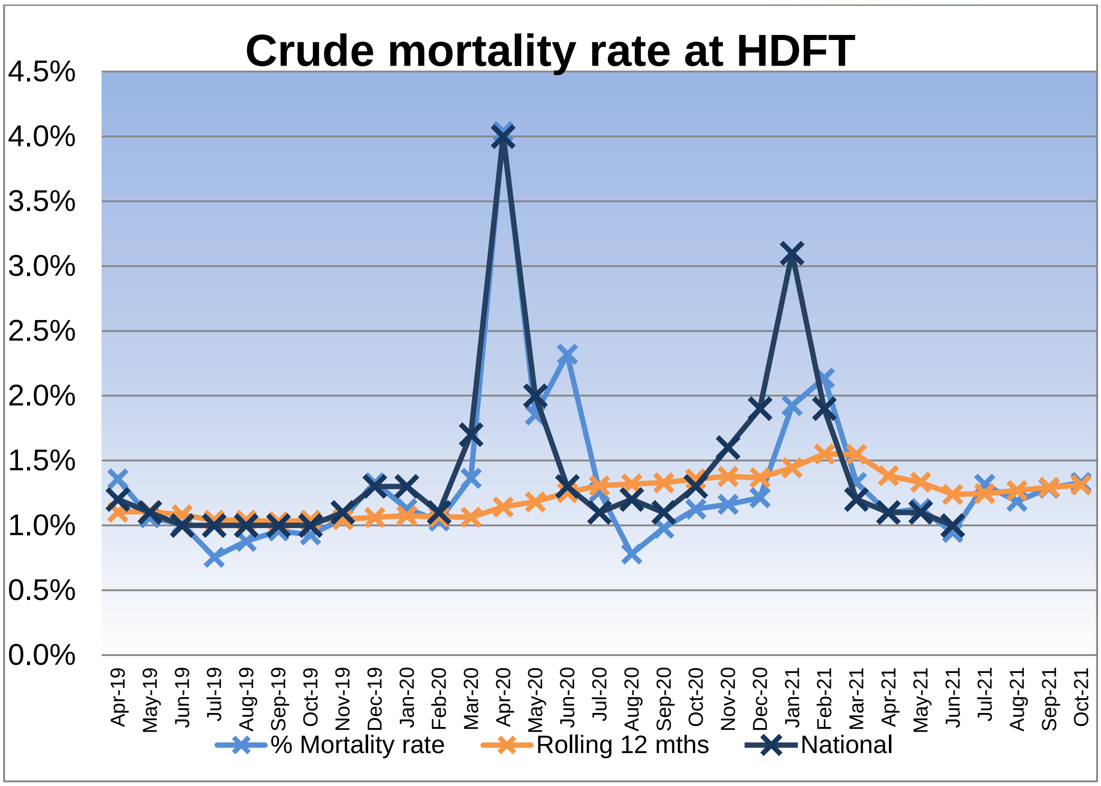


Figure 2: Expanded crude mortality rates over the last 2 years (%deaths per hospital admission)

3.2 Standardised Mortality Rates (HSMR and SHMI)

Figures 3-8 show the most recent data available for HSMR and SHMI. There has been a recent problem with data release from NHS Digital which has resulted in a delay to SHMI generation. Overall, our results from both indices are in line with expected rates.

3.2.1 HSMR

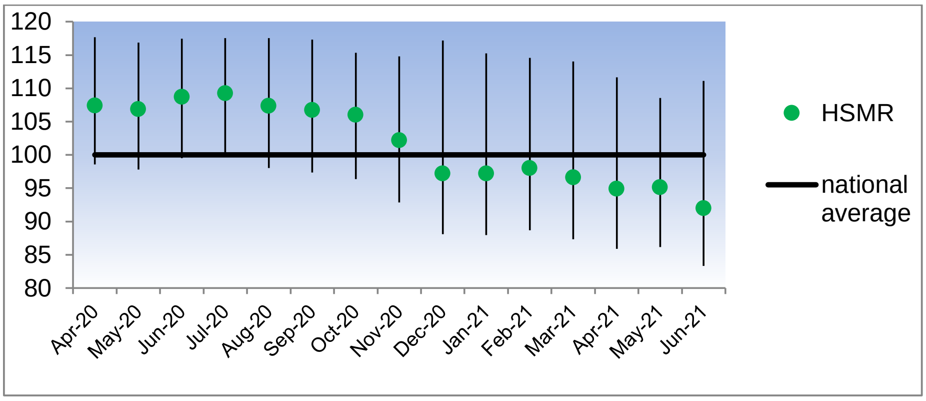


Figure 3: HSMR. Dots show the recorded values with error bars showing possible range of true values.

Figures 4 and 5 below shows our most recent HSMR data in comparison to national and regional peers. HDFT results are shown as a black diamond.

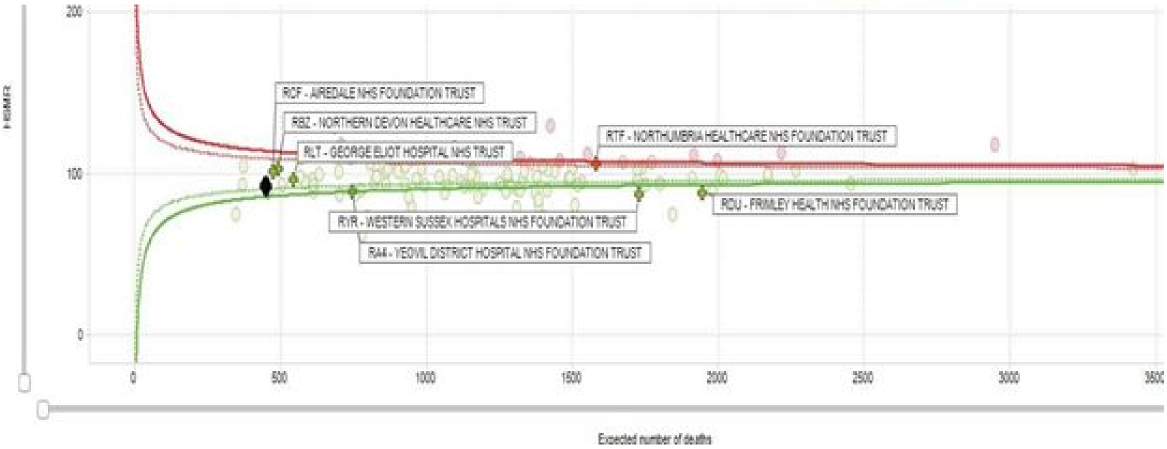


Figure 4: HMSR data for peer organisations

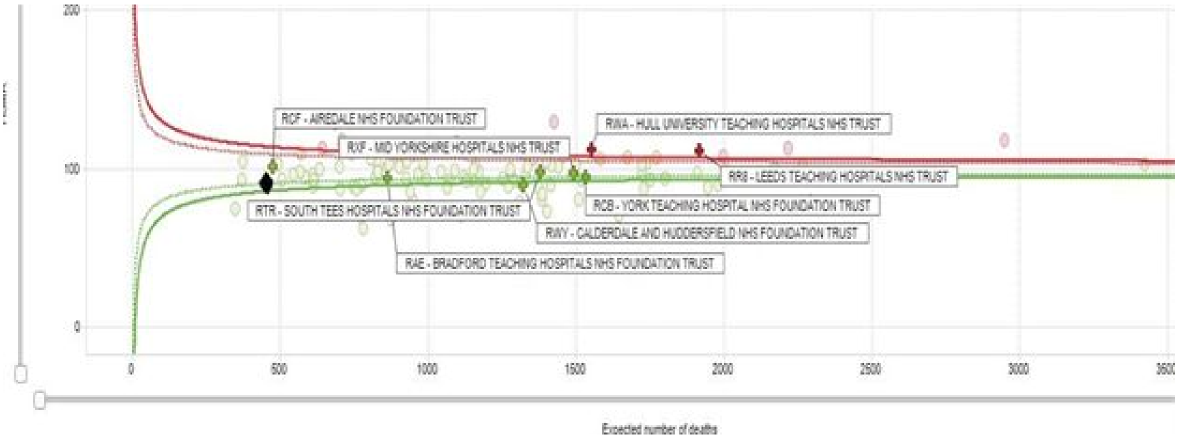


Figure 5: HMSR data for regional organisations

3.2.2 SHMI

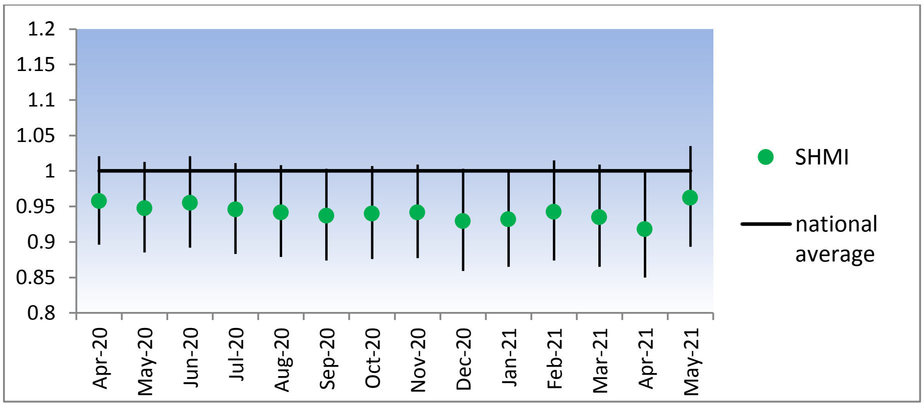


Figure 6: SHMI Dots show the recorded values with error bars showing possible range of true values.

Figures 7 -8 demonstrate our SHMI against that of peer and regional trusts:

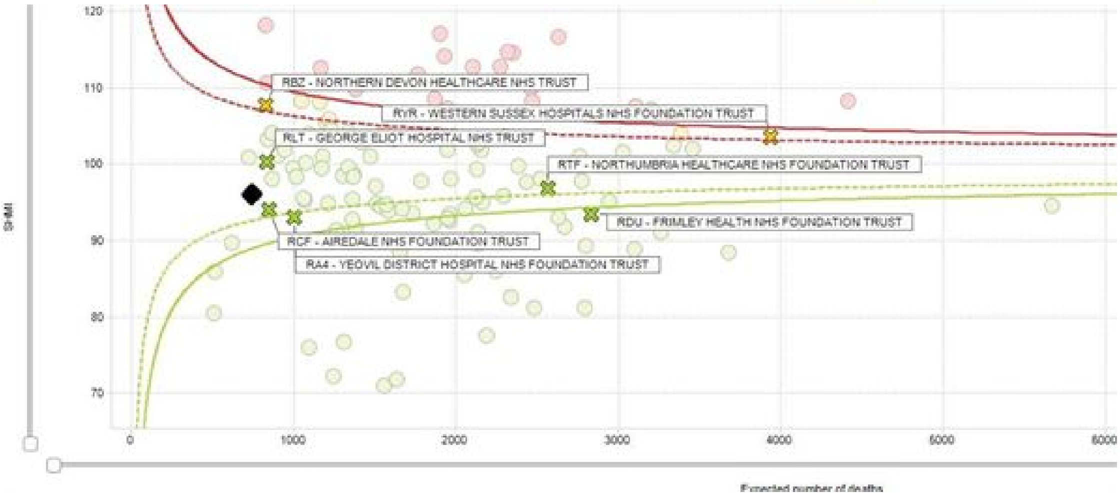


Figure 7: SHMI data for peer organisations

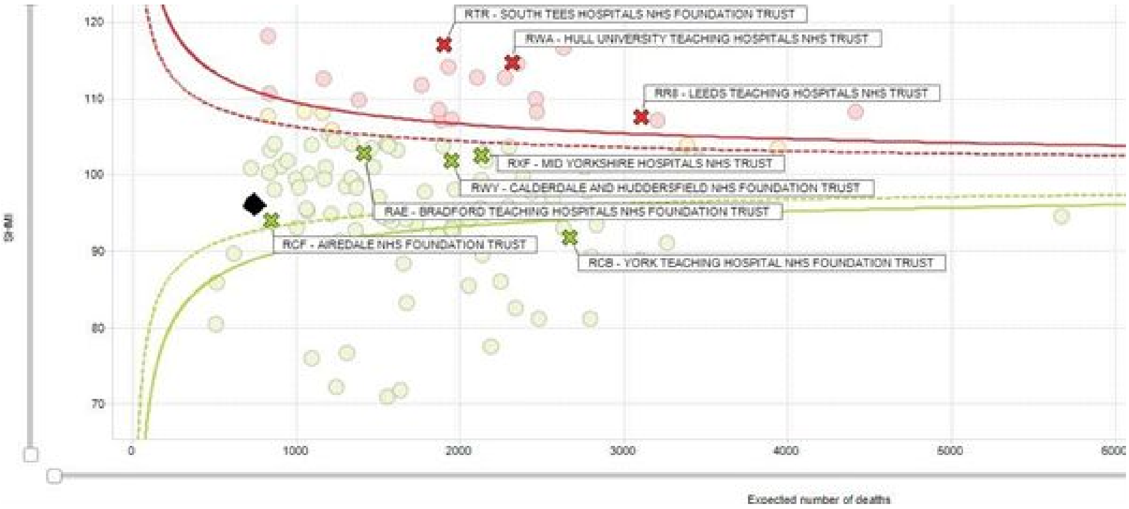


Figure 8: SHMI data for regional organisations

3.3 Structured judgement reviews

16 cases have been reviewed in this quarter, with 2 relating to deaths in this quarter and 1 from late Q1. The other 13 cases were from diagnostic groups highlighted by previous HSMR/SHMI alerts. These include 11 in-hospital deaths with a diagnosis of pneumonia and 2 with acute cerebrovascular disease. These are discussed in section 3.6.

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

Case ID	**Admission Date**	**Learning Disability**	**Serious Mental Health Issue**	**Quality of Care in first 24hr (1-5)**	**Quality of Ongoing Care if applicable (1-5)**	**Quality of End of Life care (1-5)**	**Quality of Overall Care (1-5)**	**Quality of Note-keeping (1-5)**
1	Feb 21	No	No	3	4	N/A	**4**	4
2	Jan 21	No	No	4	4	N/A	**4**	4
3	Jul 21	Yes	No	4	4	4	**4**	3
4	Jan 21	No	No	4	3	3	**4**	4
5	Feb 21	No	No	4	4	4	**4**	4
6	Jan 21	No	No	4	4	4	**4**	4
7	Nov 20	No	Yes	3	4	4	**4**	4
8	Feb 21	No	No	4	4	N/A	**4**	4
9	Jan 21	No	No	4	4	4	**4**	4
10	Jun 21	Yes	Yes	4	4	N/A	**4**	4
11	Feb 21	No	No	4	N/A	4	**4**	2
12	Oct 20	No	No	4	4	4	**4**	4
13	Mar 21	No	No	4	4	4	**4**	4
14	Mar 21	No	No	4	N/A	4	**4**	4
15	Mar 21	No	No	4	4	4	**4**	4
16	Jul 21	Yes	No	4	4	4	**4**	4
Median Score				4	4	4	**4**	4

Table 1: Structured Judgemental Reviews (SJR) conducted in Q2 2021-2022

No recurrent themes have been identified in these reviews. One case scored a “2” for “Quality of Note Keeping”. This was a case where the reviewer was unable to locate the medical admission notes. There have been no other similar incidents identified previously by SJRs. 3 cases with documented Learning Disabilities are subject to a second external review as part of the LEDER process. Feedback from these will be provided in a future report.

3.4 Covid-19 Deaths

Table 2 show the hospital's Covid-19 mortality for Q1 and Q2 2021/22. Please note that this data uses the current NHS definition of a positive Covid-19 diagnosis and does not include data where Covid-19 is included on a death certificate based on clinical suspicion. The data in the 1st column titled "Total" represents all inpatients with a positive PCR test. The 2nd column "Death within 28 days" refers to deaths that occurred after hospital discharge and is therefore in addition to the in-hospital deaths shown in column 3. Unfortunately numbers of deaths from Covid have risen again in this quarter, reflecting the almost quadrupling of cases admitted.

Confirmed Covid-19 inpatient discharges (Apr-Jun 2021)				% (of patients)	
Age category	Total	Death within 28 days	Death in hospital	% Death within 28 days	% Death in hospital
6-17	0	0	0		
18-24	0	0	0		
25-34	4	0	0	0.0%	0.0%
35-44	3	0	0	0.0%	0.0%
45-54	7	0	1	0.0%	14.3%
55-64	1	0	0	0.0%	0.0%
65-74	5	0	0	0.0%	0.0%
75-84	9	0	0	0.0%	0.0%
85+	10	0	1	0.0%	10.0%
Total	**39**	**0**	**2**	**0.0%**	**5.1%**

Confirmed Covid-19 inpatient discharges (Jul-Sep 2021)				% (of patients)	
Age category	Total	Death within 28 days	Death in hospital	% Death within 28 days	% Death in hospital
0-5	11	0	0	0.0%	0.0%
6-17	11	0	0	0.0%	0.0%
18-24	4	0	0	0.0%	0.0%
25-34	19	0	0	0.0%	0.0%
35-44	24	0	0	0.0%	0.0%
45-54	15	0	0	0.0%	0.0%
55-64	26	2	1	7.7%	3.8%
65-74	17	0	2	0.0%	11.8%
75-84	15	1	2	6.7%	13.3%
85+	16	1	4	6.3%	25.0%
Total	**158**	**4**	**9**	**2.5%**	**5.7%**

Table 2: Covid19 deaths for admissions by Quarter, either whilst still an inpatient or after discharge but within 28 days of positive test. Note that "Confirmed Covid-19" relates to patients with a positive PCR test and excludes any patient with negative PCR results whose imaging and clinical impression was of suspected Covid-19.

3.5 Mortality after Cardiac Arrest

We have recently received or annual report from the National Cardiac Arrest Audit (NCAA). This analyses data from all cardiac arrest calls from 1st April 2020 to 31st March 2021. Figures 9-12 demonstrate some key findings from this report. A total of 32 cardiac arrests were recorded, down from the numbers seen in the previous 3 years (42-49). However the rates of arrest per 1000 admissions has remained constant, so this decline likely reflects the decreased activity levels seen during the Covid waves. Figure 9 shows our cardiac arrest rates in comparison to other hospitals:

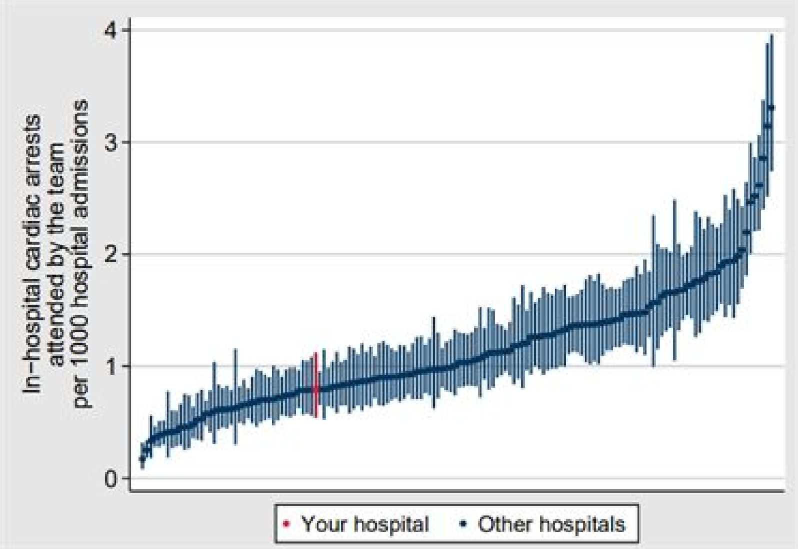


Figure 9: Rates of cardiac arrest from all participating hospitals. HDH is highlighted in red.

Figure 10 shows a breakdown of the age of patients having a cardiac arrest. It demonstrates that we see a higher proportion of cardiac arrest in an older population, which is in keeping with the demographic for our acute admissions.

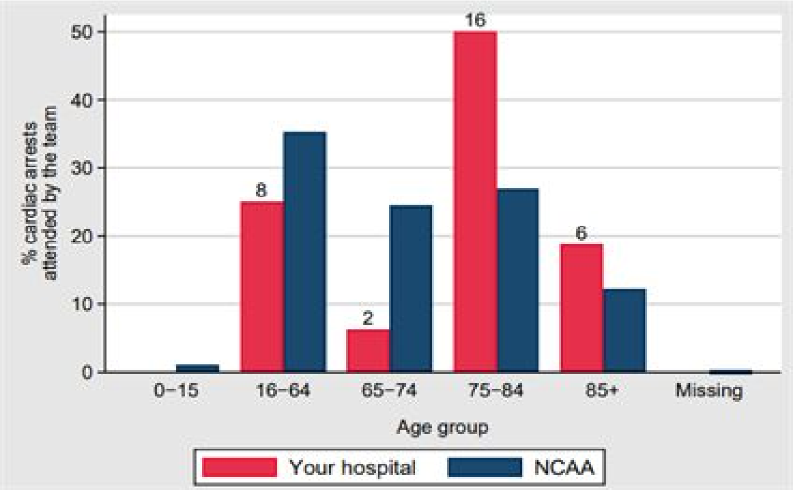


Figure 10: Breakdown of the age of patients having a cardiac arrest. HDH sees a higher proportion in the 75+ cohort than the national average

Figure 11 shows the rate of survival to hospital discharge following cardiac arrest. This data is risk adjusted to standardised for important predictors of survival such as the type and cause of cardiac arrest, previous co-morbidity and the age of the patient. HDH outcomes fall within the expected range.

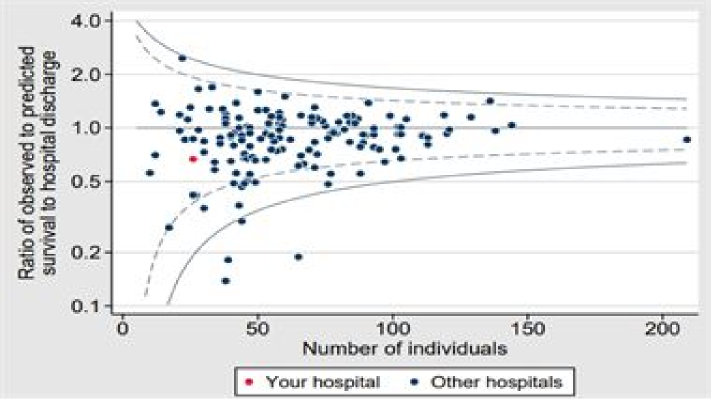


Figure 11: Risk adjusted rates of survival to hospital discharge following cardiac arrest.

Figure 12 gives more details of the outcomes of the 32 cardiac arrests. 14 patients were successfully resuscitated, but only 3 of these survived to leave hospital, an overall survival rate of only 9.4%. However 5 of the 14 were still in hospital at the close of this audit period, and I am pleased to report that all of them have been discharged with a good neurological outcome. This raises our overall survival rate to 25%, a figure in keeping with that seen in previous years.

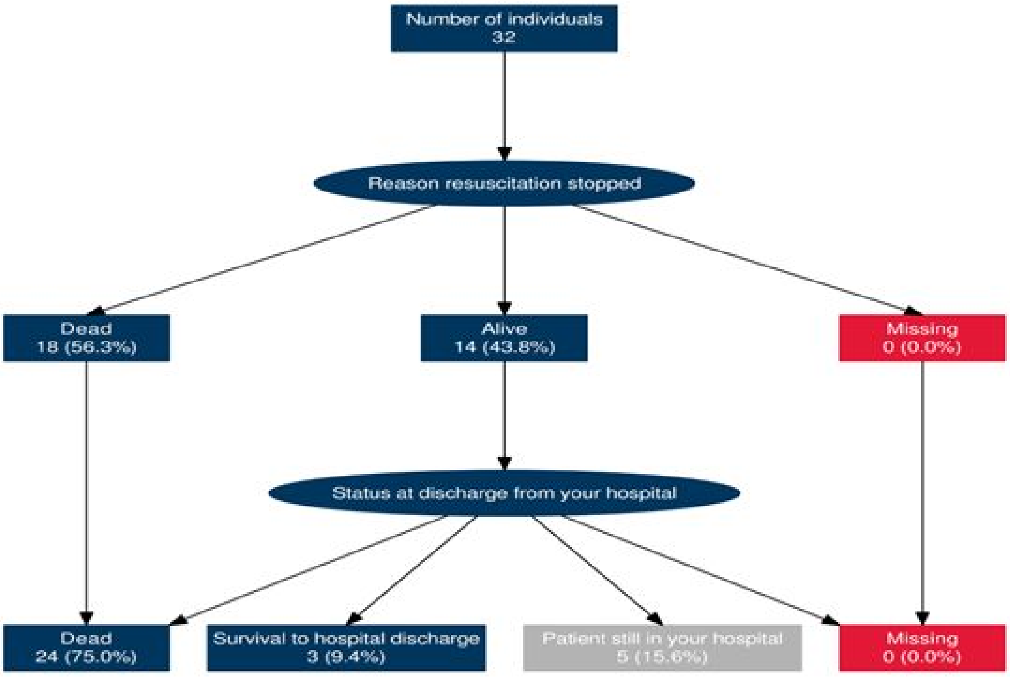

Number of individuals 32
Reason resuscitation stopped
Dead 18 (56.3%)
Alive 14 (43.8%)
Missing 0 (0.0%)
Status at discharge from your hospital
Dead 24 (75.0%)
Survival to hospital discharge 3 (9.4%)
Patient still in your hospital 5 (15.6%)
Missing 0 (0.0%)

Figure 12: Final outcomes from the 32 cardiac arrest patients

3.6 Excess Death in Patients with a Diagnosis of Pneumonia and Stroke

2 previous HMSR amber alerts had been received related to excess deaths in patients with a coding of “Pneumonia”. 11 cases with the lowest predicted mortality have been reviewed using the SJR process. No lapses in care were apparent. Some general observations were noted:

- A number of cases were incorrectly assigned to this category (eg. disseminated malignancy, chronic rejection of a lung transplant, heart failure)
- Pneumonia is often the final condition in the extremely frail
- There was evidence of good communication with families regarding treatment choices and expectations

2 cases with a diagnosis of stroke were also scrutinised, to complete the investigation reported in the Q1 Learning from Deaths report. Both these cases did not show any lapses of care, and each had significant comorbidities including severe frailty.

3.7 Medical Examiner Service

We have now been able to obtain data from all Medical Examiner Offices in the North of England. Table 3 shows the performance of HDFT’s Medical Examiner team benchmarked against our regional colleagues. This confirms that we are performing well above the regional average in 3 of the most significant metrics.

	Q1		Q2	
	Regional	HDFT	Regional	HDFT
Deaths Scrutinised	**5205/7915 (66%)**	**147/147 (100%)**	**6772/9527 (71%)**	**179/179 (100%)**
Death certificate takes longer than 3 days	**663 (13%)**	**6 (4%)**	**650 (10%)**	**2 (1%)**
Death certificate rejected by Registrar	**27 (0.7%)**	**0**	**34 (0.7%)**	**0**

Table 3: Performance of HDFT Medical Examiner team compared to the Regional Average

4.0 Future Plans and Learning

There have been no new mortality alerts issued this quarter based on HSMR or SHMI. As part of an ongoing Quality Improvement project, SJRs and additional interrogation will be applied to patients identified as dying from sepsis. This will be used to guide implementation of new international guidelines on the management of sepsis.

Dr Martin Huntley, Clinical Lead for Critical Care, is interrogating the rise in Critical Care mortality as detailed in the Q1 Learning from Deaths report. He is in contact with the ICNARC team to explore the possible reasons for the unusual pattern and whether any interventions are warranted.

Learning from Deaths will be one of the key data sources behind our “Learning at our Best” program, which looks to triangulate information from a variety of sources to create a strong learning culture across HDFT.

5.0 Recommendation

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

Board of Directors (Public)
24th November 2021

Title:	**Infection Prevention Control Annual Report 2020-21**
Responsible Director:	Executive Medical Director
Author:	Dr Lauren Heath (Consultant Microbiologist and Infection Control Doctor)

Purpose of the report and summary of key issues:	The report provides the Trust Board with key updates and actions that have taken place during 2020-21 in relation to Infection Prevention and Control.	
BAF Risk:	AIM 1: To be an outstanding place to work	
	BAF1.1 to be an outstanding place to work	
	BAF1.2 To be an inclusive employer where diversity is celebrated and valued	
	AIM 2: To work with partners to deliver integrated care	
	BAF2.1 To improve population health and wellbeing, provide integrated care and to support primary care	X
	BAF2.2 To be an active partner in population health and the transformation of health inequalities	X
	AIM 3: To deliver high quality care	
	BAF3.1 and 3.4 To provide outstanding care and outstanding patient experience	X
	BAF3.2 To provide a high quality service	X
	BAF3.3 To provide high quality care to children and young people in adults community services	X
	BAF3.5 To provide high quality public health 0-19 services	X
	AIM 4: To ensure clinical and financial sustainability	
	BAF4.1 To continually improve services we provide to our population in a way that are more efficient	X
	BAF4.2 and 4.3 To provide high quality care and to be a financially sustainable organisation	
	BAF4.4 To be financially stable to provide outstanding quality of care	
Corporate Risks	All	
Report History:	This report has been discussed in internal governance structures.	
Recommendation:	The Board is asked to note this report, and identify any areas in which further assurance is required, which is not covered in the Board papers.	

Infection Prevention and Control Annual Report

2020-2021

teamHDFT
At our best

NHS
Harrogate and District
NHS Foundation Trust

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13. IPCT annual work plan and progress report 2021-22 12

1. Executive Summary

This annual report covers a period of unprecedented challenge in the wider NHS and locally at HDFT. The COVID-19 pandemic resulted in rapid trust-wide changes to the delivery of healthcare. IPC practice remained at the heart of these changes but there was unavoidable disruption to routine investigation and reporting arrangements.

This report consists of three parts: the performance related to Infection Prevention and Control (IPC), the IPC progress report against the annual plan for 2020-2021 and the annual plan of work for 2021-2022 to reduce the risk of Healthcare Associated Infections (HCAI's).

The annual report also explains the role, function and current reporting arrangements of the Director of Infection Prevention and Control (DIPC) and the Infection Prevention and Control Team (IPCT).

The following infections are subject to mandatory reporting to Public Health England (PHE) (as was, from the 1st October 2021 is now the UK Health Security Agency-UKHSA):

- Methicillin Resistant *Staphylococcus aureus* (MRSA) Bloodstream infection (BSI)
- Methicillin Sensitive *Staphylococcus aureus* (MSSA) BSI
- *Clostridioides difficile* infections (CDI)
- *Escherichia coli* (E.coli) BSI
- *Klebsiella sp*. BSI
- *Pseudomonas aeruginosa* BSI
- Vancomycin Resistant Enterococcal (VRE) BSI

2. Achievements against the national HCAI objectives

In 2020-2021 NHSE did not publish any national HCAI objectives. The IPC team and DIPC agreed to use the objectives set for the previous year.

- MRSA – Continued zero tolerance to all MRSA bacteraemia's
- CDI – Objective of 19 Trust-apportioned cases

2.1 MRSA BSI

Table 1: Trust apportioned MRSA BSI

HDFT	**2020-2021**
	0

The last Trust apportioned case of MRSA BSI at HDFT was in 2013.

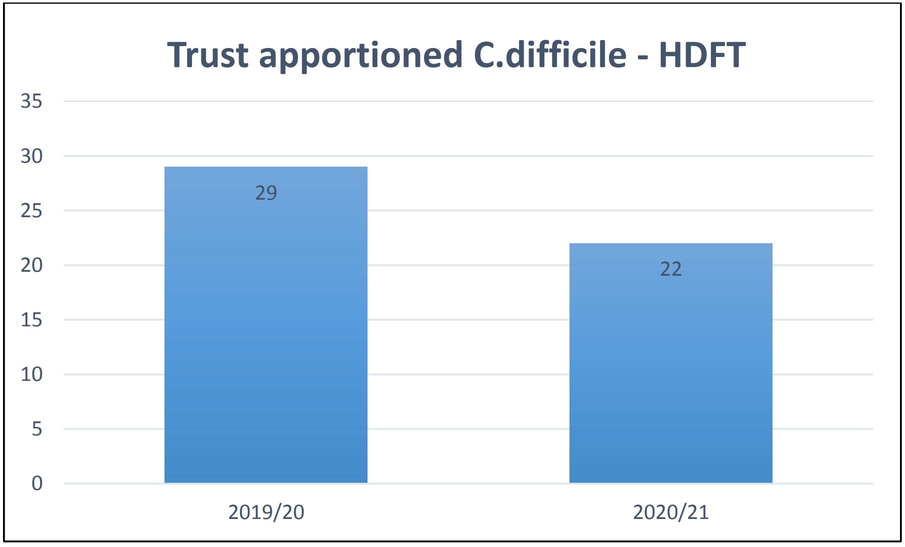
2.2 *Clostridioides difficile* infection

The *C.difficile* objective includes all healthcare associated *C.difficile* infections, this includes:

HOHA – Hospital onset healthcare associated cases. These are cases detected in the hospital three or more days after admission (Day of admission = day 1)

COHA – Community onset healthcare associated cases. These are cases that are detected in the community (or within 2 days of admission) when the patient has been an inpatient in the trust reporting the case in the previous 4 weeks.

Figure 1:



	2019/20	2020/21
HOHA	23	18
COHA	6	4
NHSE objective	19	19

There was a reduction of 7 cases in comparison to the previous year however, the total number of cases was still above the last objective set by NHSE.

These numbers reflect the total number of cases diagnosed and do not take into account whether the case was deemed “unavoidable” (i.e. no contributory lapse in care identified) by the CCG. The national guidelines state that even “unavoidable” cases must remain within the reported numbers.

The monthly CDI review meetings with the CCG were suspended for much of 2020-2021. The meetings resumed on 9/3/21.

Table 2: Summary of CDI Lapse in Care decisions

Case Number	Date positive stool sample	CCG Lapse in Care decision	Internal (IPCT) Lapse in Care decision
1	30/4/20	Not reviewed by the CCG	Unavoidable
2	25/5/20		Unavoidable
3	28/5/20		Unavoidable
4	22/6/20		Unavoidable
5	23/6/20		Post infection review missed
6	21/8/20		Avoidable – concurrent prescription of two high-risk antibiotics
7	28/8/20		Unavoidable
8	15/9/20		Unavoidable
9	28/10/20		Unavoidable
10	12/11/20		Unavoidable
11	11/12/20		Unavoidable
12	23/12/20		Unavoidable
13	5/1/21	Unavoidable	
14	14/2/21	Inconclusive – Unable to obtain enough information regarding antibiotic prescribing decision	
15	19/2/21	Unavoidable	
16	19/2/21	Unavoidable	
17	27/2/21	Avoidable (Outbreak case)	
18	6/3/21	Unavoidable	
19	16/3/21	Unavoidable	
20	1/3/21	Unavoidable	
21	19/3/21	Unavoidable	
22	25/3/21	Avoidable (Outbreak case)	

It is reassuring to see that the majority of cases were deemed to be unavoidable without a contributory lapse in care.

3. Infection Prevention and Control Team

The role of Director of Infection Prevention and Control was assigned to Jill Foster (Chief Nurse). Upon leaving the Trust in March 2021, Dr Jacqueline Andrews (Medical Director) was appointed as interim DIPC. HDFT does not have a deputy DIPC but does have a specified Infection Control Doctor(ICD). Dr Lauren Heath (Consultant Microbiologist) took over the role of ICD in April 2020.

The Infection Prevention and Control Team provides a service during weekdays from 9am to 5pm. They provide an on-call service on weekends and bank holidays between 9am and 4pm. Out of hours the Clinical Site Managers have been trained to deal with the most common IPC scenario's, they escalate any issues outside of their expertise to the on-call Consultant Microbiologist.

The IPC team is divided into a hospital and community team and consists of:

Hospital Team	
	Role
X1	Matron for Infection Prevention and Control
X1	IPC Nurse (Team Lead)
X3	IPC Nurses
X2	IPC Support Nurse
X2	Infection Surveillance Officers
X1	Infection Control Educator
X1	IPC Secretary

North Yorkshire & York Community Infection Prevention & Control Team	
Name	**Role**
X1	Team Lead IPC Nurse
X2	IPC Nurses
X1	IPC Education Resource Specialist
X1	IPC Administrator

The Matron for IPC covers both the hospital and community teams.

4. Governance and Monitoring

The Board of Directors has collective responsibility for keeping to a minimum the risk of infection and recognises its responsibility for overseeing the IPC arrangements in the Trust. The DIPC and ICD deliver the annual IPC plan and report to the Board of Directors based upon the national and local quality goals.

4.1 Infection Prevention and Control Committee (IPCC)

The IPCC is chaired by the DIPC and held on a monthly basis. The IPCC provides a forum to set the IPC strategy for the Trust and to monitor compliance with the annual IPC plan.

At the height of the COVID-19 pandemic in 20-21 the IPCC was temporarily suspended with IPC strategic and operational decision making instead being routed via Trust Gold, Silver and Bronze incident command teams.

External Reporting Arrangements

5.1 Mandatory Surveillance

The IPCT undertakes continuous surveillance of target organisms and alert conditions. Pathogenic organisms or specific infections, which could spread are identified from microbiology reports or notifications from the Consultant Microbiologists or ward staff.

The IPCT advises on the appropriate use of infection control precautions for each case and supports ward staff in caring for these patients safely.

In addition to submitting data to support the national HCAI objectives (*C.difficile* and MRSA BSI) the Trust also submits data to PHE/UKHSA on:

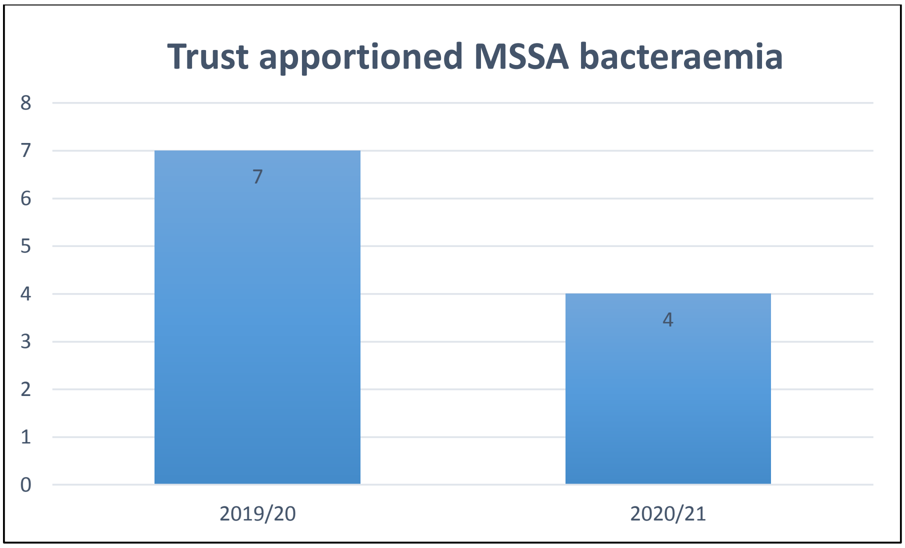
- Methicillin Sensitive Staphylococcus aureus (MSSA) BSI
- *E.coli* BSI
- *Klebsiella sp.* BSI
- *Pseudomonas aeruginosa* BSI

The data is submitted each month to PHE/UKHSA via an online Healthcare Associated Infection Data Capture System (DCS).

5.2 MSSA

There is no national objective set for MSSA bacteraemia. Data in Figure 2 indicates there were a total of 4 trust apportioned cases in 2020-21. This is a reduction compared to 7 cases in 2019-2020.

Figure 2:



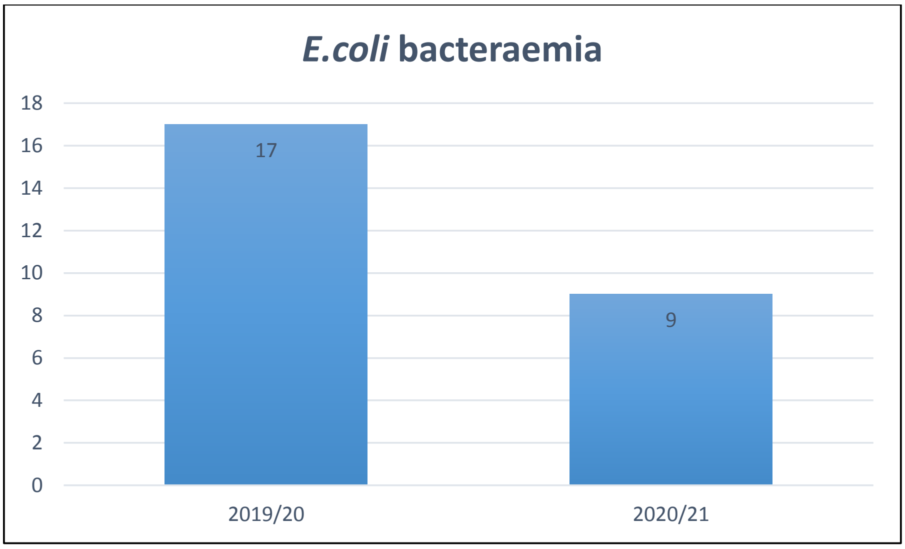
5.3 Gram negative blood stream infections (includes *E.coli*, *Klebsiella sp.* and *Pseudomonas aeruginosa*)

There is a national ambition to reduce healthcare associated Gram-negative blood stream infections by 50% by March 2021.

E.coli

E.coli are common causes of urinary tract and intra-abdominal infection. They can be associated with a wide range of healthcare associated infections including intravascular line infections, urinary catheter related infections, surgical site infections and pneumonia.

Figure 3:

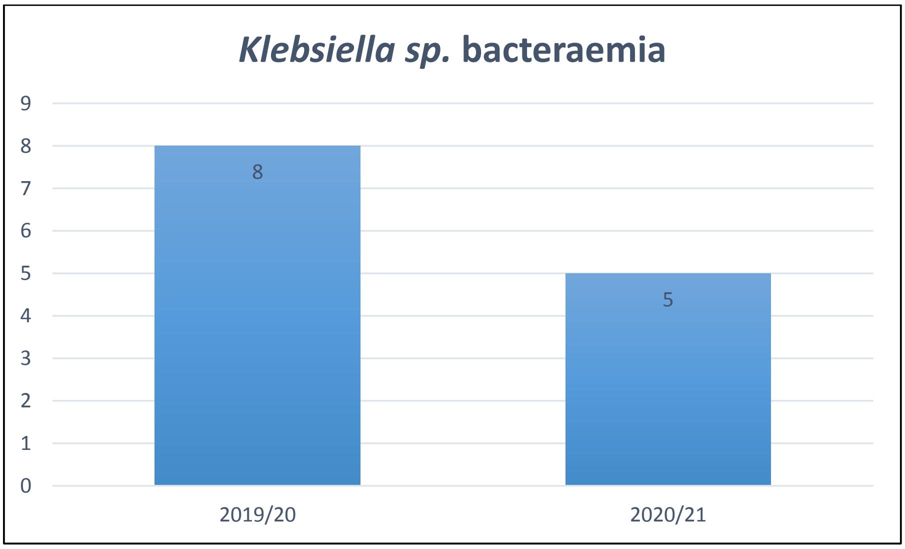


There has been a reduction in the number of trust-apportioned cases in comparison with the previous year. This is likely at least in part to be due to the COVID-19 pandemic.

Klebsiella sp.

Klebsiella sp. belong to the same family as *E.coli*. Infection with Klebsiella sp. is uncommon in immunocompetent people. They tend to be associated with opportunistic infection in patients with a compromised immune system and healthcare acquired infections.

Figure 4:



There was a small reduction in the number of trust-apportioned *Klebsiella sp.* bacteraemia's from the previous year.

Pseudomonas aeruginosa

Pseudomonas aeruginosa is a type of bacteria found commonly in the environment, including soil, water and moist environments. It is common for hospitalised patients to become colonised with Pseudomonas at moist sites (for example chronic ulcers). It is an opportunistic pathogen which tends to cause infection in patients with compromised immune systems. Very low numbers of healthcare acquired Pseudomonas bacteraemia are seen at HDFT and this has remained stable over the last two years with 0 cases in 2019/20 and a single case in 2020/21.

5.4 Surgical Site Infection (SSI) Surveillance

The Trust participates in the mandatory surveillance of elective orthopaedic surgery. For the 2020 programme, SSI following fracture neck of femur was selected. Surveillance was undertaken between July and September. 62 operations were performed for fracture neck of femur repair. The number of SSI identified was 0 (0%). This is better than the national average of 1.1%.

6. Education

The educational programme delivered by the IPCT was disrupted during this pandemic year. The popular PIC (Preventing Infection Course) was cancelled. Releasing staff from front-line service was challenging and so the IPCT developed "toolbox talks". These were 10 minute focused education sessions, delivered on wards on a regular basis. The focus was on COVID-19 and the correct use of personal protective equipment (PPE).

7. Policies and Guidelines

The Trust has IPCT policies and guidelines in place which are aligned to the Health and Social Care Act. Policies are available on the Trust intranet. The routine review of policies was put on hold due to the pressures of COVID-19. All policies were "in-date". The IPCT focused on producing local COVID-19 guidance in line with the frequently changing national guidance. The IPCT had just begun work on producing "guidance on a page" to accompany policies when the pandemic commenced and this work is therefore still ongoing.

8. Audit Programme

There is a comprehensive IPC audit programme in place at HDFT. This includes audits undertaken by the clinical staff on their wards and also audits undertaken by the IPC team. Audit results are reviewed at the monthly Hospital Infection Prevention and Control Team meeting (HIPCT) and concerns are escalated to the IPCC.

Table 3 summarises the different audits undertaken in 20-21:

Audit	Frequency	Performed by	Notes
Source isolation equipment	Annual	IPCT	
Cleanliness of patient fans	Annual	IPCT	
Commode/raised toilet seat	Monthly	Ward Hygienist	
Point of use water filters	Monthly	Ward Hygienist	Results reported to Water Safety Group
IPCQAT (see below)	Monthly	Ward Managers	Suspended at the request of the DIPC. Recommenced February 2021
IV cannula	Monthly	IPCT	

IPCQAT (Infection Prevention and Control Quality Assurance Tool) is the main audit covering compliance with IPC standard precautions including hand hygiene. This tool has now been rolled out to non-ward departments (for example outpatients, radiology etc.)

9. Antibiotic Stewardship

The Trust Leads for Antimicrobial Stewardship is Dr Katharine Scott (Consultant Microbiologist) and Paul Golightly (Lead Antimicrobial Pharmacist). Antimicrobial prescribing audits are completed quarterly. The results are presented at the Antimicrobial Prescribing Sub Group (APSG) which reports to the Antimicrobial Prescribing Committee (APC).

10. Hand Hygiene Promotional Activity

The IPCT use the “glow and show” box to teach correct hand hygiene technique. This gives the staff member immediate visual feedback on the effectiveness of their technique. It is a technique that has evaluated well in previous years but has not been used during this pandemic year because of the restrictions on face-to-face training sessions.

The IPCT were unable to participate in the October 2020 Global Hand Hygiene Awareness Campaign due to the demands on the team. They have participated in previous years and will be aiming to participate in 2021.

11. Incidents and Outbreaks

a. *Serratia marcescens* outbreak in Critical Care

A Level 2 outbreak of *Serratia marcescens* in Critical Care was identified in March 2021. Four patients acquired *Serratia marcescens* whilst on our critical care unit. An Outbreak Control Group (OCG) was formed to investigate the root cause of the outbreak and instigate measures to prevent further transmission. The OCG concluded that the outbreak occurred due to a relaxation of IPC precautions brought about by the COVID-19 pandemic (i.e. long-sleeve gowns worn sessionally in critical care when prior to the pandemic staff would have been bare below the elbow), the temporary move to the acute medical unit (AMU) and the significantly increased workload caused by the 2nd wave of COVID-19. The outbreak was brought under control by enhanced cleaning of equipment between use on different patients and the reintroduction of bed-specific colour coded aprons.

11.2 COVID-19

The first case of COVID-19 (Community onset case) was diagnosed at HDFT on 12th March 2020.

The IPC team has been engaged at both strategic and operational levels to support the Trust in the prevention and management of patients with COVID-19. The IPC team has provided Trust specific guidance and policy based on the available national guidelines produced by PHE and NHSE.

The IPCT have worked with colleagues in the IT department to create a live COVID-19 results reporting database. This has enabled the rapid communication of COVID-19 PCR results and also facilitated in the surveillance and early detection of hospital COVID-19 outbreaks.

The acquisition of COVID-19 is split into four categories:

- Community onset – Positive PCR on days 0-2 of admission
- Indeterminate onset – Positive PCR on days 3-7 of admission
- Hospital onset, probable healthcare acquired – Positive PCR on days 8-14 of admission
- Hospital onset, definite healthcare acquired – Positive PCR on day 15+ of admission

Table 4: Healthcare (HDFT) acquired COVID-19 (2020-21)

	Probable healthcare acquired	**Definite Healthcare acquired**
Cases	63	68

Hospital Outbreaks:

Date	**Ward**	**Patient Cases**	**Staff Cases**
25/5/20	Jervaulx	24	11
26/6/20	Byland/Jervaulx	2	0
23/11/20	Granby	1	3
24/11/20	Oakdale	11	5
7/12/20	Dermatology	0	5
21/1/21	Jervaulx	29	4
25/1/21	Oakdale	16	7
30/1/21	Littondale	4	0
30/1/21	Rowan	13	5
1/2/21	Byland	21	8
11/2/21	Trinity	10	6
3/3/21	Granby	3	1
	Total	**134**	**55**

The IPC team worked with the Trust Risk Management department to produce a Serious Incident report describing the hospital COVID-19 outbreaks and analysed the care of patients who acquired COVID-19 whilst in our care.

13.3 Influenza

No cases of Influenza A or B were diagnosed at HDFT in 2020-2021. The population measures put in place to manage the spread of COVID-19 had the additional affect of preventing transmission of many other seasonal respiratory viruses including Influenza. This phenomenon was seen nationwide.

13.4 Carbapenemase producing Enterobacteriaceae (CPE)

CPE are multiple resistant strains of bacteria which are carried harmlessly in the bowel. These bacteria can cause infections if transferred to another site on the body e.g. urinary tract or bloodstream. The antibiotics available to treat such infections are limited which increases the risk of treatment failure.

HDFT has a comprehensive screening programme in accordance with national guidelines produced by PHE.

The IPCT are alerted to new CPE positive patients directly by the Microbiology Biomedical Scientists.

14. IPCT annual work plan and progress report 2020-2021

Amended IPC
Service Annual Plan

15. IPCT annual work plan for 2021-22

Infection
Prevention and Con

Report Prepared by:
Dr Lauren Heath (Consultant Microbiologist and Infection Control Doctor)
On behalf of Dr Jacqueline Andrews (Medical Director and DIPC)

Harrogate and District
NHS Foundation Trust

Board Committee Report to the Board of Directors

Committee Name:	People and Culture Committee
Committee Chair:	Jeremy Cross
Date of meeting:	15 November 2021
Date of Board meeting this report is to be presented	24 November 2021

Summary of key issues

- We had an excellent presentation and discussion around the Allyship programme – both from the team at Leeds who are running the course and also from some of the attendees in Harrogate. The learnings for the people who attended were significant – and this will form a key part of our Anti Racist work in the future
- We received an update from the people team on the people plan initiatives. There is a lot of work ongoing. The metrics highlighted that sickness levels have increased significantly in the last 2 months, and also that the turnover figure has increased – though below the 15% threshold we have set ourselves. While the vacancy remains in our ED&I lead, we are looking to appoint outside specialists to cover some of the outstanding work.
- We had a discussion around Exit Interviews – there is a very low uptake of the offer for these (only 7 out of 500 leavers in the past period had a formal interview). The committee made a number of suggestions to feed in to the ongoing work in this area – including the importance of being able to nominate someone other than your immediate line manager to lead the interview. We will monitor this metric going forwards
- The number reported for completed Thrive (wellbeing) discussions was <1% against a target of 100%. While there is not yet confidence in the reporting figure shown, it was noted that this is very low, and yet the well being discussions were a key part of the appraisal process that has been changed recently. Again, this will be a metric that the committee will monitor.
- We received an update on the Culture Programme – good progress was being made on a number of fronts
- We were pleased to meet the new chair of the disability staff network, and hear the energy she was bringing to this role. We had an update from the BAME network chair. There was no representation from the LGBT+ network, and we had to receive an update on the Freedom to Speak Up process from the CEO

- We had an update from the COO on the work in ED to make sure that it was a safe place to work. The use of worn cameras has started with clear protocols for when they are to be deployed. They have been needed 3 times so far. Again, we agreed that we will receive a more regular briefing from the COO on this piece of work – and wider ED safety.
- We received the first report from the Inpulse survey that has been rolled out. The data was very rich – including a lot of verbatim comments that made the report more understandable. While the HR team are providing tools and training to assist departments with low scores, it was agreed that it remains really important for the line management of each area to take responsibility in addressing where there are issues.
- There were some encouraging early signs from some of the work in intervening during the job application process, where it was possible that BAME applicants were underrepresented. From an admittedly small sample, initial results showed both an increase in BAME shortlisted candidates AND (despite no further intervention) in actual appointment. This are encouraging first signs.
- We had 2 governors attend the meeting – Steve Treece and Andrew Jackson, both of whom gave encouraging feedback at the end of the meeting

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

- We will need to monitor the progress on the Exit Interview process
- The risks on sickness and turnover are already well documented, but we need to continue to monitor the status of these metrics

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

- None

Integrated Board Report - October 2021

Domain 4 - Workforce

Indicator	**4.1 - Staff appraisal rate**
Executive lead	Angela Wilkinson
Board Committee	People and Culture Committee
Reporting month	Oct-21
Value / RAG rating	🟥 52.8%

Indicator description

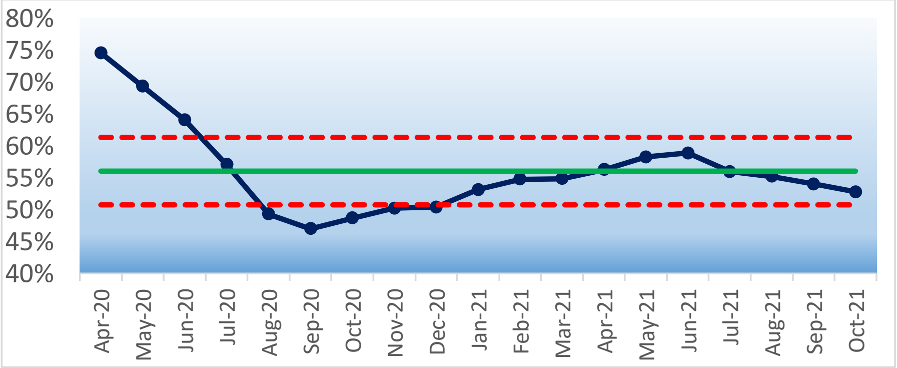
The number of staff who had an appraisal within the last 12 months. The Trust aims to have 90% of staff appraised.

Narrative

The appraisal rate in October is 52.8%, which is a small decrease from September (54.0%).

- Non-Medical appraisal % = 51.7% (previous month 53.1%)
- Medical appraisal % = 63.6% (previous month 64.0%)

SPC chart



Indicator	**4.2 - Mandatory training rate**
Executive lead	Angela Wilkinson
Board Committee	People and Culture Committee
Reporting month	Oct-21
Value / RAG rating	🟩 86.0%

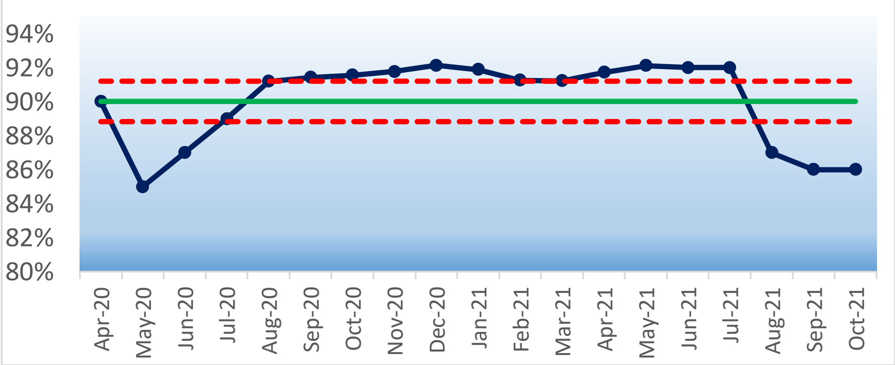
Indicator description

Latest position on the % of substantive staff trained for each mandatory training requirement

Narrative

The overall training rate for mandatory elements for substantive staff is 85% and has increased by 1% since the last reporting cycle.

SPC chart

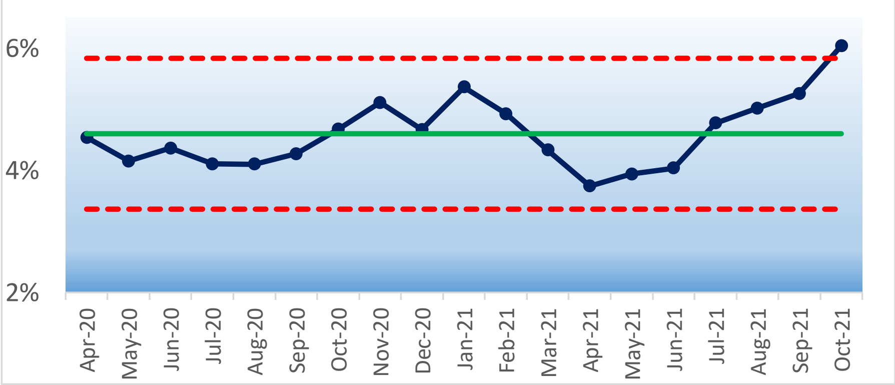


Indicator	**4.3 - Staff sickness rate**
Executive lead	Angela Wilkinson
Board Committee	People and Culture Committee
Reporting month	Oct-21
Value / RAG rating	6.0%

Indicator description

Staff sickness rate - includes short and long term sickness. The Trust has set a threshold of 3.9%.

SPC chart



Narrative

The Trust’s sickness rate continues to see an increasing trend. The sickness rate in October is 6.0%. Excluding Covid sickness, the rate for October is 5.5% which is an increase from 4.7% last month. Covid related sickness remains at a similar level compared to last month, with a slight decrease from 0.6% in September to 0.5% in October.

Short term sickness has seen a significant increase from 1.6% in September to 2.4% this month, which has contributed to the overall increase in sickness rates in October. Long term sickness remains at a steady level this month at 3.7%. The areas with the greatest increase in sickness in October are Children’s Services – Darlington, Children's Immunisation and Therapy Services in PSC Directorate.

“S10 Anxiety/stress/depression/other psychiatric illnesses” remains the top reason for sickness this month, which accounts for 31% of the overall sickness in October.

“S15 Chest & respiratory problems” is the top reason for short term sickness.

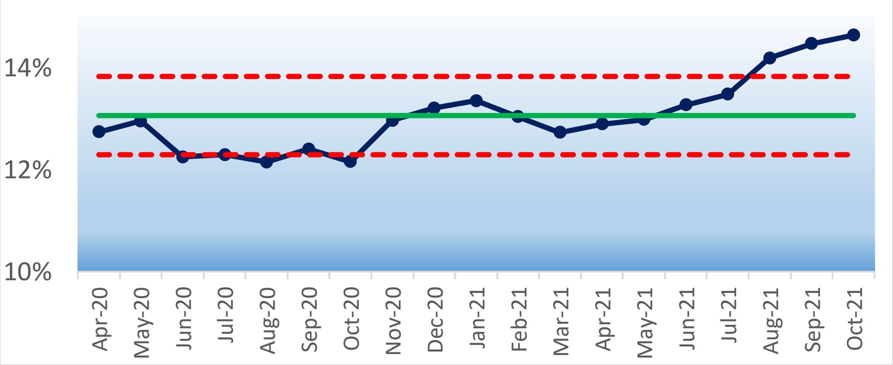
All staff groups have seen an increase in sickness rates in October, however it is the ‘Nursing and Midwifery Registered’ and ‘Additional Clinical Services’ that continue to see the highest rates of sickness.

Indicator	**4.4 Staff turnover rate**
Executive lead	Angela Wilkinson
Board Committee	People and Culture Committee
Reporting month	Oct-21
Value / RAG rating	14.6%

Indicator description

The staff turnover rate excluding trainee doctors, bank staff and staff on fixed term contracts. The turnover figures include both voluntary and involuntary turnover. Data from the Times Top 100 Employers indicated a turnover rate norm of 15%.

SPC chart



Narrative

Turnover has seen a further increase this month from 14.5% in September to 14.6%, however this remains below the Trust threshold of 15%.

The breakdown of turnover in October is 4.0% due to involuntary terminations and 10.6% due to voluntary terminations. Whilst the voluntary resignation rate has increased from last month, the involuntary resignation rate has decreased.

Based on areas with a headcount of over 20 employees, the areas with high levels of turnover are Theatres (29.9%), Acute Paediatrics (27.6%) and Endoscopy (23.7%).

The ‘Nursing and Midwifery Registered’ staff group continues to have a very high turnover rate in October, with a rate of 17.0%. This equates to 274 leavers. 68% of the terminations were voluntary resignations, with the top known reasons being ‘Work Life Balance’ and ‘Relocation’.

The staff group with the greatest increase in turnover in comparison to the previous month is within the ‘Additional Clinical Services’ staff group and turnover in October is 15.6%. The areas that have seen the greatest increase in turnover this month in this staff group were Endoscopy and Radiology.

Indicator	**4.5 - Children's Services - 0-5 Service - vacancies**
Executive lead	Angela Wilkinson
Board Committee	People and Culture Committee
Reporting month	
Value / RAG rating	

Indicator description

This indicator is under development.

SPC chart

Narrative

Indicator	**4.6 - Workforce Race Equality Standard (WRES) - Relative likelihood of staff being shortlisted across all posts**
Executive lead	Angela Wilkinson
Board Committee	People and Culture Committee
Reporting month	
Value / RAG rating	

Indicator description

This indicator is under development.

SPC chart

Narrative

Indicator	**4.7 - Workforce Race Equality Standard (WRES) - Relative likelihood of staff being appointed across all posts**
Executive lead	Angela Wilkinson
Board Committee	People and Culture Committee
Reporting month	
Value / RAG rating	

Indicator description

This indicator is under development.

SPC chart

Narrative

Board of Directors Meeting
24th November 2021

Title:	**Director of Workforce & OD Report**
Responsible Director:	Director of Workforce & OD
Author:	Deputy Director of Workforce & OD

Purpose of the report and summary of key issues:	This report details Workforce priorities in terms of:- • Major Actions Commissioned and Actions underway • Positive News and Assurance • Any Matters of Concerns and Risks to Escalate	
BAF Risk:	AIM 1: To be an outstanding place to work	
	BAF1.1 to be an outstanding place to work	x
	BAF1.2 To be an inclusive employer where diversity is celebrated and valued	x
	AIM 2: To work with partners to deliver integrated care	
	BAF2.1 To improve population health and wellbeing, provide integrated care and to support primary care	
	BAF2.2 To be an active partner in population health and the transformation of health inequalities	
	AIM 3: To deliver high quality care	
	BAF3.1 and 3.4 To provide outstanding care and outstanding patient experience	
	BAF3.2 To provide a high quality service	
	BAF3.3 To provide high quality care to children and young people in adults community services	
	BAF3.5 To provide high quality public health 0-19 services	
	AIM 4: To ensure clinical and financial sustainability	
	BAF4.1 To continually improve services we provide to our population in a way that are more efficient	
	BAF4.2 and 4.3 To provide high quality care and to be a financially sustainable organisation	
	BAF4.4 To be financially stable to provide outstanding quality of care	
Corporate Risks	As detailed within the report.	
Report History:	October and November SMT	
Recommendation:	The Board of Directors are requested to receive and accept this report.	

Director of Workforce and OD Report

Harrogate and District
NHS Foundation Trust

Matters of concern & risks to escalate

Workforce Matters

- Demand and capacity imbalance continuing to impact upon service delivery across occupational health, EDI and HR operations in particular a shortage of applicants and skills in the marketplace also impacting .

Sickness Absence

- The Trust's sickness rate continues to see an increasing trend. The sickness rate in October is 6.04%
- Excluding Covid sickness the Trust sickness rate for October is 5.51% which is an increase from 4.70% last month
- Covid related sickness remains at a similar level compared to last month, with a slight decrease from 0.56% in September to 0.54% in October. The staff group with the highest Covid sickness rate is 'Administrative and Clerical', with a rate of 0.88%.
- Short term sickness has seen a significant increase from 1.63% in September to 2.38% this month, which has contributed to the overall increase in sickness rates in October. Long term sickness remains at steady level this month compared to last, with a small increase from 3.63% to 3.66%.
- All Directorates have a notable increase to sickness rates in October in comparison to last month, with the Planned and Surgical Directorate seeing the greatest increase of 1.20%, taking the Directorate to a sickness rate of 6.61%.

Turnover

- Turnover has seen a further increase this month from 14.47% in September to 14.64%, however this remains below the Trust threshold of 15%.
- Turnover has increased the greatest within Endoscopy and Outpatients this month in comparison to September turnover figures.

Major actions commissioned & work underway

Workforce Matters

- Workforce resilience group convened to review measuers to support and maintain workforce during winter
- Flexible Working Policy updated to reflect legislative changes
- Remote and Agile Working Policy approved for implementation by Partnership Forum. Webinars being arranged to brief managers.
- Theatres Investigation ongoing – conduct issues highlighted being managed in accordance with Trust Policies and Procedures
- Potential industrial action discussions underway – GMB (dispute regarding national pay award)
- Support to Chair recruitment underway
- Long Service Awards planning undeway

Director of Workforce and OD Report

Harrogate and District
NHS Foundation Trust

Positive news & assurance	Decisions made & decisions required of the Board
HealthRoster and MSS • 44 Wards / Departments have transferred across to HealthRoster. • 1,467 employees and 194 managers and supervisors have transferred onto MSS.	• No decisions required of the Board.

Board Assurance Framework

1. STRATEGIC OBJECTIVE: TO BE AN OUTSTANDING PLACE TO WORK

Risk ID	Principle Objective	Principle Risk to the Delivery of Objective	Inherent Risk Rating			Residual (Current) Risk Rating			Target Risk Score	Target Date Risk Score will be met/closed	Corporate Risks Linked to BAF	Positive Assurance			Gaps in Assurances/Controls	Responsible Committee	Lead Executive Director	November 2021 Updates
			Likelihood	Conseq	Rating	Likelihood	Conseq	Rating				Existing Key Controls	Internal	External				
BAF#1.1	To be an outstanding place to work	There is a risk HDFT's culture will be compromised due to an insufficient focus on the culture of the Trust and the health and wellbeing of staff.	3	4	12	3	4	12	2x4=8	Apr-22	CRR6 – Wellbeing of Staff	Your Voice Vision and Values Programme which incorporates multiple improvement projects/programmes of work First Line Leaders Programme and other development programmes Shadow SMT Reverse mentoring programme EDI work programme Inpulse Survey and Analysis	Board of Directors Senior Management Team People and Culture Committee	Staff Survey Action Plan	Cultural programmes in place and are being embedded. Data is being analysed by directorates and managers. Actions are being reviewed and implemented. Presentation was made by each directorate at November SMT. Analysis to assess the impacted on these and to determine how well embedded the cultural programmes are in HDFT and HIF remains outstanding.	People and Culture Committee	A Wilkinson, Director of Workforce and OD	Target risk score amended from 2x2=4 to 2x4=8. The consequence rating has been amended inline with the inherent and current risk. Additional mitigation included – inpulse survey analysis Reassessment of gaps in control to reflect the current conditions.
BAF#1.2	To be an inclusive employer where diversity is celebrated and valued.	There is a risk that HDFT's culture may be compromised due to a lack of diversity.	4	5	20	3	4	12	2x4=8	Apr-22	CRR6 – Wellbeing of staff	Your Voice Vision and Values Programme which incorporates multiple improvement projects/programmes of work First Line Leaders Programme and other development programmes Shadow SMT Reverse mentoring programme EDI work programme Inpulse Survey and Analysis	Board of Directors SMT People and Culture Committee	Staff Survey	EDI programme governance paused, a need to re-establish	People and Culture Committee	A Wilkinson, Director of Workforce and OD	EDI programme governance remains paused with work continuing with an external organisation to mitigate risk.

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

Risk ID	Principle Objective	Principle Risk to the Delivery of Objective	Inherent Risk Rating			Residual (Current) Risk Rating			Target Risk Score	Target Date Risk Score will be met/closed	Corporate Risk Register	Assurances in Controls			Gaps in Assurances/Controls	Responsible Committee	Lead Executive Director	November 2021 Update
			Likelihood	Conseq	Rating	Likelihood	Conseq	Rating				Existing Key Controls	Internal	External				
BAF#2.1	To improve population health and wellbeing, provide integrated care and to support primary care	There is a risk that the Trust does not maximise its contribution to improving population health and reducing health inequalities because of a lack of strategic relationships with primary care and local authorities and an internal focus which will impact on our strategic ambition to improve population health and wellbeing, provide integrated care and to support primary care.	3	3	9	3	3	9	2x3=6	Apr-23		Medical Director attendance at LMC and HARA with focus on development of an aligned focus on health inequalities as a strategic priority Appointment of Director of Strategy	MD Board Report SMT Medical Directorate Team meeting	HARA Yorkshire Health Network LMC	This risk could be exasperated due to the potential local government and NHS (integrating care) reorganisation	SMT	S Russell, Chief Executive J Andrews, Executive Medical Director	Continued review of the Trust Strategy and Clinical Strategy with the appointment of the Director of Strategy.
BAF#2.2	To be an active partner in population health and the transformation of health inequalities	Risk that the population is not able to fully benefit from being part of an integrated care system because our acute services face towards West Yorkshire ICS and our place based population health activities sit within HCV ICS and there is insufficient executive capacity to participate in 2 ICSs.	3	3	9	3	3	9	2x3=6	Apr-23		West Yorkshire ICS and Humber Coast and Vale ICS meetings by Executive Team members Appointment of Director of Strategy				SMT	J Andrews, Executive Medical Director	Updated existing controls and reducing in gaps in assurance with the commencement of Director of Strategy in September 2021

3. STRATEGIC OBJECTIVE: TO DELIVER HIGH QUALITY CARE

Risk ID	Principle Objective	Principle Risk to the Delivery of Objective	Inherent Risk Rating			Residual (Current) Risk Rating			Target Risk Score	Target Date Risk Score will be met/closed	Corporate Risk Register	Assurances in Controls			Gaps in Assurances/ Controls	Responsible Committee	Lead Executive Director	November 2021 Update
			Likelihood	Conseq	Rating	Likelihood	Conseq	Rating				Existing Key Controls	Internal	External				
BAF#3.1	To provide outstanding care and outstanding patient experience	There is a risk to achieving outstanding quality of care and patient experience due to insufficient focus on a culture of quality improvement.	4	4	16	3	4	12	2 x 4 = 8	Apr-22	None	A number of key quality governance changes have taken place over the last few months to strengthen the line of sight of quality of care and experience in our services. These include establishment of Quality Governance Management Group (QGMG) which includes 3 main fora – Patient Safety Forum, Clinical Effectiveness Forum and Making Experiences Count Forum. These groups will provide Executive level oversight of quality, identify risk and mitigations and triangulate learning and improvement. Governance structure has received a root and branch review and the creation of the three forums above will ensure greater control.	CQC Action Plan Quality Account Caring at Our Best programme Appointment of Quality Matron to support rollout of ward/team accreditation	CQC Inspections Bi-monthly Assurance meetings with CCG	Do not have consistent quality control in place	Quality Committee	Emma Nunez, Director of Nursing	Existing controls update to reflect developments in recent months
BAF#3.2	To provide a high quality service	Risk that a number of our clinical services are not operationally and financially sustainable because of the size of population we serve and associated financial income, the changing shape of the clinical workforce and preferences for ways of working and also our ability to deliver sub-specialty programmes of work	4	4	16	4	4	16	2x4 = 8	Apr-23	None	**External:** Carnell Farrer report Ongoing Clinical Services review to develop Clinical Strategy Ongoing conversations with WYATT	SMT Directorate Oversight on Annual Clinical Plans Quality Committee Board of Directors	WYATT Committee in Common	No Project Management Support for clinical review and support to draft strategy	Quality Committee	J Andrews, Executive Medical Director	Continues to be a risk reviewed within the ICS
BAF#3.3	To provide high quality care to children and young people in adults community services	There is a risk that there is not sufficient visability of the child in adult pathways which will impact on the individualised care for patients.	4	4	16	3	4	12	2 x 4 = 8	Apr-22	None	This remains an organisational priority (links to CQC recommendations from 2018). Focus on areas that are main hospital sites: Radiology, ED, Outpatients and Theatres. 'Hopes for Healthcare' sets out our organisational actions following engagement with children and young people on what they want from our services and each Directorate is working towards implementing these. Each Directorate is nominating a children's champion who will provide the Directorate link from the quarterly Children's Champions meeting back to the Directorate. This will be monitored via QGMG.	Adult and Young People Safeguarding Reports	CQC Outstanding Report OFSTED Reports JTAI Reports	Lack of tangible metrics	Quality Committee	Emma Nunez, Director of Nursing	Mitigation updated within month
BAF#3.4	To provide outstanding care and outstanding patient experience	There is a risk that the Trust is unable to deliver treatment and care to the required national standards which may cause patient satisfaction to drop and harm to arise	3	4	12	4	3	12	2 x 3 = 6	Apr 22	CRR41 - RTT	Planned Care Recovery Programme in Place Weekly access meetings to track weekly progress against activity targets Clinical prioritisation of all patients on admitted waiting list to assign (P1-6) priority and regularly review Use of independent sector to increase inpatient, daycase and diagnostic capacity Collaboration initiatives with other Acute Trusts Theatres utilisation workstream Elective Recovery progressing, ,Endoscopy Unit now fully operational	SMT/ Resource Committee/ Trust Board reporting Performance Reporting - Resources Review	NHSE/I Reporting		Quality Committee	Russell Nightingale, Chief Operating Officer	Current controls updated

BAF#3.5	To provide a high quality public health 0-19 service	There is a risk to providing a preventative 0-19 service because there is a significant rise in safeguarding and there is an inability to recruit and retain sufficient school nurses and health visitors.	5	4	20	4	4	16	2x4=8	Apr-22	CRR5 – Nursing Shortage CRR57 – Safeguarding Demand	Recruitment & Retention Group set up & action plan in place and being progressed (includes skill mix work, setting up services on NHSP, rolling monthly recruitment in line with ward based nursing) Business case submitted to enhance Safeguarding resource which would support the specialist team and 0 -19 service pressures. Would support 'breaking the cycle' by freeing up 0 -19 capacity to undertake preventative work. Request made for support from wider Trust (needs to be nurses with experience of working with children and families) Modelling of demand & capacity (review of current demand & capacity model / demand & capacity review) Development of OPEL to increase visibility of pressure & actions taken Agile / Base & Home working - Developing offers with teams to support alternative ways of working • Work commenced on 0 -19 'Safer staffing' tool Services recommencing face to face contacts, however recognising that many community services have not returned to pre-pandemic arrangements.	SMT/ Quality Committee/ Resource Committee		The national mandate for roll out of Covid vaccinations for healthy 12-15 year olds is likely to impact on ongoing pressures		Emma Nunez, Director of Nursing	Current mitigation and gaps in control updated.

4. STRATEGIC OBJECTIVE: TO ENSURE CLINICAL AND FINANCIAL SUSTAINABILITY

Risk ID	Principle Objective	Principle Risk to the Delivery of Objective	Inherent Risk Rating			Residual (Current) Risk Rating			Target Risk Score	Target Date Risk Score will be met/closed	Change since last Report	Existing Key Controls	Assurances in Controls		Gaps in Assurances/ Controls	Responsible Committee	Lead Executive Director	November 2021 Update
			Likelihood	Conseq	Rating	Likelihood	Conseq	Rating					Internal	External				
BAF#4.1	To continually improve services we provide to our population in a way that are more efficient	Due to a prolonged recovery from CoVid-19 there is a risk that the focus on the Trust's strategic ambitions is compromised, which will Impact upon service transformation and underlying financial improvement	4	4	16	2	4	8	2x4=8	Mar-22	None	Current financial regime; national framework, ICS discussions; engagement in regional and local service transformation programmes; internal transformation programme; alliances with Leeds; membership and engagement with WYAAT	SMT reports and oversight Resource Committee reports and oversight Board of Directors reports and oversight	WYAAT reports and Committee in Common engagement and oversight NHSE/I regulatory oversight	**Internal:** capacity to deliver internal service transformation **External:** no governance structure or programme of work with Leeds regarding transformation	Resource Committee	J Coulter, Deputy Chief Executive/ Finance Director	ICS development continues with strong representation from HDFT.
BAF#4.2	To provide high quality care and to be a financially sustainable organisation	Due to the difficulty of generating sufficient internal funds through inward investment or additional cash releasing savings, there is a risk to long term financial sustainability and ability to invest in capital, which will impact upon the quality of care that can be provided.	4	4	16	2	4	8	2x4=8	Mar-23	None	Capital asset register and planning process; financial plan; current financial regime Strength of balance sheet Engaged with ICS	Capital Oversight Group		**Internal:** No efficiency programme	Resource Committee	J Coulter, Deputy Chief Executive/ Finance Director	Ongoing discussions based on winter planning and national and regional allocations. H2 planning now in place.
BAF#4.3	To provide high quality care and to be a financially sustainable orgnisation	There is a risk that the digital maturity of the Trust is restricted because of the insufficient leadership capacity and the inability to invest sufficient resource in infrastructure and new technologies which will result in missed opportunities to improve efficiency and safety	4	4	16	3	4	12	2x4=8	Apr-22	None	1. Digital Strategy 2. Digital Board Training provided by NHS Digital/NHS Providers NHSI Digital Maturity Programme	Capital Oversight Group Digital Strategy Group		No Trust or ICS Estate Strategy or plan in place	Resource Committee	J Coulter, Deputy Chief Executive/ Finance Director	Mitigation updated
#4.4	To be financially stable to provide outstanding quality of care	Due to the allocation formula not providing sufficient resources to meet the needs of the unique demography of the local area, there is a risk that standards of care are compromised which will impact on the Trust's ambition to provide outstanding care and its reputation for quality	4	4	16	3	4	12	2x4=8	Apr 22	None	Quality governance arrangements; Contracts with commissioners Annual audit cycle PLACE Assessments 4. ICS and Place based networks Current financial regime	Integrated Board Report Chief Nurse Report Quality Committee minutes Clinical Audit Reports SMT, Resource Committee and Board reports and oversight	CCG Meetings CQC inspection reports Memorandum of Understanding with CCG Memorandum of Understanding with ICS's HARA engagement Relationships with Local Authorities Ongoing dialogue Chief Executive and Deputy	Lack of system wide financial plan	Resource Committee	J Coulter, Deputy Chief Executive/ Finance Director	Mitigation updated

					🟥			🟥	🟧					Chief Executive/Finance Director has with ICS's and regulators Carnell Farrer Review				

Risk Matrix

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

Changes in Ratings

↔ No change in risk rating since from previous Assurance Framework

↓ Risk rating has been downgraded from previous version

↑ Risk rating has increased from previous version

Progress on Actons

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

6.3 Director of Strategy Report

Harrogate and District
NHS Foundation Trust

Matters of concern & risks to escalate

- Timescales for refresh of Trust Strategy and development of Clinical Strategy are achievable, but tight.

Major actions commissioned & work underway

- Approach to refresh of the Trust Strategy and development of a Clinical Strategy supported by SMT. Staff, stakeholder and public engagement planned for Nov 21 – Feb 22; three Clinical Service Workshops planned for Dec 21 – Feb 22.
- Review of programme governance underway, including business cases, and links to quality/operational governance and planning process.
- Assessment of HDFT against the HCV Anchor Institutions Framework to start
- Engagement with Project Search (support for employment of people with learning disabilities and autism) started
- Lead Director for review of Interventional Radiology in WY&H
- Planning for Board Workshop, with NYCC and NYCCG reps, in December on HDFT's role in the Harrogate & District "place"

Positive news & assurance

- Successful workshop on 0-19 services held; output will feed into the Trust Strategy & Clinical Strategy work
- HDFT feedback on the HCV ICS governance and structures submitted
- Positive reactions from several clinical services to the start of work on the Clinical Strategy

Decisions made & decisions required of the Board

- Support for the approach and timescales for the Trust Strategy and Clinical Strategy work, including Board Workshop in Feb 22 and sign off in Apr 22.

Trust Board
24 November 2021

Title:	Refreshing our Trust Strategy and Clinical Strategy
Responsible Director:	Director of Strategy
Author:	Matt Graham, Director of Strategy

Purpose of the report and summary of key issues:	The aim of this paper is to set out the approach to refreshing the Trust Strategy and Clinical Strategy and receive feedback and support from Board.	
BAF Risk:	AIM 1: To be an outstanding place to work	
	BAF1.1 to be an outstanding place to work	X
	BAF1.2 To be an inclusive employer where diversity is celebrated and valued	X
	AIM 2: To work with partners to deliver integrated care	
	BAF2.1 To improve population health and wellbeing, provide integrated care and to support primary care	X
	BAF2.2 To be an active partner in population health and the transformation of health inequalities	X
	AIM 3: To deliver high quality care	
	BAF3.1 and 3.4 To provide outstanding care and outstanding patient experience	X
	BAF3.2 To provide a high quality service	X
	BAF3.3 To provide high quality care to children and young people in adults community services	X
	BAF3.5 To provide high quality public health 0-19 services	X
	AIM 4: To ensure clinical and financial sustainability	
	BAF4.1 To continually improve services we provide to our population in a way that are more efficient	X
	BAF4.2 and 4.3 To provide high quality care and to be a financially sustainable organisation	X
	BAF4.4 To be financially stable to provide outstanding quality of care	X
Corporate Risks	None	
Report History:	Directors' Team, 30 September 2021 Senior Management Team (SMT), 20 October 2021	
Recommendation:	Trust Board is requested to: • Note the approach to refreshing the Trust Strategy and Clinical Strategy set out in the paper • Discuss and provide feedback on the approach • Provide leadership to support and champion the process so that all service, functions and levels of the trust are involved in and contribute to developing the strategy.	

REFRESHING OUR TRUST STRATEGY AND CLINICAL STRATEGY

1. **Background.** The most recent Trust Strategy was published in 2014 to cover the period 2014-2019. The single page summary of the Strategy is at Appendix A. Since 2014 the NHS has seen the development of Integrated Care Systems, increased collaboration and integration in places and through provider collaboratives, and an increasing focus on health and wellbeing, health inequalities and population health. The trust has also developed a new set of values and behaviours, "KITE" and, in late 2019/early 2020, began work on a new mission, vision and objectives, its "True North" (Appendix B). The pandemic has also led to significant changes in how services are delivered. Putting all this together means that the Trust needs to review and refresh its Trust Strategy and Clinical Strategy.

2. **Aim.** The aim of this paper is to set out the approach to refreshing the Trust Strategy and Clinical Strategy and receive feedback and support from Trust Board.

3. **Recommendation.** Trust Board is requested to:

   - Note the approach to refreshing the Trust Strategy and Clinical Strategy set out in the paper
   - Discuss and provide feedback on the approach
   - Provide leadership to support and champion the process so that all service, functions and levels of the trust are involved in and contribute to developing the strategy.

4. **What is "Strategy"?** "Strategy" is a widely used term, but is often used to mean different things by different people, so, for clarity and common understanding, it is worth defining what we mean by strategy.

   To start with it may be helpful to state what strategy is not. It is not:

   - A plan – although a plan is needed to execute the strategy
   - Only a set of "strategic objectives" or some "large-scale transformation" projects
   - About the longterm or about things we are going to do in the future – it is about what we need to do now, our priorities, to deliver our purpose and improve.
   - Only for the board and senior leadership

- For a set period of time (a “5 year strategy”) – strategy should be enduring (unless there is a fundamental change in the role of the organisation or its environment).

The aim of strategy is to establish clarity and shared understanding about the “purpose” of the organisation (what the organisation exists to do) and how the organisation believes it will deliver on that purpose. It is the organisation’s philosophy and beliefs about how it will be successful and high performing. Strategy aligns the organisation to its purpose and mobilises its resources and its staff, at all levels and in all functions, to deliver. It provides a guide for decision making and prioritisation so that choices are made in support of the purpose and in line with the principles. Most importantly, strategy is for the whole organisation, at every level so it needs to be simple, understandable, memorable and applicable.

5. **HDFT Strategy.** An organisation’s strategy can be captured in many different ways, but one simple approach, which is often used by NHS trusts, is to describe it in terms of:

- **Purpose.** An organisation’s purpose (sometimes called its mission or “True North”) is what it exists to do, the overall outcome that the organisation is here to deliver.
- **Values and Behaviours.** Our values are our underlying beliefs; behaviours are how our values are expressed in our interactions with others.
- **Strategic Themes.** The key areas in which the organisation must focus on to be successful and which will enable the organisation to achieve its purpose; the areas of its business which are fundamental to its success.
- **Capabilities & Resources.** Capabilities are the concepts, systems and processes (the thinking) which the organisation must be able to do to be successful. Resources are the things the organisation needs in order to deliver its services. They are often described as the “enablers”.
- **Implementation Plan.** An implementation plan is required to execute the Strategy. The implementation plan will look ahead 3-5 years, with a more detailed plan for the first year; it will be refreshed each year to reflect progress, challenges and new opportunities. The implementation plan sets our priorities for what we need to do now to improve in each of the Strategic Themes and to develop our Capabilities and Resources. The plan will consist of:
    - **Breakthrough Objectives.** A small number of objectives covering the Strategic Themes to which every part of the organisation can contribute. Different parts of the organisation may contribute in different ways, but every member of staff should be able to see how their actions will help achieve the objective (the “golden thread” – see section 7).

- **Programmes.** Cross-organisational initiatives to deliver new capabilities or service changes. Programmes are likely to bring together clinical, workforce, estates, equipment, digital elements in order to deliver benefits.

HDFT's previous strategies have broadly followed this structure. The intention is to build on the previous strategies to develop a new, updated Trust Strategy in the same format.

6. **Supporting Strategies.** Supporting the overall Strategy and providing more detail in specific areas are supporting strategies for the Strategic Themes, Capabilities and Resources. The final set of supporting strategies will depend on how the strategy is described based on feedback from the trust and our stakeholders, but examples could include:

Strategic Themes

- Quality Strategy – how we deliver high quality, safe and effective, care.
- Patient Strategy – how we deliver great patient experience by understanding our patients
- Clinical Strategy – what services we provide and how we provide them (the clinical model)
- Anchor Institution Strategy[1] - how we use our resources to benefit the wider community for instance through support for employment, education and training, the environment, the economy etc.

Capabilities and Resources Strategies

- People Strategy – how we recruit, retain, train and educate, lead our staff
- Estates & Equipment Strategy – how we use and develop our facilities and assets
- Digital Strategy – how we use digital technology and data to deliver services
- Continuous Learning & Improvement Strategy – how we learn and improve our services all the time.

7. **Strategy Cascade (the "Golden Thread").** To align and mobilise the organisation it is critical that the Trust Strategy is cascaded through the organisation. This means directorates, services and corporate functions considering their role in delivering the Trust Strategy and translating it into their own local Strategy using the framework of the Breakthrough Objectives and Programmes (either their contribution to Trust-wide

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[1] "Anchor Institutions" are organisations which are embedded in their local communities, employing many people, spending substantial amounts of money, owning land and assets, and, as such, can have a significant, positive impact on their communities through how they operate and use their resources.

programmes or programmes within their own area). Ultimately it should be possible to follow a “golden thread” from individual and team objectives all the way back to the Trust Strategy so it is clear how everyone and every part of the trust is playing its part in delivering the overall Trust Strategy.

8. **Clinical Strategy.** The Clinical Strategy describes what services we will offer and their clinical models. It looks 5+ years ahead to ensure that our services will be clinically sustainable for the future. For each service it will answer the following two questions:

What services will we offer?

- Deliver – services (or elements of a service) which our population needs locally which we should deliver ourselves
- Partner – services which our population needs locally which need to be delivered in partnership with another provider
- Build – services at which we excel and which we could provide for a larger population
- Stop – services which do not need to be provided locally and which we cannot clinically sustain.

(NB. A service may identify elements in some or all of these categories)

What is the Clinical Model for the service?

Taking into account:

- A whole person, whole pathway perspective – all ages, health and wellbeing, prevention to tertiary
- Integration between: health and social care; acute, community, primary care; physical and mental health; acute provider collaboration
- Delivery in the community vs delivery in hospital
- How digital technology enables different models of delivery
- How future medical technology, new medicines will change the clinical model
- How different professional roles can be best utilised to deliver the service

9. **Developing the Trust Strategy and Clinical Strategy**. Both the Trust Strategy and Clinical Strategy will be developed in parallel from the bottom up based on input from patients, public, staff and system partners. The target is for both strategies to be signed off by SMT and the Board in April 2022.

Dates	Trust Strategy	Clinical Strategy
October 2021	• Prepare public and patient engagement (with support from Healthwatch, Governors)	• Prepare service data packs
	• Prepare staff engagement	• Prepare service workshops (NB In person or virtual TBC depending on the Covid situation)
	• Arrange system partner and stakeholder interviews	
	• Arrange interviews with Board, SMT, Service Leaders	
	• Prepare Board and SMT workshops	• Prepare Board and SMT workshops
	• Share strategy development approach with SMT (20 October)	
November 2021	• Attend Directorate Boards to share approach to strategy development	
	• System partner and stakeholder interviews	
	• Board, SMT, Service Lead interviews	
	• Survey of staff (start end of November)	• Share service data packs with service leads (medical, nursing, AHP, operations) (mid-November)
December 2021	• System partner and stakeholder interviews	
	• Board, SMT, Service Lead interviews	
	• Survey of staff (end in mid-December)	• Service Workshop 1 (13 and 14 December)
January 2022	• Patient and public survey (3-23 January)	• Service Workshop 2 (19 and 25 January)
February 2022	• 1st Draft Trust Strategy (3 February)	• Service Workshop 3 (15 and 16 February)
	• SMT Workshop to review Trust Strategy (16 February)	
	• Board Workshop to review Trust Strategy (23 February)	• 1st Draft Clinical Strategy (28 February)
March 2022	• 2nd Draft Trust Strategy (3 March)	• Service leads review and feedback (by 14 March)
	• SMT & Board review and feedback	• SMT Workshop to review Clinical Strategy (16 March)

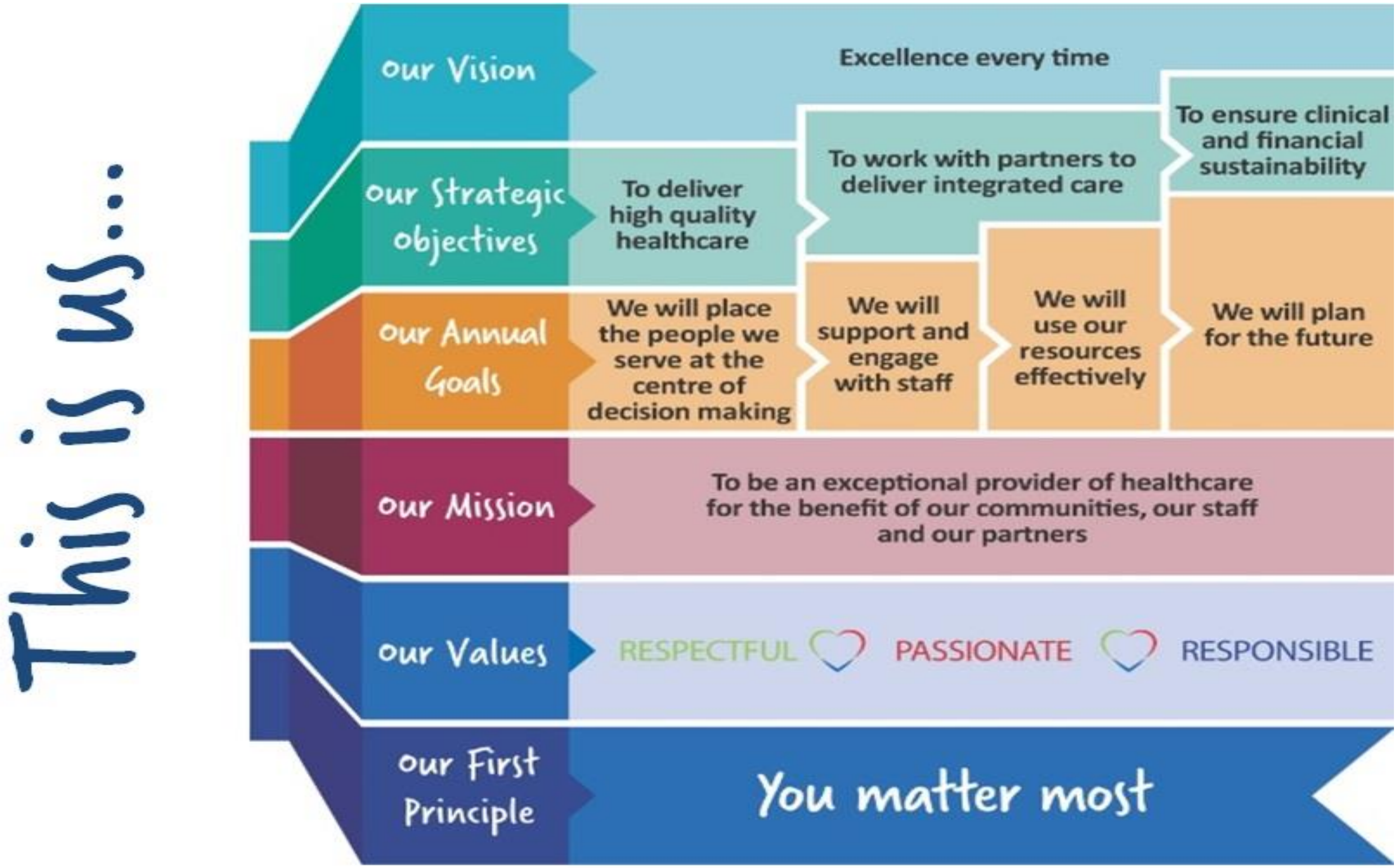
Dates	Trust Strategy	Clinical Strategy
		- Board review of Clinical Strategy (23 March)
	- 3rd Draft Trust Strategy (31 March)	- 2nd Draft Clinical Strategy (31 March)
April 2022	- Exec review and sign off (7 April)	- Exec review and sign off (7 April)
	- Final Clinical Strategy (13 April)	- Final Clinical Strategy (13 April)
	- SMT sign off - recommendation to Board (20 April)	- SMT sign off – recommendation to Board (20 April)
	- Board sign off (27 April)	- Board sign off (27 April)

10. **Conclusion**. Having not updated its Strategy since 2014, HDFT needs to review and refresh its Trust Strategy and Clinical Strategy. The aim of the Trust Strategy is to provide clarity and shared understanding about the “purpose” of HDFT (what the organisation exists to do) and how the organisation believes it will deliver on that purpose through the strategic themes, capabilities and resources, underpinned by our “KITE” values and behaviours. The Clinical Strategy describes what services the trust will provide and how they will be delivered through a clinical model. Both strategies will be developed in parallel, from the bottom up through extensive patient, public, staff and partner engagement and involvement, over the next 6 months with the aim of approving both at the April 2022 Board.

Appendices

A. Trust Strategy 2014-2019
B. Draft “True North” developed late 2019

APPENDIX A – TRUST STRATEGY 2014-2019



This is us...

our Vision: Excellence every time

our Strategic objectives:
- To deliver high quality healthcare
- To work with partners to deliver integrated care
- To ensure clinical and financial sustainability

our Annual Goals:
- We will place the people we serve at the centre of decision making
- We will support and engage with staff
- We will use our resources effectively
- We will plan for the future

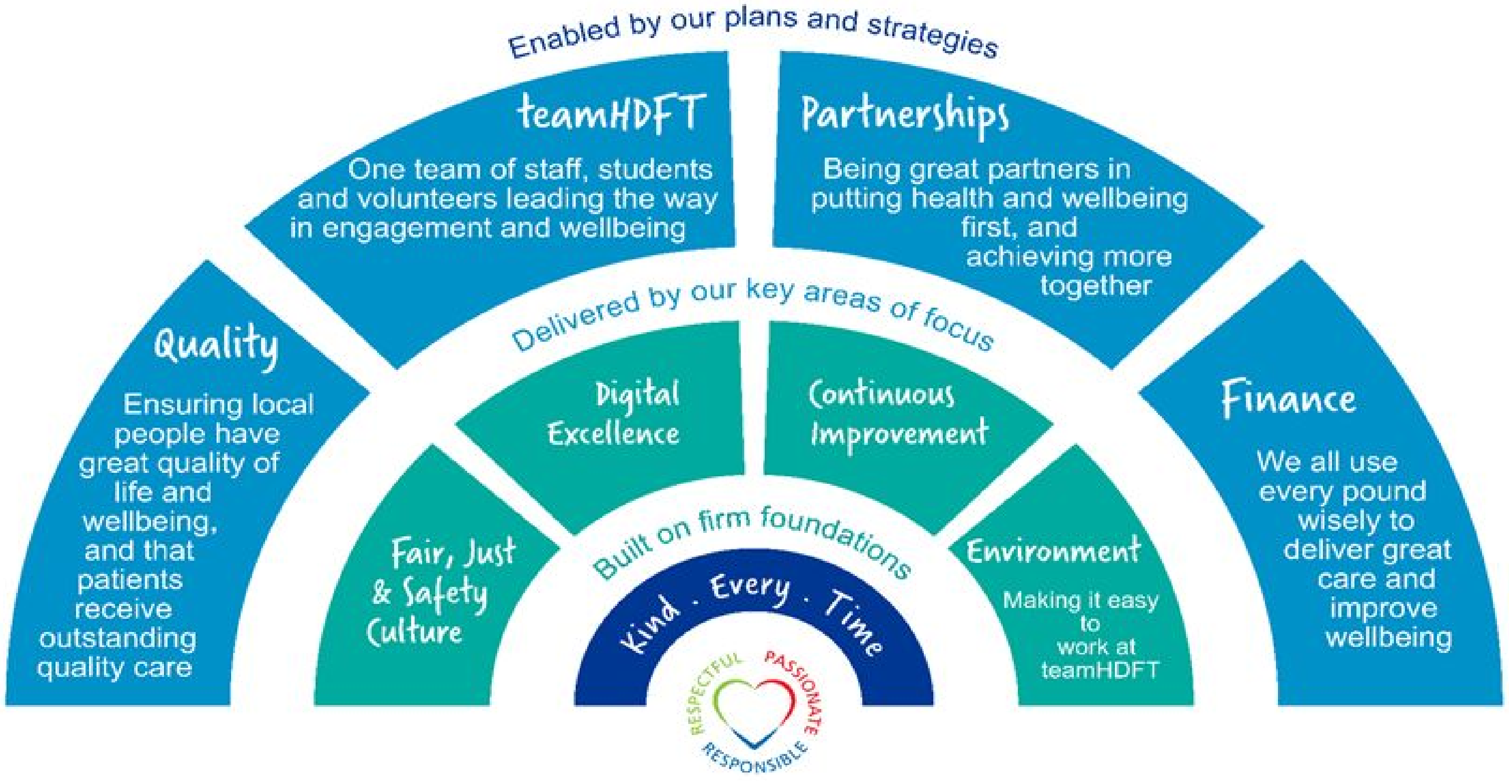
our Mission: To be an exceptional provider of healthcare for the benefit of our communities, our staff and our partners

our Values: RESPECTFUL PASSIONATE RESPONSIBLE

our First Principle: You matter most

APPENDIX B – DRAFT “TRUE NORTH” (DEVELOPED LATE 2019)

teamHDFT - Where health and wellbeing come first



Enabled by our plans and strategies

teamHDFT

One team of staff, students and volunteers leading the way in engagement and wellbeing

Partnerships

Being great partners in putting health and wellbeing first, and achieving more together

Quality

Ensuring local people have great quality of life and wellbeing, and that patients receive outstanding quality care

Finance

We all use every pound wisely to deliver great care and improve wellbeing

Delivered by our key areas of focus

Digital Excellence

Continuous Improvement

Fair, Just & Safety Culture

Environment

Making it easy to work at teamHDFT

Built on firm foundations

Kind . Every . Time

Board of Directors (Public)
24th November 2021

Title:	H2 financial planning
Responsible Director:	Deputy Chief Executive / Finance Director
Author:	Head of Finance / Finance Director

Purpose of the report and summary of key issues:	This document has been developed to update the Committee in relation to the H2 financial planning process and the impact on HDFT. The Committee is asked to note the contents of the paper.	
BAF Risk:	AIM 1: To be an outstanding place to work	
	BAF1.1 to be an outstanding place to work	
	BAF1.2 To be an inclusive employer where diversity is celebrated and valued	
	AIM 2: To work with partners to deliver integrated care	
	BAF2.1 To improve population health and wellbeing, provide integrated care and to support primary care	X
	BAF2.2 To be an active partner in population health and the transformation of health inequalities	X
	AIM 3: To deliver high quality care	
	BAF3.1 and 3.4 To provide outstanding care and outstanding patient experience	
	BAF3.2 To provide a high quality service	
	BAF3.3 To provide high quality care to children and young people in adults community services	
	BAF3.5 To provide high quality public health 0-19 services	
	AIM 4: To ensure clinical and financial sustainability	
	BAF4.1 To continually improve services we provide to our population in a way that are more efficient	X
	BAF4.2 and 4.3 To provide high quality care and to be a financially sustainable organisation	X
	BAF4.4 To be financially stable to provide outstanding quality of care	X
Corporate Risks	There are currently no issues of risk to be updated on the Corporate risk register related to this report. Risks are being managed within local risk registers, and will be escalated when appropriate.	
Report History:	This report builds on the report to Resource committee in October. Continued discussion of some of the content through system meetings	
Recommendation:	The Committee is asked to note and discuss the contents of this report.	

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HIF HARROGATE INTEGRATED FACILITIES Taking Pride in our Services

NHS Harrogate and District NHS Foundation Trust

H2 financial planning update

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Planning guidance

- Planning guidance was issued on 30th September
- Key priorities contained within the guidance:

  - ➢Support the health and wellbeing of staff
  - ➢Deliver the CoVid vaccination programme and meet the needs of patients with CoVid
  - ➢Restore elective work and cancer care
  - ➢Manage urgent and emergency care, through winter, and transform community services to reduce ED attendances and support lower hospital length of stay
  - ➢Expand primary care access and manage the increasing demend for mental health services
  - ➢Work collaboratively to deliver these priorities

In addition, focus should be on reducing health inequalities in whatever we do.

These priorities are consistent with H1, and will continue.

Financial planning for H2

The key elements within the financial framework for H2 are:

- Block contracts to continue for the next six months
- Pay award is funded
- Pay award costs for NHS colleagues working in services that are part of local authority contracts will be funded in H2 through the NHS allocations
- There is a national efficiency expectation of 0.82% from general funds
- There is also a reduction in funding to support CoVid costs of 6%
- There is an additional targeted reduction in allocations for systems that are further from their long term plan trajectories – note that this impacts upon the North Yorkshire system
- There is a new Elective Recovery Fund (ERF) offer, with additional funding available if activity is delivered above a baseline based upon work undertaken in 2019/20. The baseline to compare delivery against is 89% of RTT Clock stops from 2019/20.
- Winter capacity funding has been identified separately, with an allocation available to the system to support managing winter pressures.

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Finance for H2 – what does this mean for HDFT?

- National efficiency funding calculation

general efficiency	1.2m
CoVid reduction	0.5m
targeted system reduction	0.9m
Total national calculation	2.6m

- We assumed for internal planning that we would need to deliver an efficiency improvement of £3.1m, and we have set budgets on that basis.
- Local authority pay award will cost HDFT £1.1m, and we are in discussion through the ICS to get the necessary transfer of funding
- We have made no assumption that we would receive any ERF income in our plans currently. As in H1, this will be dependent upon both our performance and the performance of other partners across the ICS.
- Winter capacity funding of £2.9m is available for the North Yorkshire and York system, which has been agreed will be allocated to the local A&E delivery boards to agree investments. For HDFT this equates to £0.55m, and we are assuming for financial planning purposes that income will equal costs.

Finance for H2 – internal trust financial plan

Summary plan

High Level Analysis	H1 Actual £000's	H2 Forecast Actuals £000's	FY Forecast Actuals £000's
Commissioner Income	**134,113**	**£137,045**	**£271,158**
Directorate Income	**23,256**	**£20,427**	**£43,683**
Pay Costs	-99,088	-103,137	-202,224
Non Pay Costs	-58,029	-54,135	-112,164
Expenditure	**-157,117**	**-157,271**	**-314,388**
Surplus / (Deficit)	**252**	**201**	**453**

Assumptions:

- CIP fully delivered
- Salix impact ignored for H2; we are due to receive grant income of £14m to spend on capital improvements, so we exclude this as part of our financial performance assessment
- Costs outside of the system allocation excluded (eg vaccine programme) – these will be I&E neutral, as our costs will be reimbursed
- The plan currently EXCLUDES Local Authority pay award funding being received from the NHS, this is activiely being discussed across the system
- Excludes any income or costs related to winter capacity or ERF (assumed these will match)

This summary plan is further broken down into Directorates, and all budget holders have an agreed budget for H2.

Financial plan – North Yorkshire system

- Income allocations have been confirmed and agreed across North Yorkshire, including the Covid and Growth allocation. There are still ongoing discussions around the Local Authority pay award funding from the NHS, but any risk will be mitigated across the system.

- Assessment of financial risk across the system results in a forecast that the system will deliver a balanced financial plan for H2, and a balanced financial outturn, and a balanced H2 forecast position has been submitted by the North Yorkshire system

- We have collectively worked through the ERF assumptions, as this value is system based, to assess the risk or otherwise of financial and activity plans. There are currently no assumptions in our plan that any ERF funding will be received. However, if all HDFT/system plans are met, ERF of c£1m will be earned by HDFT.

- Winter capacity funding allocation has been agreed across the constituent A&E Delivery Boards

- Regional fund to support delivery of elective activity – a fund of £100m has been made available to the North East and Yorkshire Region to support delivery of elective care activity. This was announced in early November, and is additional to system allocations. Significant discussions are being held across the ICS and Provider collaborative to determine the appropriate use and allocation of any funding that the system receives. The outcome of these discussions will need to be factored into our plans once they are agreed.

Next steps

- The system-wide plan is being submitted this week
- The individual organisational financial plan will be submitted on 25th November. This will be in line with the budgets that we have internally set and in line with the system-wide planning submission

- The Board is asked to note the conclusion of the system and local planning process for H2, and the submission of the system plan by the ICS.

Board Committee report to the Board of Directors

Committee Name:	Resources Committee
Committee Chair:	Maureen Taylor
Date of last meeting:	25th October 2021
Date of Board meeting for which this report is prepared	24th November 2021

Summary of key issues:

1. **Month 6 – September 2021**
2. The Trust has continued to maintain its planned break-even position in August. A surplus of £252k has actually been achieved due to Salix grant received. The month 6 position includes £3m for pay award and payments relating to back-pay under the Flowers ruling. Income to meet these has been accrued.
3. All directorates are underspending with the exception of LTUC where there is an overspend of £528k at month 6 due to staffing costs. An acuity review has been undertaken and the outcome awaited. Agency costs were within the agency cap in September and remain so in the year to date. The majority of agency costs are within LTUC directorate mainly due to filling medical staffing vacancies. The target CIP for the year is £4.3m (£1.4m from H1 and £3.1m for H2), schemes totalling £ 3.4m have so far been identified.
4. The capital programme continues to underspend significantly (£12.8m behind plan at the end of September of which £3.6m relates to the Salix programme). Reviews on major schemes are being conducted by Executive/Clinical director leads. Options for managing capital resources most effectively are being considered.
5. The Trust achieved 90% against the 95% Better Payment Practice Code target in September which is a 10% improvement from the previous month. The cash position remains healthy at around £40m.
6. For planned care recovery, activity was below plan on all points of delivery. Elective recovery is impacted by waiting list initiative changes and annual leave rollover. Sessions ensure the most clinically pressurised activity is covered. The forecast for October is currently below plan but improving week by week. Dedicated project support in theatres commencing in October.
7. RTT waiting list continued to rise in September. Patients waiting over 52 weeks increases by 5.4% from August. There are 4,482 patients awaiting a procedure of which 38% are Trauma and Orthopaedics, 12% Ophthalmology and 19% General Surgery.
8. ED attendances have reduced from earlier in the year but remain above

2019/20. Performance against the ED 4 hour target was 83.7%. The new front door model trial ended in October and a case for change is being made. This could be in place permanently by February 2022.

9. The 62 day cancer standard was met in September (88.2%). 2WW referrals continue to be higher than the number of weekly appointment slots and subsequently the 2WW target was not met in September (92%). The target for 2WW breast symptomatic patients was not met in September (96.3%) however the breast clinic backlog has now been cleared and the standard is now being met. The primary 2WW issues are now in Urology.
10. The volume of safeguarding strategies involving 0-19 teams remains high, impacting on capacity within these teams to deliver their preventative role.
11. Still a high number of Community dental patients waiting over 52 weeks, this is due to a historic mismatch between capacity and demand as well as Covid-19 pressures.
12. Substantive staff in post in August was ahead of plan by 66.93 whole time equivalents (wte) with bank 13.07 wte ahead of plan and agency numbers behind plan by 13.42 wte.
13. The vacancy rate at the end of August was 6.23%, Children's and Community and Corporate directorates are ahead of plan whilst LTUC and PSC are behind plan. There are 35.33 wte school nurse and health visitor vacancies within Children's and Community directorate, a small reduction from last month. There is over recruitment of band 5 nurses and support staff to mitigate this. Vacancies in the CC directorate continue to be of concern.
14. There is a strong recruitment pipeline in nursing but some work is needed to strengthen the pipeline for care support workers.
15. The Salix update report was received and noted.
16. A report on the H2 planning process was received. There are a number of priorities to be delivered. There is an expectation that the elective recovery priority is delivered and this is to eliminate all 104 week waiters, reduce 52 week waiters and to stabilise/reduce the total RTT waiting list.
17. Block contracts will continue for H2 with pay awards funded, an efficiency expectation, a reduction in Covid funding and winter capacity funding. Internal planning has set an efficiency target of £3.1m against a national figure of £2.6m. Winter funding to be allocated within North Yorkshire and York system. Plans for activity and performance, workforce and finance to be submitted in November.
18. An updated Terms of Reference for the Committee was considered. A final version will be available for approval at the next meeting.

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

- Vacancies in Health visitors and school nurses as well as gaps in theatres.
- Capital programme significantly behind plan

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

None

Board Committee report to the Board of Directors

Committee Name:	Resources Committee
Committee Chair:	Maureen Taylor
Date of last meeting:	22nd November 2021
Date of Board meeting for which this report is prepared	24th November 2021

Summary of key issues:

1. **Month 7 – October 2021**
2. The Trust surplus at month 7 is £2.718m including Salix grant received, after adjusting for this the position is beak-even.
3. All directorates are underspending with the exception of LTUC where there is an overspend of £510k at month 7 and this is across pay and non-pay costs. Directorate positions have some common areas of risk including medical staffing pressures, significant underspends in Children's Services, Adult Community Services, Theatres and Endoscopy, CIP targets for the second half year and activity levels being re-established in PSC.
4. The outcome of the acuity review is awaited. Agency costs were within the agency cap in October and remain so in the year to date. The target CIP for the year is £4.3m (£1.4m from H1 and £3.1m for H2), schemes totalling £ 3.785m have so far been identified.
5. The capital programme continues to underspend significantly (£11.9m behind plan at the end of October of which £4.7m relates to the Salix programme). The likely forecast for the year is £29.4m against a plan of £31.8m.
6. The Trust achieved 92% against the 95% Better Payment Practice Code target in October. The cash position remains healthy at around £40m.
7. An increase in COVID admissions has needed the opening of additional beds with creation of a COVID ward.
8. For planned care recovery, focus remains on increasing elective activity. There is 12 week dedicated project support in theatres. Clinical sessions ensure the most clinically pressurised activity is covered.
9. RTT waiting list reduced by 225 in October. Patients waiting over 52 weeks increased by 6% from September. There are 4,883 patients awaiting a procedure of which 38% are Trauma and Orthopaedics, 12% Ophthalmology and 19% General Surgery.
10. ED attendances remain above the 2019/20 level and this together with high occupancy within the hospital is impacting on flow through the hospital. Performance against the ED 4 hour target was 75.9% the highest performance within the HCV region. There were twelve 12-hour

breaches and eleven 12-hour ambulance handover breaches in October.

11. Three cancer standards were not met in October (62 day standard 82%, 2 week wait standard 84% and 2 week wait breast symptomatic 51.6%). The 31 day cancer standard was met in October at 98%. Colorectal breaches remain a focus. 2WW referrals continue to be higher than the number of weekly appointment slots. Actions include additional breast clinics and outsourcing to the private sector.
12. The volume of safeguarding strategies involving 0-19 teams remains high, impacting on capacity within these teams to deliver their preventative role. To minimise the impact of staffing gaps and absence levels in the 0-19 service, management is being done across contracts. Non-urgent activity has been paused and a flexible approach to timelines for mandated contacts has been introduced.
13. Still a high number of Community dental patients waiting over 52 weeks, plans in place to link clinical teams across HCV, to embed best practice. Waiting List Initiative sessions will target patients waiting over 80 weeks.
14. Substantive staff in post in August was ahead of plan by 159.13 whole time equivalents (wte) largely due to the incorporation of Northumberland 0-19 services from 1st October. Bank staffing was 68.03 wte ahead of plan and agency also ahead of plan by 8.91 wte.
15. The vacancy rate at the end of October was 5.61% (a reduction from 6.23% in September), Children’s and Community and Corporate directorates are ahead of plan whilst LTUC and PSC are behind plan. There are 36.21 wte school nurse and health visitor vacancies within Children’s and Community directorate, a small increase from last month. There is over recruitment of band 5 nurses and support staff to mitigate this. Vacancies in the CC directorate continue to be of concern.
16. In-patient ward nurse vacancies stand at 43.28 wte, new staff in the pipeline will reduce this to 27 wte in March 2022. In-patient ward care support worker vacancies stand at 7.3 wte but are expected to rise to 18.39 wte by March 2022. Further work needed to strengthen the pipeline for care support workers.
17. Theatre vacancies and recruitment has been identified as a key area. There are currently 25.98 wte vacancies in theatres with 18 posts in various stages of recruitment.
18. An update on the H2 planning process was received. Across the North Yorkshire and York (NYY) system income allocations have been confirmed but discussions continue on the Local Authority pay award. A balanced H2 forecast has been submitted across the NYY system. No Elective Recovery Fund income has been assumed so far. An approach to allocation winter capacity funding has been agreed with HDFT due to receive £550,000. A fund of £100m is available across the system to support delivery of elective activity, discussions held to determine a fair allocation of any funding that is received.
19. The Salix decarbonisation scheme is being delivered as a variation to the existing Carbon Energy Fund (CEF) energy performance Project Agreement with Imtech, which the Trust entered into in 2015. The project agreement needs re-stating to accommodate this significant programme of works. The Committee considered a report outlining the variations

required and also the recommendations from the Carbon Energy Fund, Dac Beachcroft, legal advisors and Willis Towers Watson, insurance advisors. Due to the commercial nature of the agreement, details relating to this are contained within a confidential item on the Board agenda for 24th November 2021.

20. A verbal progress report was given on the Cath Lab post project evaluation. The report will be presented at the December meeting of the Committee.
21. An update on commissioned contract issues was provided. A quarterly report will be received in future showing all contract variations.
22. An updated Terms of Reference for the Committee was considered and approved with some minor adjustments to headings to ensure issues related to workforce and activity have the same prominence as Finance. agreed.
23. The Committee supported increasing the Living Wage to £9.90 per hour in line with the recommendations of the Living Wage Foundation. The Committee also supported that the living wage uplift be automatically applied each year with the resulting cost reported to the Committee through the Finance report. Details regarding how the uplift relates to Apprentices are still being worked through and it is proposed that delegated authority be given to the Deputy Chief Executive/Finance Director and the Director of Workforce and Organisational Development to agree and implement the uplift for this staff group.

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

- Vacancies in Health visitors and school nurses as well as gaps in theatres.
- Capital programme significantly behind plan

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

Carbon Energy Fund Energy Performance Project Agreement.
See Confidential item on the Board agenda.

The Living Wage 2021/22
The Trust implemented the Living Wage in 2015 and has increased it each year in line with the recommendations of the Living Wage Foundation. The Resources Committee recommends to the Board of Directors:

1) to increase the Living Wage supplement in line with Living Wage Foundation recommendations.

2) to continue to allow staff to have the benefit of receiving the payment on a monthly basis and to backdate the payment to 1st November 2021.

3) that future Living Wage reviews are automatically applied to the earnings of the lower paid staff within the Trust.

4) That delegated authority be given to the Deputy Chief Executive/Finance Director and the Director of Workforce and Organisational Development to agree and implement the uplift for Apprentices.

Integrated Board Report - October 2021

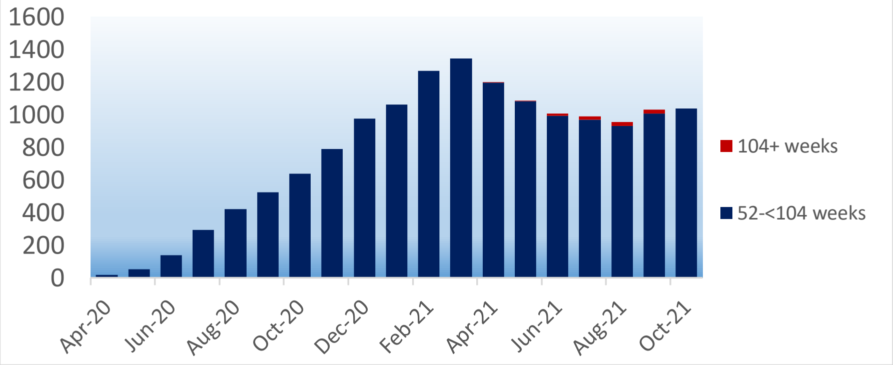
Domain 5 - Responsive

Indicator	**5.1 - RTT Incomplete pathways - 52+ weeks**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Oct-21
Value / RAG rating	1041

Indicator description

The number of incomplete pathways waiting over 52 weeks.

Trend chart



Narrative

Due to the Covid-19 pandemic and the ceasing of elective work, waiting times have risen significantly. The over 52 weeks waiters peaked in March 2021. Risks remain in two main specialties of T&O and Community Dental (which together account for 78% of the over 52 week waiters). Current end of financial year target is to reduce this figure to below 950 patients.

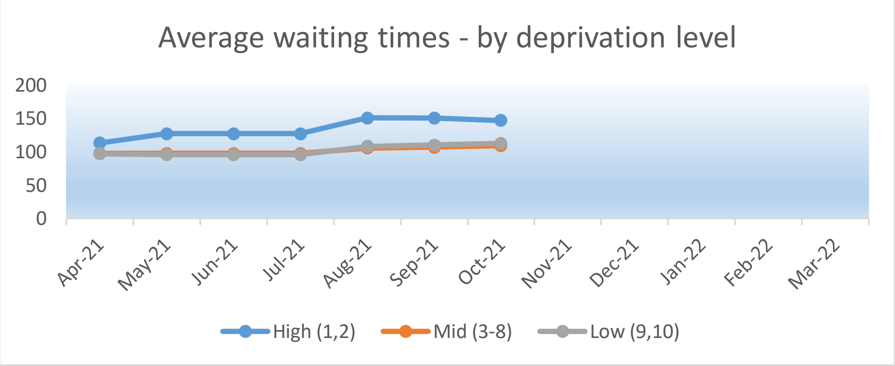
Twice weekly extremis waiting list meetings are now underway chaired by Deputy COO and each patient discussed using red2green methodology looking as reducing days off any pathway intervention.

Indicator	**5.2 - RTT waiting times - by level of deprivation**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Oct-21
Value / RAG rating	🟨

Indicator description

The average RTT waiting time by level of deprivation.

Trend chart



Narrative

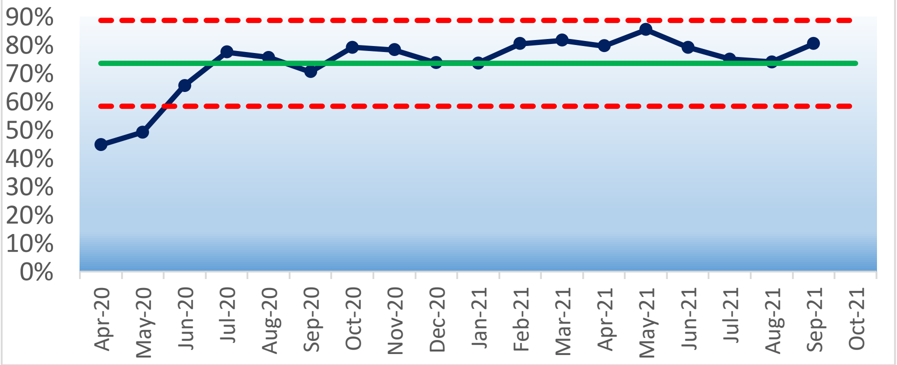
The Trust has carried out an analysis of waiting times by ethnicity, by deprivation and for patients with learning disabilities. There does not appear to be any inequity in waiting times by ethnicity or for patients with learning disabilities but these will continue to be tracked on a monthly basis. There does appear to be a difference in waiting times by deprivation with patients from the most deprived postcodes waiting longer. A further analysis of this is being carried out looking at the data by clinical priority and by specialty.

Indicator	**5.3 - Diagnostic waiting times - 6-week standard**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Sep-21
Value / RAG rating	80.5%

Indicator description

Percentage of patients waiting 6 weeks or less for a diagnostic test. The operational standard is 99%.

SPC chart



Narrative

81% of patients were waiting less than 6 weeks for a diagnostic test at end October against a 99% target.

There were 512 over 6 week breaches, of which 469 Dexa cases are beyond the 6ww target. Extra kit ordered and being delivered in November 21. Space and staffing arranged for 7 day working. Compliance forecast end of January 22.

Indicator	**5.4 - Outpatients lost to follow-up - number of follow up patients past due date**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	
Value / RAG rating	

Indicator description

This indicator is under development.

Narrative

A data quality exercise is underway to review the follow up outpatient waiting list data and to understand the full scope of this problem and determine how many patients still require a follow up appointment. It is likely that we will refine the metric for reporting in this report as part of this work.

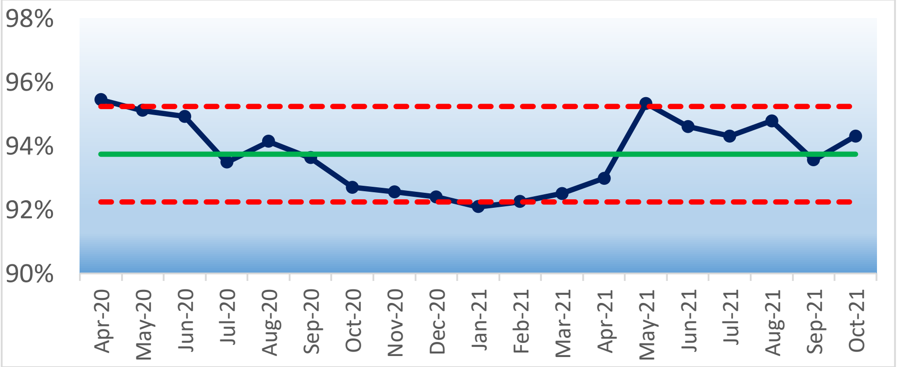
SPC chart

Indicator	**5.5 - Data quality on ethnic group - inpatients**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Oct-21
Value / RAG rating	🟥 94.3%

Indicator description

The number of inpatients with a valid ethnic group recorded on the Trust's PAS system.

SPC chart



Narrative

The Trust remains below the required standard of 97%. A revised focus on ethnicity data collection is underway, this measure is monitored at Trust weekly access meetings.

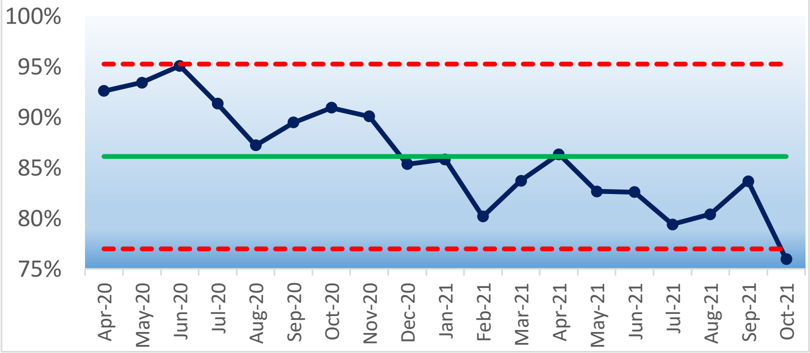
- Made contact with the lead at Central London Community NHS Trust (CLCH) who have improved their ethnicity recording rates on their patient records – they are organising a webinar to talk through their actions that we will join once details shared
- Reminded staff of the process regarding the collection of this data including reception staff aware that they should be collecting ethnic category, if not already there, as part of the demographic check.
- Progress of new Kiosks – previously electronic check in kiosks included a step to complete / update ethnic category. Removed as a result of COVID, awaiting new kiosks to re-introduce process.
- Exploring option of sending electronic forms to patients for completion and return.

Indicator	**5.6 - A&E 4 hour standard**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Oct-21
Value / RAG rating	🟥 75.9%

Indicator description

Percentage of patients spending less than 4 hours in Accident & Emergency (A&E). The data includes all A&E Departments, including Minor Injury Units (MIUs). The operational standard is 95%.

SPC chart



Narrative

Performance against the A&E 4-hour standard decreased to 75.9%, remaining below the 95% standard. 63% of all admitted breach patients cited awaiting hospital bed as the breach reason. Drivers for this increase includes an increase in covid admissions (peaking at 29 inpatients), 3 domiciliary care providers pulling out of the Harrogate market leading to pressures sourcing care packages and significant staffing challenges across both hospital and social care challenging timely discharge.

To support hospital flow and hence reduce breaches for this patient cohort, the Trust is:

- implementing Criteria to Reside flow software by Dec-21;
- developing a 2 hour crisis response service (admission avoidance) – implementation date March 22;
- expanding ARCH ED in-reach (admission avoidance) –Business case approved;
- maximising SDEC opportunities (admission avoidance);
- educating other specialties to avoid using ED as their triage and assessment service.

Other actions to support performance include:

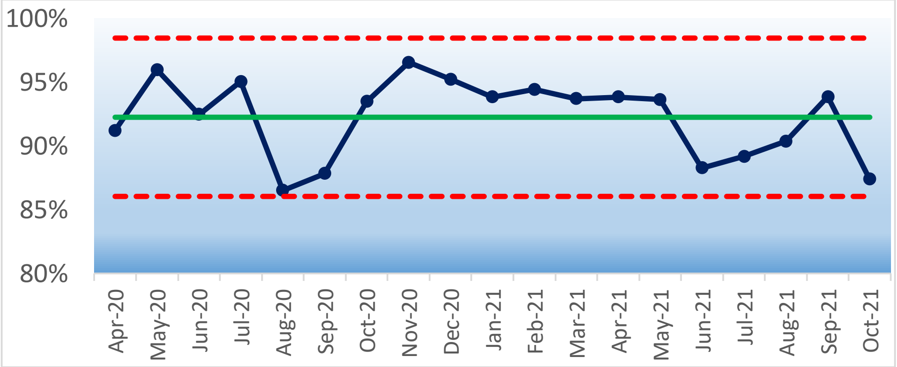
- 111 FIRST (Bookable appointments for the ED) – complete – launched Oct-20
- Emergency Medicine Streaming Model - Pilot undertaken & draft business case written
- NHS England Triage tool - In Progress – Early adopter site with 6 week implementation plan
- YAS direct access to SDEC pathway to enable YAS to bypass ED - Complete - Launched Sept 21
- Acute Referral Team (ART) line - Opportunities to expand pathways and dispositions e.g. hot clinics. Aligned with NHS Triage tool
- Existing x-ray in ED upgraded and second x-ray installed to offer a swifter digital imaging solution - Completed – June 2021 (0 breaches pertain to plain film)
- Relocation of 2nd CT to be co-located in the ED by Q1 2022/23

Indicator	**5.7 - Ambulance handovers - % within 15 mins**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Oct-21
Value / RAG rating	87.4%

Indicator description

The percentage of ambulance patients who were handed over to Emergency Department staff within 15 mins.

SPC chart



Narrative

Ambulance handover performance deteriorated in October. There were 37 over 30-minute handover breaches including 11 over 60-minute breaches in October.

Actions included in wider UEC plan for focussed improvement.

Indicator	**5.8 A&E - number of 12 hour trolley waits**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Oct-21
Value / RAG rating	🟥 8

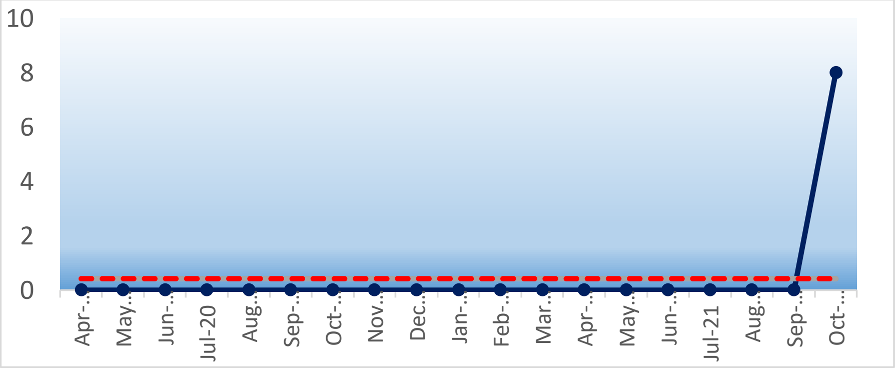
Indicator description

The number of patients spending more than 12 hours in the Emergency Department between a decision to admit and being admitted.

Narrative

There were 8 over 12 hour trolley waits reported in October. All 8 cases occurred over a 48 hour period of high bed occpuancy. LTUC Directorate are reviewing the cases and preparing RCAs (Root Cause Analyses).

SPC chart

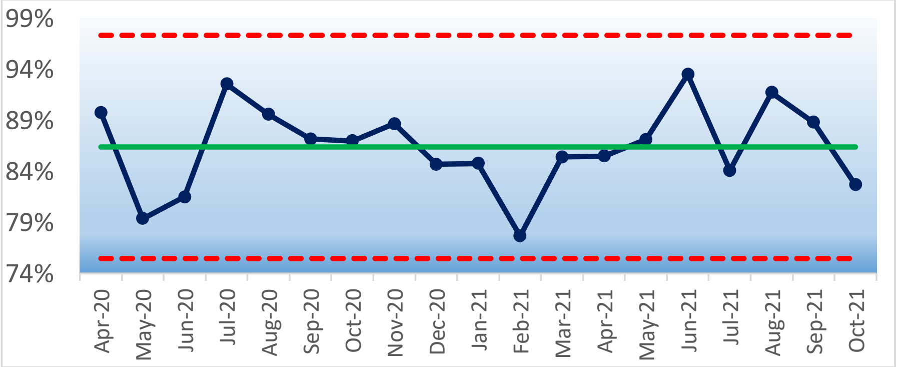


Indicator	**5.9.1 - Cancer - 62 day wait for first treatment from urgent GP referral to treatment**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Oct-21
Value / RAG rating	82.7%

Indicator description

Percentage of cancer patients starting first treatment within 62 days of urgent GP referral. The operational standard is 85%.

SPC chart



Narrative

Provisional data indicates that the 62 day standard was not delivered in October (82.0%). There were 64.0 accountable treatments (72 patients) in October with 11.5 treated outside 62 days. Of the 10 tumour sites treated in October, performance was below 85% for 4 (Gynaecology, Haematology, Head and Neck, and Colorectal). All pathway delays will be reviewed by the breach panel at the end of November. There was a high number of Colorectal delays due to absence/theatre capacity and a recovery plan is currently being worked through.

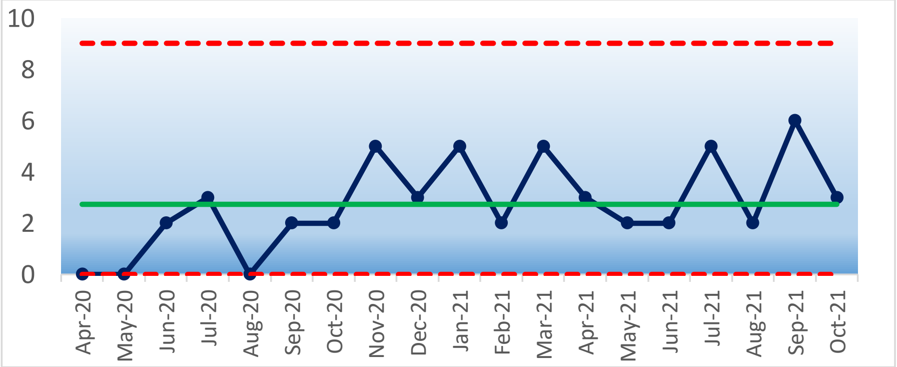
Provisional data indicates that 69% (9/13) of patients treated at tertiary centres in October were transferred for treatment by day 38, which is a deterioration on last month (73%). There are 47 patients on the backlog of which 35 patients are Colorectal. Planned WLI uptake of litst through November and December are already scheduled so performance will reduce whilst backlog clearance is a main focus.

Indicator	**5.9.2 - Cancer - 62 day standard - number of 104 days waiters**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Oct-21
Value / RAG rating	3 🟥

Indicator description

The number of cancer patients waiting 104 days or more since urgent GP referral.

SPC chart



Narrative

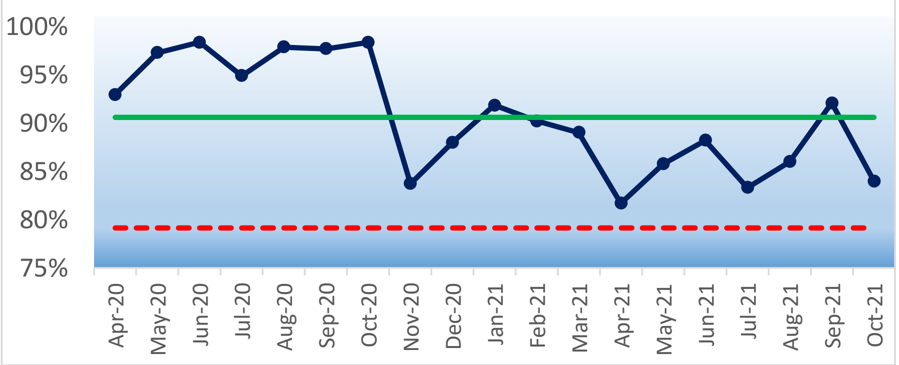
3 patients waited 104+ days for treatment in October (1 x Harrogate Haematology; 1 x Harrogate Colorectal, 1 x Leeds Prostate). The Leeds patients was transferred after day 38 but the pathways was then further delayed due to a lack of theatre capacity at Leeds. The Harrogate delays were predominately due to diagnostic/medical complexity. All patients have now received treatment and their pathways will be reviewed by the breach panel at the end of November.

Indicator	**5.10 - Cancer - 14 days maximum wait from urgent GP referral for all urgent suspect cancer referrals**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Oct-21
Value / RAG rating	84.0%

Indicator description

Percentage of urgent GP referrals for suspected cancer seen within 14 days. The operational standard is 93%.

SPC chart



Narrative

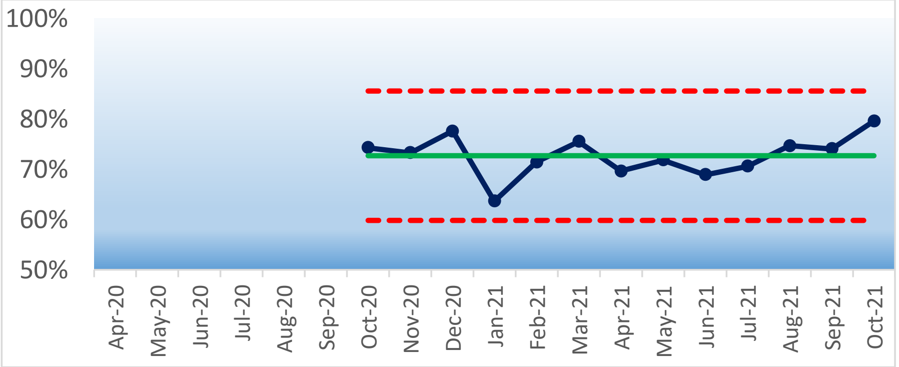
1,030 patients attended their first appointment for suspected cancer in October, which is a 12.1% increase on last month (919). 165 patients were seen after day 14 (compared to 73 last month) and of these, 92 were Breast referrals, 24 were Lower GI referrals, 14 were Urology referrals, 9 were Upper GI referrals, and 7 were Gynae referrals. The breast 2WW standard has been impacted by capacity, but additional private provider clinics have been carried out, bringing the Trust back on track towards the end of November. There have also been considerable challenges for the last few months in Urology due to absence and this position is continuing into November.

Indicator	**5.11 - Cancer - 28 days faster diagnosis standard (suspected cancer referrals)**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Oct-21
Value / RAG rating	79.6%

Indicator description

From January 2022, Trusts are required to deliver the new 28 days faster diagnosis standard for all suspected cancer referrals. The proposed operational standard is 75%.

SPC chart



Narrative

Provisional data indicates that combined performance for the three 28 days standards (2WW suspected cancer, 2WW non-cancer breast symptoms, Screening) has improved in recent months and in October was above the proposed operational standard of 75%. Performance for both 2WW standards remains above 80%.

Indicator	**5.12 - Cancer - 31 days maximum wait from diagnosis to treatment for all cancers**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Oct-21
Value / RAG rating	🟩 98.0%

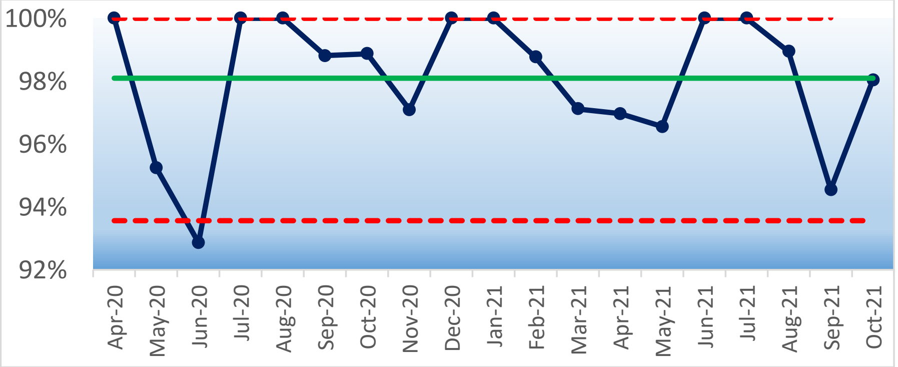
Indicator description

Percentage of cancer patients starting first treatment within 31 days of diagnosis. The operational standard is 96%.

Narrative

Provisional data indicate that 102 patients received First Definitive Treatment for cancer in October which is at a similar level to the number of patients treated last month (110). Two patients were treated after day 31 (1 x colorectal, 1 x Gynae), meaning the the 96% operational standard was delivered in October. All pathway delays will be reviewed by the breach panel at the end of November.

SPC chart



Indicator	**5.13 - Children's Services - 0-12 months and 2-3 years caseload**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	
Value / RAG rating	

Indicator description

This indicator is under development.

SPC chart

Narrative

Indicator	**5.13 - Children's Services - Safeguarding caseload**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	
Value / RAG rating	

Indicator description

This indicator is under development.

SPC chart

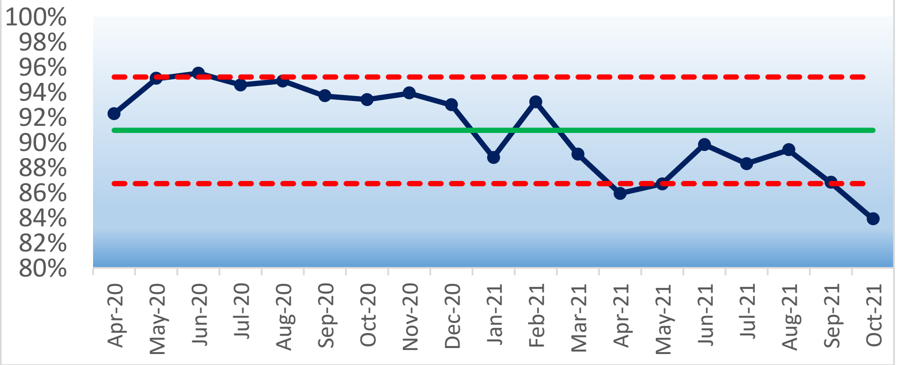
Narrative

Indicator	**5.15 - Children's Services - Ante-natal visits**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Oct-21
Value / RAG rating	83.9%

Indicator description

The number of mothers receiving a first face to face antenatal contact at 28 weeks or above before birth.

SPC chart



Narrative

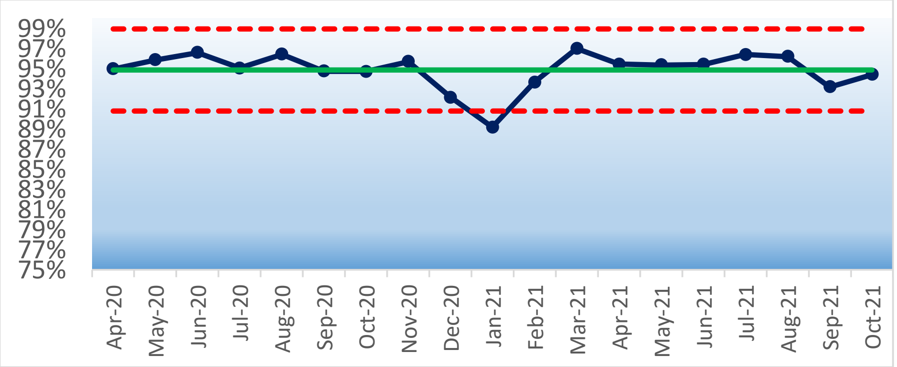
84% of eligible pregnant women received an initial antenatal visit in October.

Indicator	**5.16 - Children's Services - 10-14 day new birth visit**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Oct-21
Value / RAG rating	94.4%

Indicator description

The number of eligible infants who received a face-to-face Health Visitor new birth visit undertaken within 14 days from birth.

SPC chart



Narrative

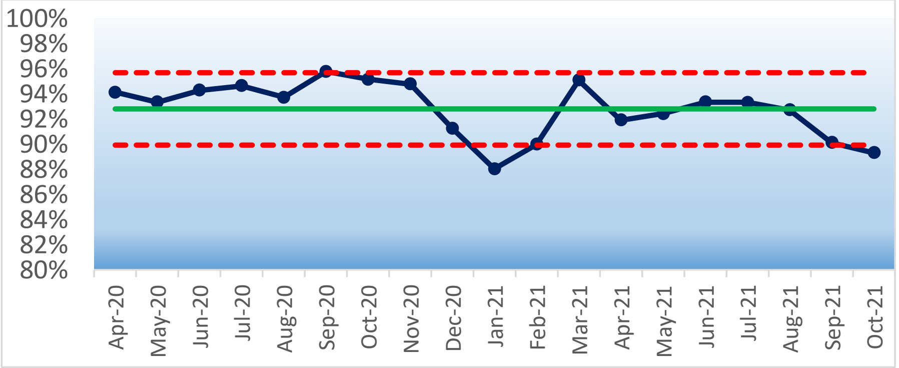
94% of infants received a new birth visit within 10-14 days of birth during October.

Indicator	**5.17 - Children's Services - 6-8 week visit**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Oct-21
Value / RAG rating	89.3%

Indicator description

The number eligible infants who received 6-8 week review by 8 weeks of age.

SPC chart



Narrative

89% of infants received a 6-8 week visit by 8 weeks of age during October.

Indicator	**5.18 - Children's Services - 12 month review**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Oct-21
Value / RAG rating	95.4%

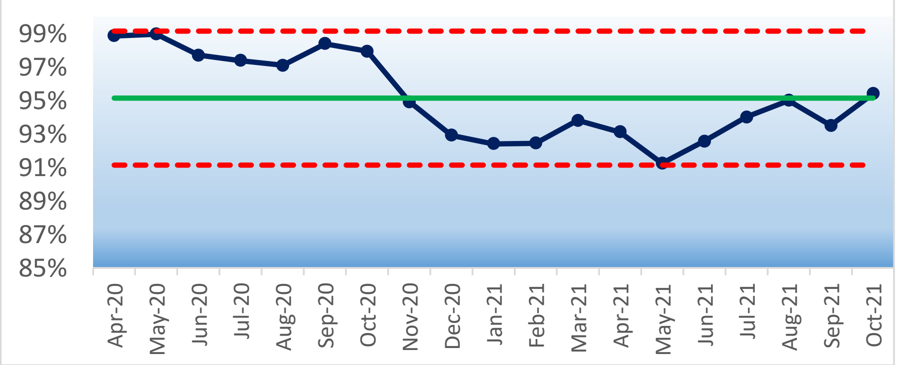
Indicator description

The number of children that received a 12 month review by 15 months of age.

Narrative

95% of eligible children received a 12 month review by 15 months of age during October.

SPC chart

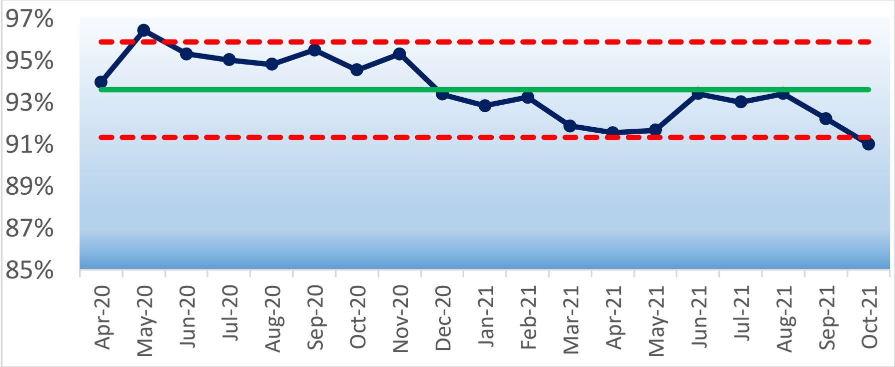


Indicator	**5.19 - Children's Services - 2.5 year review**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Oct-21
Value / RAG rating	🟩 91.0%

Indicator description

The number of eligible children receiving a 2-2.5 year review by the time they were 2.5 years.

SPC chart



Narrative

91% of eligible children received a 2-2.5 year review by 2.5 years of age during October.

Indicator	**5.20 - Children's Services - % children with all 5 mandated contacts**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	
Value / RAG rating	

Indicator description

This indicator is under development.

SPC chart

Narrative

Indicator	**5.21 - Children's Services - Delivery of Immunisation trajectory**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	
Value / RAG rating	

Indicator description

This indicator is under development.

SPC chart

Narrative

Indicator	**5.22 - Children's Services - OPEL level**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	
Value / RAG rating	

Indicator description

This indicator is under development.

SPC chart

Narrative

Indicator	**5.23 - Community Care Adult Teams - performance against new timeliness standards**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	
Value / RAG rating	

Indicator description

This indicator is under development.

SPC chart

Narrative

Indicator	**5.20 - Community Care Adult Teams - Number of virtual beds delivered in Supported Discharge Service**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	
Value / RAG rating	

Indicator description

This indicator is under development.

SPC chart

Narrative

Indicator	**5.25 - Community Care Adult Teams - Number of cancelled routine visits**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	
Value / RAG rating	

Indicator description

This indicator is under development.

SPC chart

Narrative

Indicator	**5.26 - Community Care Adult Teams - OPEL level**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	
Value / RAG rating	

Indicator description

This indicator is under development.

SPC chart

Narrative

Indicator	**5.27 - GPOOH - telephone clinical assessment for URGENT cases within 20 minutes of call prioritisation**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Oct-21
Value / RAG rating	🟥 42.1%

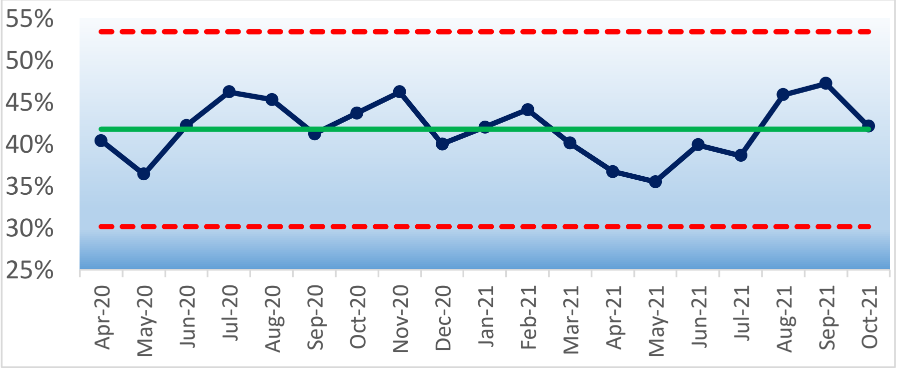
Indicator description

The percentage of telephone clinical assessment for URGENT cases carried out within 20 minutes of call prioritisation.

Narrative

In October, 42% of urgent GPOOH cases received a telephone clinical assessment within 20 minutes of call prioritisation, remaining below the 95% target.

SPC chart



Indicator	**5.28 - GPOOH - Home visit: Face to face consultations started for URGENT cases within 2 hrs**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Oct-21
Value / RAG rating	92.1%

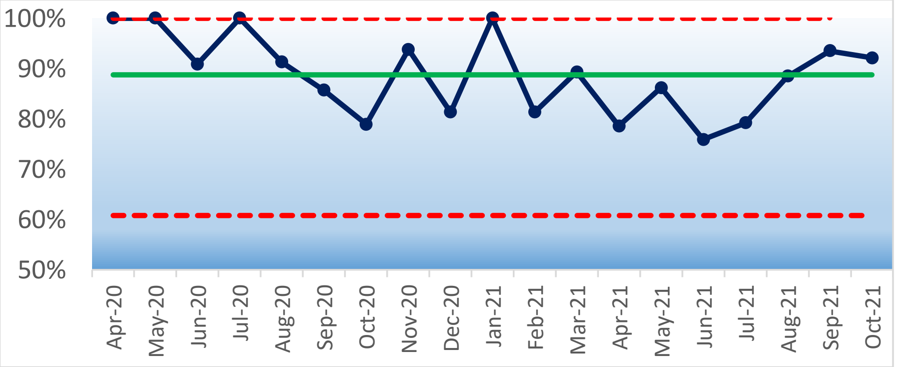
Indicator description

The percentage of home visit face to face consultations started for URGENT cases within 2 hrs.

Narrative

In October, 92% of urgent GPOOH cases received a home visit face to face consultation within 2 hours. There has been an increase in the number of face to face consultations requested as the country moves out of the most recent Covid wave and demand and capacity planning is underway looking to see if the 95% target is achievable with the increase.

SPC chart



Integrated Board Report - October 2021

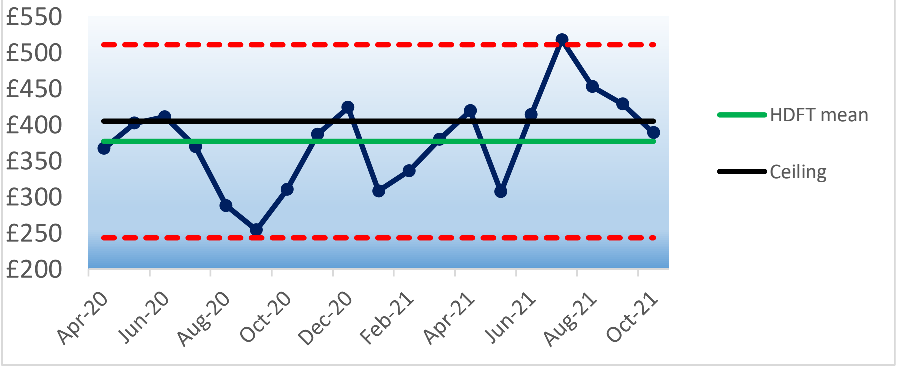
Domain 6 - Efficiency and Finance

Indicator	**6.1 - Agency spend**
Executive lead	Jonathan Coulter, Finance Director
Board Committee	Resources Committee
Reporting month	Oct-21
Value / RAG rating	£389

Indicator description

Expenditure in relation to Agency staff (£'000s). The Trust aims to have less than 3% of the total pay bill on agency staff.

SPC chart



Narrative

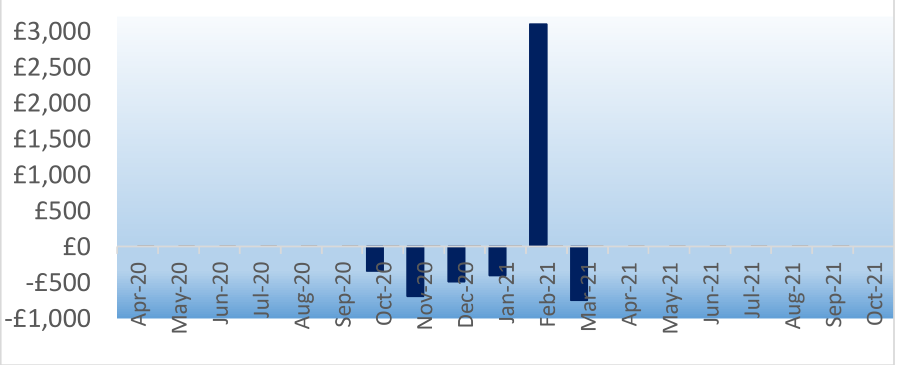
Agency spend in month is below the agency ceiling, with reduction in spend in the PSC Directorate. Pressures continue in LTUC Directorate, especially in relation to key medical staffing vacancies in ED, Cardiology, Neurology and SDEC (Same Day Emergency Care). These are likely to continue through the financial year. An assessment of agency rates from agencies supplying nursing staff is being undertaken as currently there is inconsistency that needs to be challenged.

Indicator	**6.2 - Surplus / deficit and variance to plan**
Executive lead	Jonathan Coulter, Finance Director
Board Committee	Resources Committee
Reporting month	Oct-21
Value / RAG rating	🟩 £0

Indicator description

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.

Trend chart



Narrative

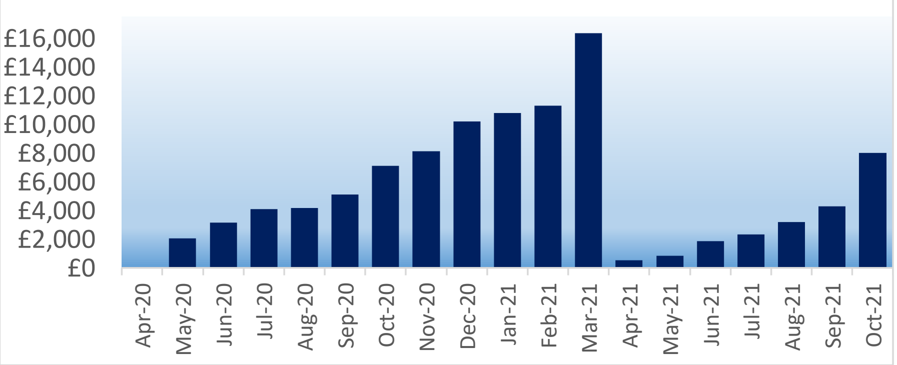
The financial position remains at breakeven, both in month and year to date. This is in line with our plan. The forecast is to continue to deliver our plan through to the end of the year.

Indicator	**6.3 - Capital spend**
Executive lead	Jonathan Coulter, Finance Director
Board Committee	Resources Committee
Reporting month	Oct-21
Value / RAG rating	£8,006

Indicator description

Cumulative Capital Expenditure by month (£'000s)

Trend chart



Narrative

Capital spend has increased in Month 7 but the position year to date remains significantly behind plan. The Salix works are proceeding and the full cost is expected to be expended by the end of March, but the current forecast slippage against the programme as a whole ranges from £2.3m (likely) to £4.9m (worst case). Controls have been introduced to review spend and schemes regularly with Executive oversight. Options are being developed to appropriately utilise any slippage.

Indicator	**6.4 Cash balance**
Executive lead	Jonathan Coulter, Finance Director
Board Committee	Resources Committee
Reporting month	Oct-21
Value / RAG rating	£40,738

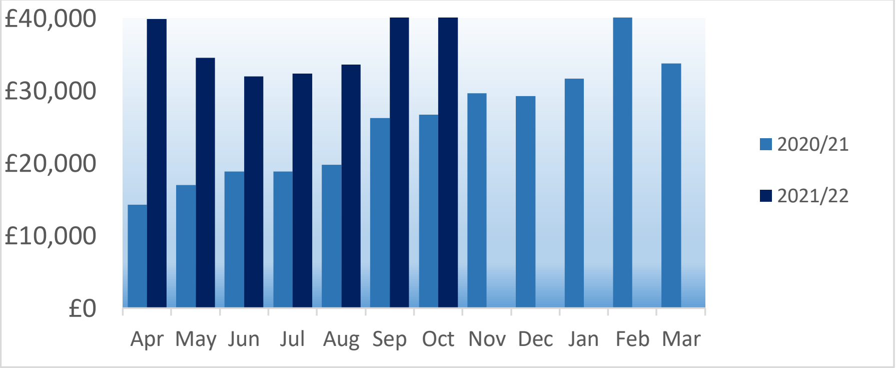
Indicator description

The Trust's cash balance by month (£'000s)

Narrative

The cash balance remains positive as at the end of Month 7, with no concerns currently. The PSPP performance remains positive also, improving further in month to 92% by number (89% by value).

Trend chart

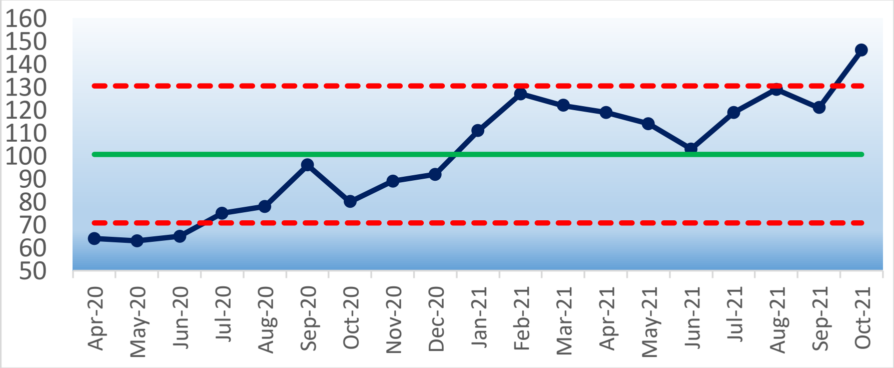


Indicator	**6.5.1 - Long stay patients - stranded (>7 days LOS)**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Oct-21
Value / RAG rating	146

Indicator description

The average number of patients that were in the hospital with a length of stay of over 7 days (previously defined as stranded patients by NHS Improvement). The data excludes children, as per the NHS Improvement definition.

SPC chart



Narrative

The number of long stay patients (> 7 days) increased in October.

For the patients in hospital as at 28/10/21, 47 did not meet the criteria to reside and 179 did (they have been assessed as requiring treatment that can only be provided in hospital). Of the 47 that were assessed as not meeting the criteria to reside, 3 were awaiting internal interventions (e.g. a consultant to say they could be discharged, test results etc). For the remaining 44, external delays were the main reasons they had not been discharged that day. Discussions with social care are underway to understand what mutual aid can be provided to unblock some of the national issues faced by social care.

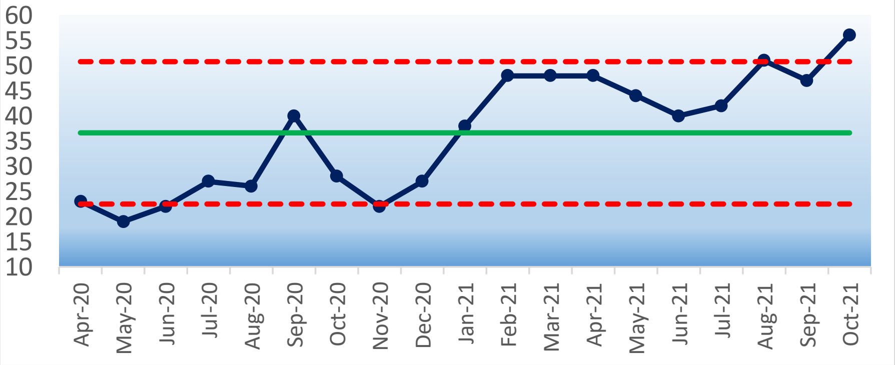
A process is underway to relaunch the discharge policy once the new guidance is issued and also get the system in that makes the delays visible every day along with their cause.

Indicator	**6.5.2 - Long stay patients - superstranded (>21 days LOS)**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Oct-21
Value / RAG rating	🟥 56

Indicator description

The average number of patients that were in the hospital with a length of stay of over 21 days (previously defined as super-stranded patients by NHS Improvement). The data excludes children, as per the NHS Improvement definition.

SPC chart



Narrative

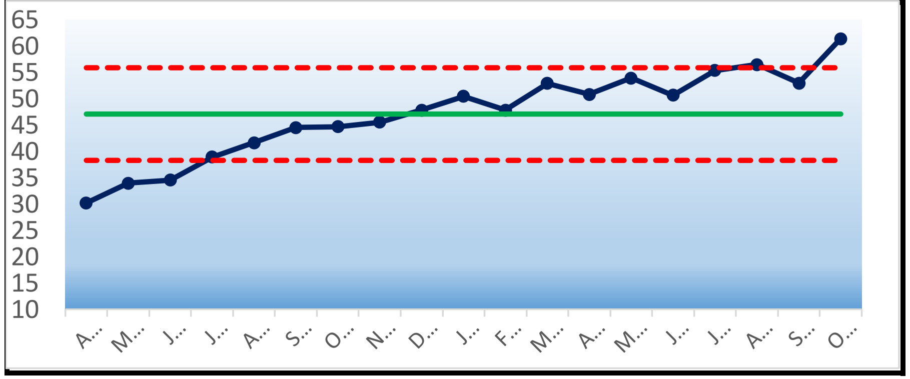
The number of long stay patients (> 21 days) increased in October.

Indicator	**6.6 - Occupied bed days per 1,000 population**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Oct-21
Value / RAG rating	61.4

Indicator description

The number of occupied bed days expressed per 1,000 population, using the mid-2020 population estimate for Harrogate.

SPC chart



Narrative

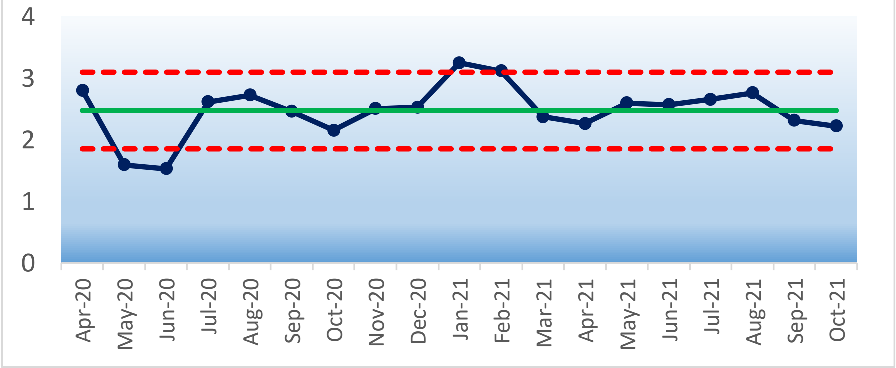
As can be seen on the chart, occupied bed days have steadily increased since the start of the pandemic period and is now at the highest bed occupancy level of all time. By comparison, in the 2 years prior to the pandemic, occupied bed days per 1,000 population averaged 57.8 and now the Trust are at 61.4 highlighting some of the flow issues.

Indicator	**6.7.1 Length of stay - elective**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Oct-21
Value / RAG rating	2.2

Indicator description

Average length of stay in days for elective (waiting list) patients. The data excludes day case patients.

SPC chart



Narrative

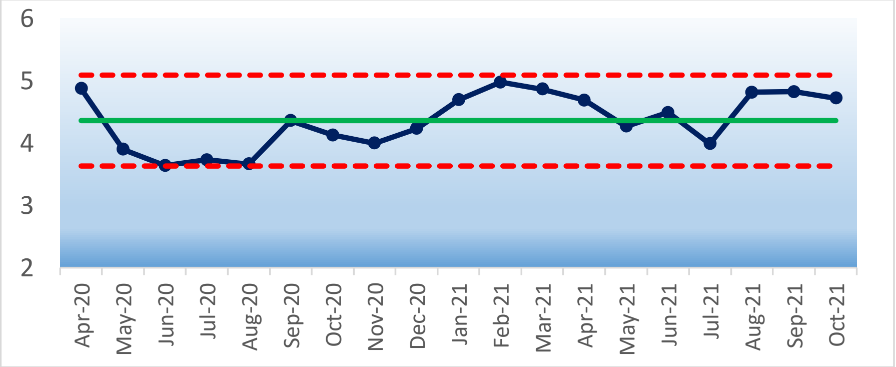
Elective length of stay reduced in October, remaining below our local stretch target of 2.5 days.

Indicator	**6.7.2 Length of stay - non-elective**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Oct-21
Value / RAG rating	🟥 4.7

Indicator description

Average length of stay in days for non-elective (emergency) patients.

SPC chart



Narrative

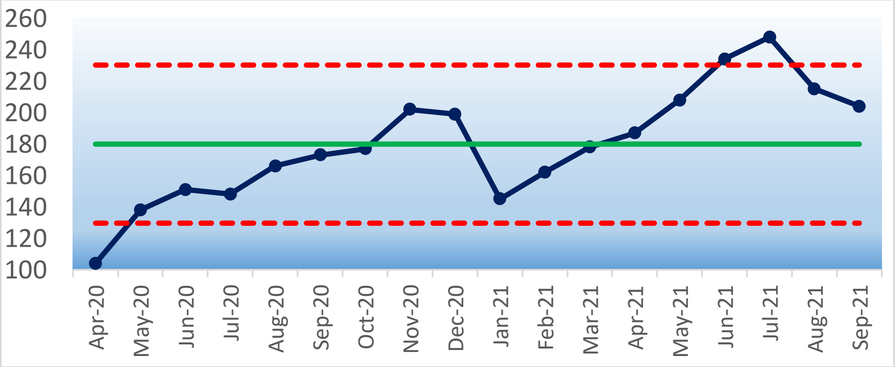
Non-Elective length of stay remained high at 4.7 days in October, mainly impacted by issues with outflow and social care.

Indicator	**6.8 - Avoidable admissions**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Sep-21
Value / RAG rating	204

Indicator description

The number of avoidable emergency admissions as per the national definition. The admissions included are those where the primary diagnosis of the patient does not normally require a hospital admission.

SPC chart



Narrative

There were 215 avoidable admissions in August, a reduction on recent months. The most common diagnoses remain as urinary tract infections, pneumonia and upper respiratory tract infections in children. Excluding children and admissions via CAT/SDEC, the figure was 146.

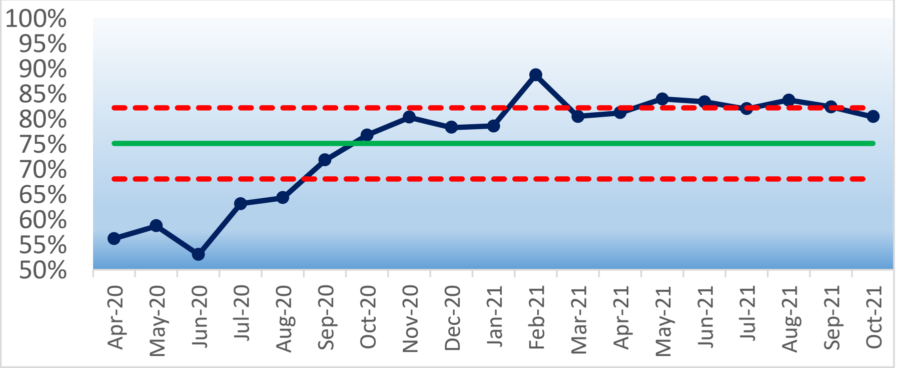
This is below pre-Covid levels - the average per month in 2018/19 was 270.

Indicator	**6.9 - Theatre utilisation (elective sessions)**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Oct-21
Value / RAG rating	🟥 80.4%

Indicator description

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.

SPC chart



Narrative

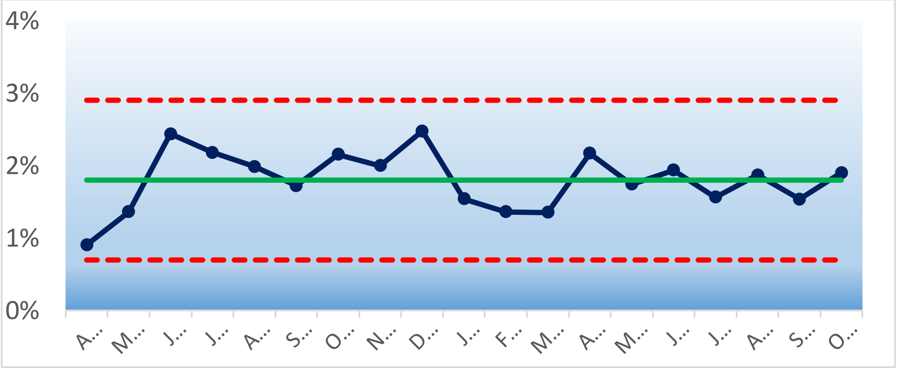
Theatre utilisation remains below the local intermediate target of 90% and has seen a 2% reduction on the previous month due to staff vacancies and annual leave. Dedicated theatre improvement team in place from 1st November. Impact to be monitored and discussed and dedicated report to next month's Trust Board.

Indicator	**6.10 - Day case conversion rate**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Oct-21
Value / RAG rating	1.9%

Indicator description

The percentage of intended elective day case admissions that ended up staying overnight or longer.

SPC chart



Narrative

1.5% (36 patients) of intended day cases stayed overnight or longer in September.

Integrated Board Report - October 2021

Domain 7 - Activity

Indicator	**7.1 - GP referrals against plan and 2019/20 baseline**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	
Value / RAG rating	

Indicator description

This indicator is under development.

SPC chart

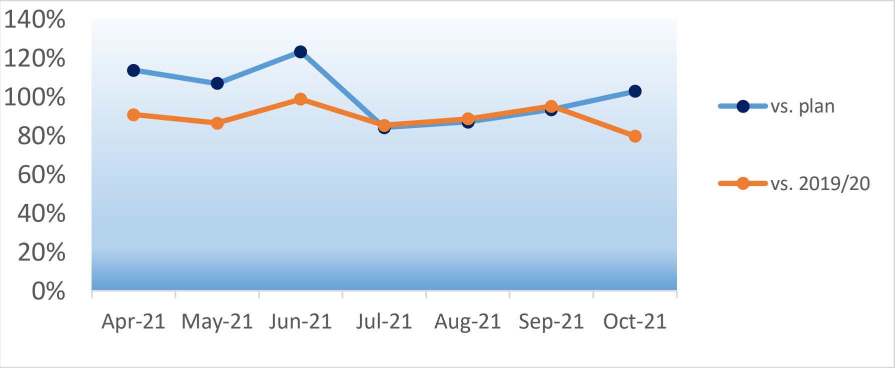
Narrative

Indicator	**7.2 - Outpatient activity (consultant led) against plan**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Oct-21
Value / RAG rating	102.8%

Indicator description

Outpatient activity (consultant led) against plan and 2019/20 baseline. The data includes new and follow up attendances.

Trend chart



Narrative

Outpatient activity was 3% above plan in October. This means that the Trust has not delivered the Elective Recovery Fund (ERF) requirements.

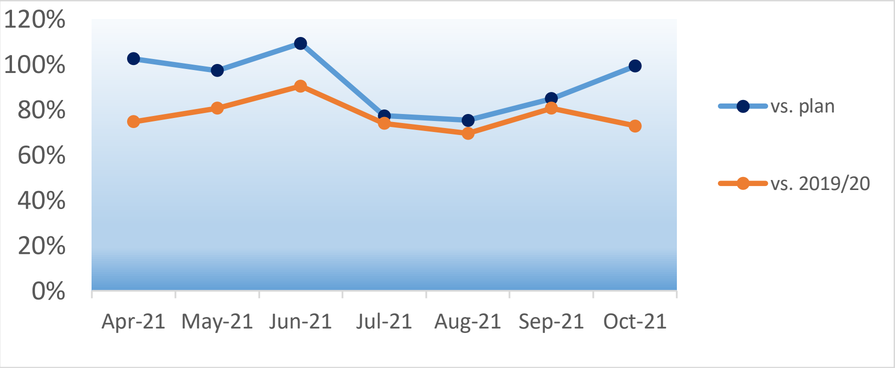
Please note that the Oct-21 plan figures have been updated to reflect the updated H2 plans submitted to NHSE/I in early November.

Indicator	**7.3 - Elective activity against plan**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Oct-21
Value / RAG rating	99.3%

Indicator description

Elective activity against plan and 2019/20 baseline. The data includes both elective inpatient and elective day case admissions.

Trend chart



Narrative

Elective admissions were 25% below plan in October. Day case activity was 24% below plan and inpatient activity 36% below plan. As a result, the Trust has not delivered the Elective Recovery Fund (ERF) requirements.

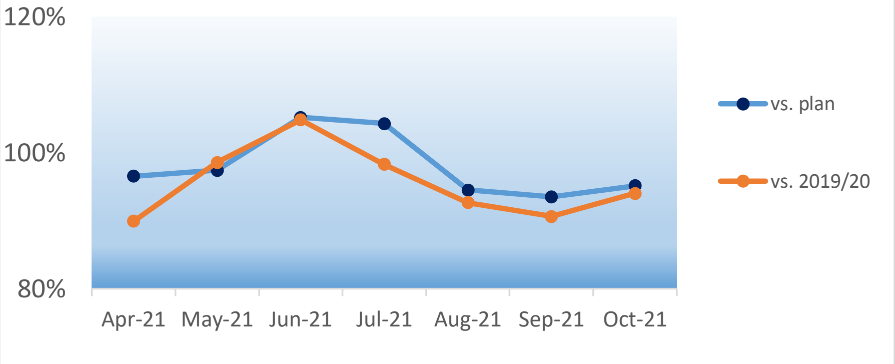
Please note that the Oct-21 plan figures have been updated to reflect the updated H2 plans submitted to NHSE/I in early November.

Indicator	**7.4 - Non-elective activity against plan**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Oct-21
Value / RAG rating	95.1%

Indicator description

Non-elective activity against plan and 2019/20 baseline.

Trend chart



Narrative

Non-elective activity was 5% below plan in October.

Please note that the Oct-21 plan figures have been updated to reflect the updated H2 plans submitted to NHSE/I in early November.

Indicator	**7.5 - Emergency Department attendances against plan**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Oct-21
Value / RAG rating	101.6%

Indicator description

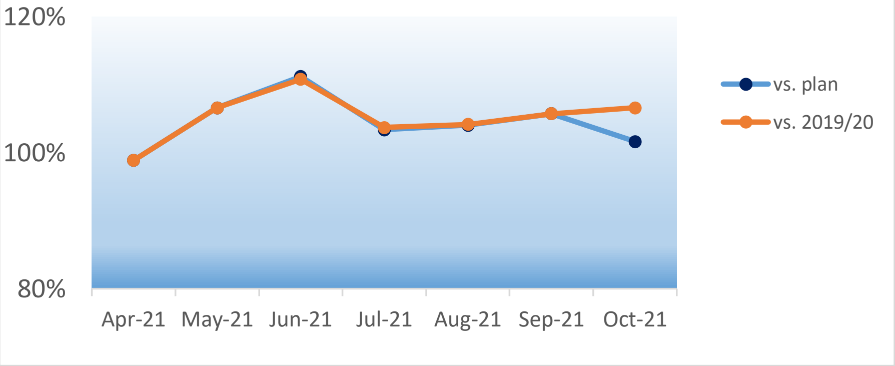
Emergency Department attendances against plan and 2019/20 baseline.

Narrative

Emergency Department attendances were 2% above plan in October.

Please note that the Oct-21 plan figures have been updated to reflect the updated H2 plans submitted to NHSE/I in early November.

Trend chart



Board of Directors
November 2021

Title:	Finance Position October 2021
Responsible Director:	Finance Director
Author:	Finance Director Deputy Director of Finance

Purpose of the report and summary of key issues:	The report has been developed to give information and assurance on the financial position as reported as at the end of October 2021. The position includes information on Revenue, Capital and Payment Practice. The Board is asked to note the contents of the paper.	
BAF Risk:	AIM 1: To be an outstanding place to work	
	BAF1.1 to be an outstanding place to work	x
	BAF1.2 To be an inclusive employer where diversity is celebrated and valued	
	AIM 2: To work with partners to deliver integrated care	
	BAF2.1 To improve population health and wellbeing, provide integrated care and to support primary care	
	BAF2.2 To be an active partner in population health and the transformation of health inequalities	
	AIM 3: To deliver high quality care	
	BAF3.1 and 3.4 To provide outstanding care and outstanding patient experience	
	BAF3.2 To provide a high quality service	x
	BAF3.3 To provide high quality care to children and young people in adults community services	
	BAF3.5 To provide high quality public health 0-19 services	
	AIM 4: To ensure clinical and financial sustainability	
	BAF4.1 To continually improve services we provide to our population in a way that are more efficient	x
	BAF4.2 and 4.3 To provide high quality care and to be a financially sustainable organisation	x
	BAF4.4 To be financially stable to provide outstanding quality of care	x
Corporate Risks	No Change	
Report History:	Information within the reported is supported by Directorate Board discussions, and the monthly Resource Review sessions.	
Recommendation:	The Board is asked to note and discuss the contents of this report.	

Harrogate and District NHS Foundation Trust

Board of Directors

Financial Position – October 2021

1. Purpose of the report

This paper has been developed to update the Board of Directors on progress against the annual Financial Plan. The Board of Directors is asked to note the contents of the report.

As described below, the Trust Revenue position is aligned to plan. There are specific issues described in relation to the Capital Programme and Better Payment Practice Code (BPPC) performance.

2. Introduction

The paper is an update on the Trust Financial Position, and continues the monthly updates received by the Board. The paper aims to provide assurance on the financial position, as well as provide opportunity to discuss the key financial issues across the organisation.

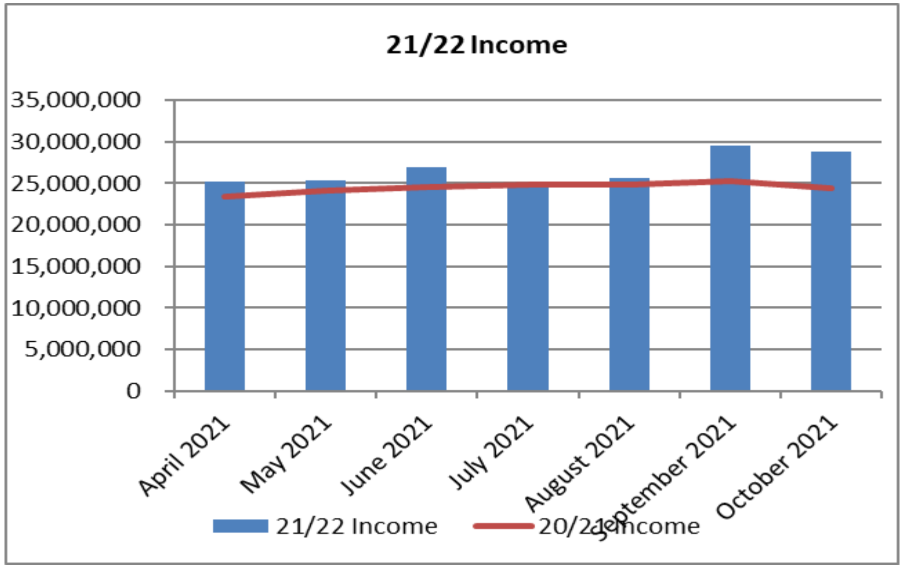
Information within the reported is supported by Directorate Board discussions, and the monthly Resource Review sessions.

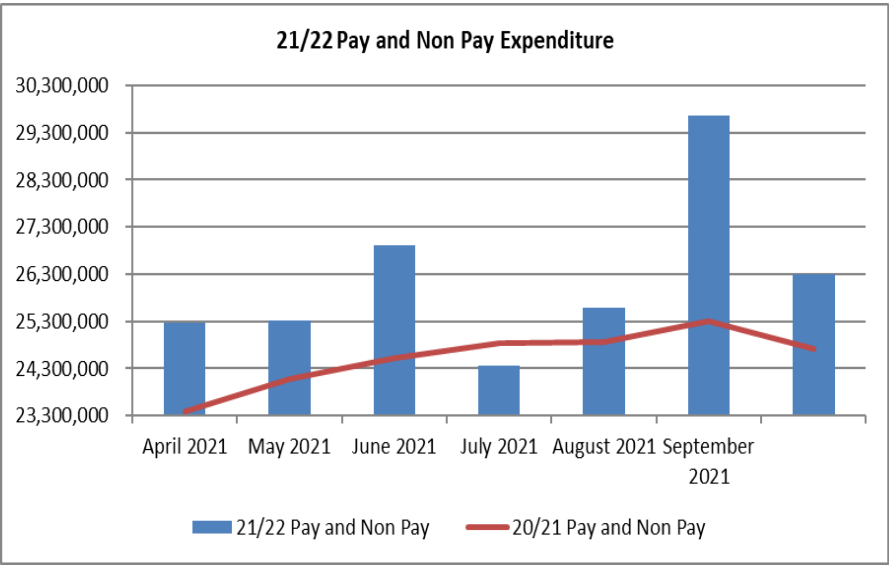
3. Financial Position

High Level Analysis	Mth Budget £000's	Mth Actual £000's	Variance £000's	YTD Budget £000's	YTD Actual £000's	YTD Variance £000's
Commissioner Income	**21,001**	**24,723**	**3,723**	**£152,810**	**£158,837**	**£6,026**
Directorate Income	**3,554**	**4,047**	**493**	**£25,048**	**£27,303**	**£2,255**
Pay Costs	-17,600	-17,091	509	-117,684	-116,179	1,505
Non Pay Costs	-8,864	-9,213	-349	-63,393	-67,243	-3,850
Expenditure	**-26,464**	**-26,305**	**160**	**-181,077**	**-183,422**	**-2,344**
Surplus / (Deficit)	**-1,910**	**2,466**	**4,376**	**-3,219**	**2,718**	**5,937**

Notes *YTD income budget to increase following H2 system finance plan agreement **Salix Income of £2.7m included in the position

3.1 Revenue





The position above of a £2,718k surplus is a positive position for the second half of 2021/22. The position includes income associated with the Salix grant. Adjusting for this results in a breakeven position, in line with the plan and expectations set by NHS England and NHS Improvement (NHSEI).

The H2 forecast (October to March) at this point remains a breakeven position.

Month 7 has reverted back to run rate with the addition of the Northumberland 0-19 service, an increase in pay spend of £438k a month. Pay spend is expected to increase in the upcoming months as the Immunisation/Flu campaigns commence in the community alongside the 12-15year old vaccination programme.

The income allocation for H2 has finally been agreed with CCG's in the main this will remain as a block payment, this includes a Covid and growth allocation. It has been confirmed that the Local Authority pay award has been allocated to local ICS however we are still working through this with the CCG, £950k. Income budgets will be updated for M8 to reflect the revised contract values but the information wasn't available before the budget deadline.

Community &Childrens	YTD Budget £000's	YTD Actual £000's	Variance £000's
Income	**1,023**	**1,016**	**-7**
Pay Costs	-34,831	-33,567	1,264
Non Pay Costs	-3,615	-2,837	778
Expenditure	**-38,445**	**-36,404**	**2,042**
Total	**-37,422**	**-35,388**	**2,034**

LTUC	YTD Budget £000's	YTD Actual £000's	Variance £000's
Income	**3,963**	**4,022**	**59**
Pay Costs	-34,783	-35,128	-345
Non Pay Costs	-13,086	-13,311	-225
Expenditure	**-47,870**	**-48,439**	**-569**
Total	**-43,907**	**-44,417**	**-510**

PSC	YTD Budget £000's	YTD Actual £000's	Variance £000's
Income	**450**	**535**	**85**
Pay Costs	-31,815	-31,632	184
Non Pay Costs	-12,615	-11,608	1,007
Expenditure	**-44,430**	**-43,240**	**1,190**
Total	**-43,980**	**-42,704**	**1,276**

Corporate	YTD Budget £000's	YTD Actual £000's	Variance £000's
Income	**5,302**	**7,916**	**2,614**
Pay Costs	-10,195	-10,063	132
Non Pay Costs	-22,077	-21,708	369
Expenditure	**-32,272**	**-31,771**	**501**
Total	**-26,970**	**-23,855**	**3,115**

HIF	YTD Budget £000's	YTD Actual £000's	Variance £000's
Income	**11,901**	**11,711**	**-190**
Pay Costs	-5,693	-5,335	358
Non Pay Costs	-6,111	-6,130	-19
Expenditure	**-11,804**	**-11,465**	**339**
Total	**97**	**247**	**149**

There is a clear importance in managing directorate budgets to ensure the Trust financial plan is achieved.

Directorate performance is outlined to the side.

The Children's directorate now includes Northumberland 0-19 service and the 12-15year old vaccination programme.

Within the directorate positions are some common areas of risk.

These include –

- Ward expenditure positions – Currently overspending in LTUC. Acuity review impact still to be assessed.
- Medical Staffing pressures – there are some localised staffing pressures, with plans being developed and/or managed at Directorate level.
- Significant underspends within Children's Services, Adult Community Services, Theatres and Endoscopy.
- Activity levels being re-established in PSC and backlogs being addressed across Directorates.
- Delivery of H2 CIP.
- General risk of covering staff in Acute area's from Covid sickness/Isolation if this rises again.
- Winter pressures
- Utility pressures

These areas will be closely monitored across the year.

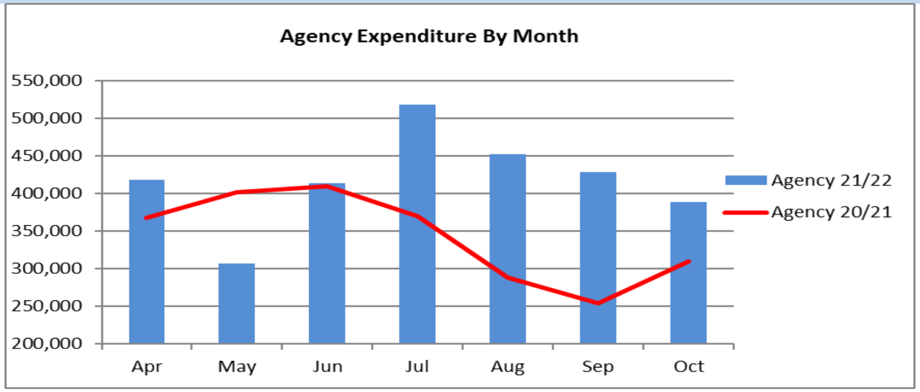
HR and Finance colleagues continue to reconcile vacancies across the directorates.

3.2 Agency

Month 7 expenditure on Agency is £389k. This is a reduction of £40k compared to the previous month, the main reduction being from PSC across a number of services.

Of the agency costs to date, this has mainly been incurred in LTUC directorate, 65%, the majority in relation to Medical Staffing covering numerous vacancies and sickness, ED, Cardiology, Neurology and SDEC these costs are likely to continue for the rest of the year.

	Actual							
	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	YTD
Total Agency	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Medical	-216	-169	-264	-334	-306	-231	-216	-1,735
Nursing	-123	-100	-110	-146	-113	-157	-124	-873
Other Clinical	-17	5	-9	-13	-10	-13	-15	-72
Non Clinical	-63	-42	-30	-24	-25	-28	-34	-247
Total Agency	**-419**	**-307**	**-414**	**-518**	**-453**	**-429**	**-389**	**-2,928**
Agency Ceiling	-448	-448	-448	-448	-448	-448	-448	**-3,136**
Variance	**-29**	**-141**	**-34**	**70**	**5**	**-19**	**-59**	**-208**



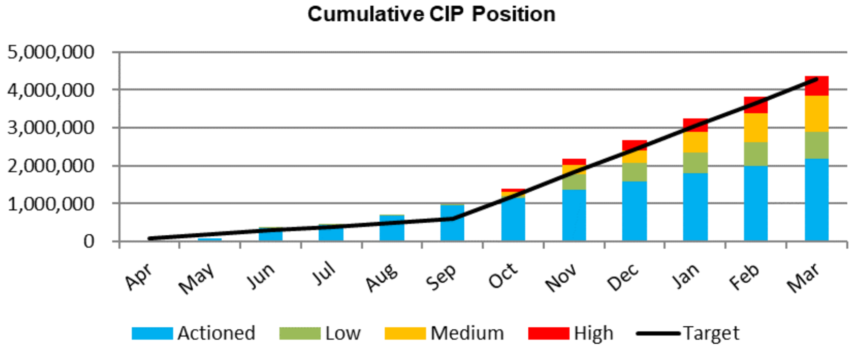
3.3 CIP

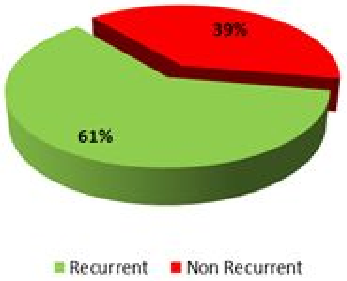
A 3% efficiency programme for the second half of the year was agreed, due to the anticipated income reduction from the CCG, as part of the H2 financial framework.

The H2 target is £3.1m, this was in additional to any carried forward targets.

Directorates have been developing CIP programmes for H2 and the current position is summarised below, the gap has reduced dramatically, however there is still a significant amount flagged as medium to high risk and 39% of the schemes are non recurrent.

Target	Actioned	Low	Medium	High	Unidentified	Total	Total %age	Risk Adjusted Plans	Risk adjusted shortfall	Risk Adj %age
4,285,800	2,197,000	699,700	367,000	521,750	500,350	3,785,450	**88%**	3,259,665	1,026,135	**76%**
% of target	**51%**	**16%**	**9%**	**12%**	**12%**					





3.4 Capital

The current spend to the end of October is £8.006m against a plan of £19.9m. This continues to be a significant variance to plan. Part of this issue relates to performance against the Salix programme (£4.7m) and is being managed through the Salix Project Board.

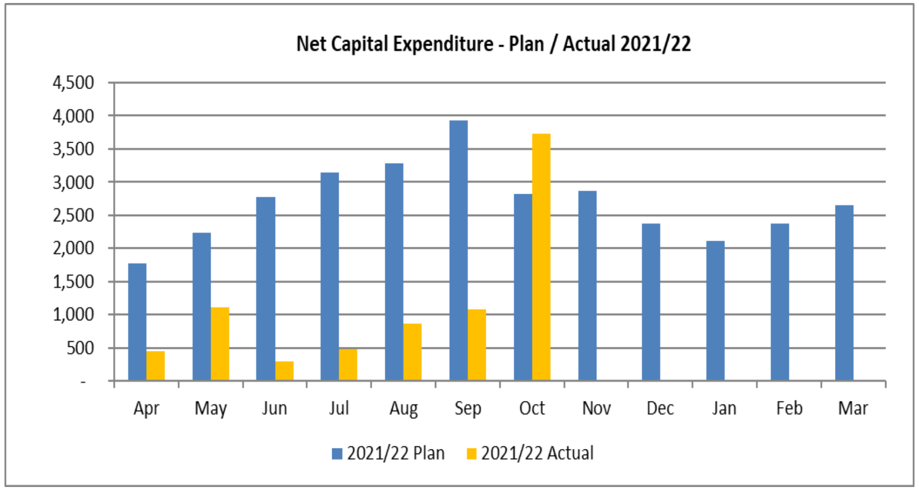
The graph on the right outlines the scale of expenditure still required in 2021/22.

Actions taken to date

- All schemes and progress have been reviewed.
- Directorates have been asked to focus on previously prioritised schemes.
- If slippage does become available Directorates have been asked to prioritise further capital schemes.

Charity funded capital spend to date is £12k mainly in relation to the SROC area.

To note a further £1.6m has been received for replacement of diagnostic equipment.



Scheme	Plan	YTD	Likely Forecast	Worst Case
Salix	14,180	4,692	14,353	13,471
ICS/WYATT	4,848	491	3,390	3,390
Trust Wide	12,750	2,823	11,690	9,958
Total	**31,778**	**8,006**	**29,433**	**26,819**

3.5 Better Payment Practice Code

Better Payment Practice Code				
	In Month		YTD	
	Number	£000's	Number	£000's
Total Invoices paid in Period	3,787	8,618	23,009	45,991
Total Invoices paid within target	3,474	7,708	20,759	39,862
% Paid within target	92%	89%	90%	87%

The Trust is required to adhere to the Better Payment Practice Code, which targets the payment of 95% of invoices within 30 days.

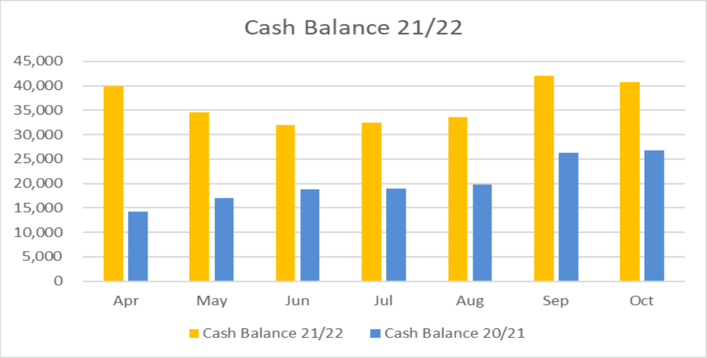
Improvements in processes within the Payments Team, as well as the resolution of historic debts and the improved payment terms as part of the Covid response has resulted in a significant improvement in performance.

September position reported at 89%, maintaining current performance.

The Purchase Order process is being reviewed to improve performance further.

3.6 Cash Balance

The Trust cash balance remains positive as at the end of October with no current concerns.



4. Financial Implication/Risk assessment

As described within the report. The Trust continues to balance the overall position, however, there remains pressures in some areas, with underspending issues as much an issue as those areas overspending.

The finances have been agreed for the second half of 21/22 but delivery of a CIP programme will be fundamental to deliver financial balance in H2.

5. Risks

There are currently no issues of risk to be updated on the Corporate risk register related to this report. Risks are being managed within local risk registers, and will be escalated when appropriate.

6. Recommendation

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

Jonathan Coulter
Deputy Chief Executive / Finance Director

teamHDFT
At our best

NHS
Harrogate and District
NHS Foundation Trust

Board of Directors (Public)
24th November 2021

Title:	Operational Performance Update
Responsible Director:	Chief Operating Officer
Author:	Chief Operating Officer

Purpose of the report and summary of key issues:	To inform the Trust Board of the month 7 position regarding operational performance	
BAF Risk:	AIM 1: To be an outstanding place to work	
	BAF1.1 to be an outstanding place to work	
	BAF1.2 To be an inclusive employer where diversity is celebrated and valued	
	AIM 2: To work with partners to deliver integrated care	
	BAF2.1 To improve population health and wellbeing, provide integrated care and to support primary care	✓
	BAF2.2 To be an active partner in population health and the transformation of health inequalities	✓
	AIM 3: To deliver high quality care	
	BAF3.1 and 3.4 To provide outstanding care and outstanding patient experience	✓
	BAF3.2 To provide a high quality service	✓
	BAF3.3 To provide high quality care to children and young people in adults community services	✓
	BAF3.5 To provide high quality public health 0-19 services	✓
	AIM 4: To ensure clinical and financial sustainability	
	BAF4.1 To continually improve services we provide to our population in a way that are more efficient	✓
	BAF4.2 and 4.3 To provide high quality care and to be a financially sustainable organisation	✓
	BAF4.4 To be financially stable to provide outstanding quality of care	
Report History:	Monthly Trust Board Update	
Recommendation:	It is recommended that Trust Board note the items contained within this report.	

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Trust Board - Operational Update

November 2021

Russell Nightingale
Chief Operating Officer

Operational Update November 2021 (October Performance)

Matters of concern & risks to escalate

- Increase in COVID admissions resulting in requirement to open additional beds and create COVID ward (31 patient peak)
- 159 elective theatres lists ran out of a possible 233 (68%), lost lists primarily due to theatre staffing vacancies and sickness across October
- Two week wait cancer performance – 82% against the 93% standard *(5.1)* blip in increased breast capacity
- Elective demand remains high and the Trust continues at full capacity (>100% bed occupancy)
- Demand for new outpatient ECHO test has increased by 39% based on 2019 demand *(5.3)*
- 4-hour ED performance – October performance deteriorated to 75.9%, significant bed pressures impacting on flow, continued increase in presentations, 9% above 2019/20 levels. *(5.6)*
- Eight x 12-hour trolley waits in ED, significant bed pressures impacting on flow through the department (5.8)
- 11 x 60-minute ambulance handover breaches in October (all under 80 minutes)

Major actions commissioned & work underway

- ARCHS recruitment on track to match the increased 35 patient bed model in the community approved at resource committee
- Urgent Care Practice Educator has developed a training programme to be run in conjunction with an external training course to develop ENPs into Urgent Care Practitioners (UCP). This will widen their scope of practice and enable them to work in both the urgent care stream and as the front door streamer
- Dedicated Theatre recovery team in place from 1st November combined with external culture programme team to support theatre staff, already showing a marked improvement
- UEC Flow Dashboard now completed and in trial stage, due for full rollout in November
- 51-point UEC action plan has been developed with all actions to be completed by March 2022.
- Winter plan written and shared with system partners. 550k allocated to HDFT, schemes prioritised: Pharmacy w/e cover, Winter Ward, Transfer team, increased weekend middle grade doctor cover, additional patient transport, GP streaming model, expanded respiratory virtual ward, increase site management
- NIV consolidated on Bolton Ward until December

Positive news & assurance

- Cancer 31-day wait target achieved at 98% *(5.1.2)*
- 1,030 patients attended their first appointment for suspected cancer in October, which is a 12.1% increase on last month (919)
- Cancer 28 days faster diagnosis 74.6%, just below the 75% standard *(5.11)*
- Referral to treatment total waiting list reduced in October (5.1.3); 92nd percentile remained at 41 weeks (5.1.3)
- 52+ week waits at 1,070, below the trajectory of 1.089 *(5.1.4)*
- H2 M1 plan met for all measures (Slide 3)
- Continuing to support LTHT and YTH with Endoscopy demand c.150 patients per month
- Providing System aid to York as it continues to declare OPEL 3 / 4
- Total RTT waiting list reduced for the first time in 11 months
- Safe and successful site shutdown for power and oxygen manifold repair

Decisions made & decisions required

- All new HDH GP Out of Hours posts to be advertised with the ED element included in the job description to widen the workforce pool
- Flow meetings now changed to ECIST recommended best practice model (8:30, 12:30, 16:30 meetings) with required membership and scripted updates to ensure consistency. Meetings now recorded on Teams for governance oversight
- Review of RTT validation process to align to need of H2, external support introduced
- Additional non-elective capacity opened (15 beds)
- Commissioning of additional ambulance transport to support discharge from ED

Planned Care Recovery

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H2 Activity Plan - HDFT
Outpatients

	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Number of episodes moved or discharged to a Patient Initiated Follow Up (PIFU) Plan	10	10	214	214	214	290
	10					

Consultant-led first outpatient attendances (Spec acute) Plan	4,435	4,653	4,189	4,809	4,285	4,185
Consultant-led first outpatient attendances (Spec acute) Actual	4,434					
Consultant-led follow-up outpatient attendances (Spec acute) Plan	8,747	9,242	8,131	9,780	8,375	9,702
Consultant-led follow-up outpatient attendances (Spec acute) Actual	9,101					

Elective Admissions

Total number of Specific Acute elective spells in the period Plan	2,513	2,561	2,292	2,529	2,516	2,605
Total number of Specific Acute elective spells in the period Actual	2,498					
Total number of Specific Acute elective day case spells in the period Plan	2,332	2,345	2,094	2,318	2,310	2,388
Total number of Specific Acute elective day case spells in the period Actual	2,317					
Total number of Specific Acute elective ordinary spells in the period Plan	181	216	198	211	206	217
Total number of Specific Acute elective ordinary spells in the period Actual	181					

RTT

Number of Completed Admitted RTT Pathways Plan	866	972	871	961	956	989
Number of Completed Admitted RTT Pathways Actual	970					
Number of Completed Non-Admitted RTT Pathways Plan	3,930	4,020	3,563	4,221	3,661	3,822
Number of Completed Non-Admitted RTT Pathways Actual	4,591					
Number of New RTT Pathways (Clockstarts) Plan	7,466	7,334	5,855	7,023	6,122	6,302
Number of New RTT Pathways (Clockstarts) Actual	7,142					

The number of incomplete RTT pathways waiting 52+weeks Plan	1,089	1,069	1,049	1,029	1,009	978
The number of incomplete RTT pathways waiting 52+weeks Actual	1,070					
The number of incomplete RTT pathways waiting 104+weeks Plan	33	33	30	27	14	0
The number of incomplete RTT pathways waiting 104+weeks Actual	33					
The total number of incomplete RTT pathways Plan	22,900	22,500	22,350	22,200	22,050	21,900
The total number of incomplete RTT pathways Actual	22423					

Cancer

The number of cancer 62 day pathways waiting 63 days or more after an urgent suspected cancer referral Plan	46	46	46	46	35	27
The number of cancer 62 day pathways waiting 63 days or more after an urgent suspected cancer referral Actual	41					

H2 Plan used from Oct onwards reflects H1 level outturn, increasing elective admissions to reduce gap to 19/20 continues to be the focus. There is 12-week dedicated project support in theatres that commenced in October to aid recovery.

To mitigate the WLI changes and annual leave rollover dynamic, clinical sessions are in place to ensure most clinically pressured activity is covered .

The Trust increased beds on the Elective Surgical Unit, these remain in place to help mitigate increased activity levels.

The 5th room to support capsule endoscopy remains operational and Endoscopy lists are available seven days per week, there is currently a reduction in demand for Endoscopy, HDFT continue to support LTHT and YTH with endoscopy work c.150 patients per month to increase activity levels. Review of endoscopy use underway and its ability to support arrivals for day case theatre work.

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	TOTAL
Primary Care Referrals 2019/20	4,785	5,137	4,683	5,112	4,494	4,652	5,116						55,922
Primary Care Referrals 2021/22	4,730	4,988	5,464	5,286	4,688	5,394	5,115						35,665
%	99%	97%	117%	103%	104%	116%	100%						106%

Advice and Guidance 2019/20	434	439	420	539	404	481	513						5,571
Advice and Guidance 2021/22	653	690	695	654	611	708	750						4,761
% Increase / Decrease	50%	57%	65%	21%	51%	47%	46%						47%

Total New OP F2F 2021/22	5,476	5,491	6,152	6,104	5,541	6,148	5,895						40,807
Total New OP Non F2F 2021/22	1,612	1,542	1,817	1,498	1,338	1,532	1,405						10,744
Total New OP F2F % 2021/22	77%	78%	77%	80%	81%	80%	81%						79%
Total New OP Non F2F % 2021/22	23%	22%	23%	20%	19%	20%	19%						21%
Total Follow Up OP F2F % 2021/22	10,686	10,647	12,141	11,589	11,227	12,505	11,817						80,612
Total Follow Up OP Non F2F % 2021/22	4,110	3,851	4,069	3,748	3,216	3,991	3,728						26,713
Total Follow Up OP F2F % 2021/22	72%	73%	75%	76%	78%	76%	76%						75%
Total Follow Up OP Non F2F % 2021/22	28%	27%	25%	24%	22%	24%	24%						25%
Total OP F2F %	74%	75%	76%	77%	79%	77%	78%						76%
Total OP Non F2F %	26%	25%	24%	23%	21%	23%	22%						24%

Cancer	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Patients Treated within 62D	85.5%	87.1%	92.3%	83.30%	91.70%	89%	82%					
Patients Waiting >62D	21	38	35	50	60	29	41					
Patients treated within 31D of diagnosis	97.0%	96.6%	100%	100%	98.90%	94.50%	98%					
Urgent Referrals (2WW) seen	808	891	949	896	879	920	1030					
Urgent Referrals (2WW) seen within 14D	81.7%	85.7%	88.2%	83.30%	86%	92.10%	84%					

Diagnostic Tests - % of patients waiting >6W	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Magnetic Resonance Imaging	16%	21%	15%	19%	17%	7%	4%						
Computed Tomography	6%	4%	3%	11%	5%	4%	5%						
Non-Obstetric Ultrasound	16%	13%	6%	12%	13%	14%	9%						
Colonoscopy	12%	4%	3%	3%	5%	8%	9%						
Flexi Sigmoidoscopy	14%	6%	7%	5%	0%	6%	9%						
Gastroscopy	13%	9%	7%	4%	8%	13%	7%						
Cardiology - Echocardiography	[illegible]	[illegible]	3%	8%	62%	56%	34%						

Elective Recovery

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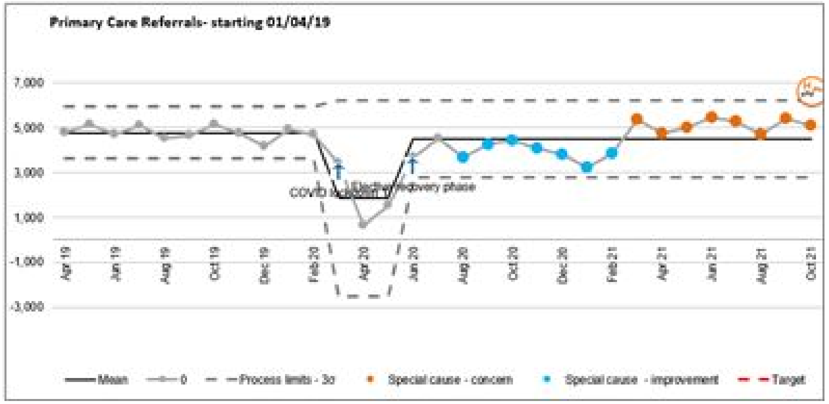
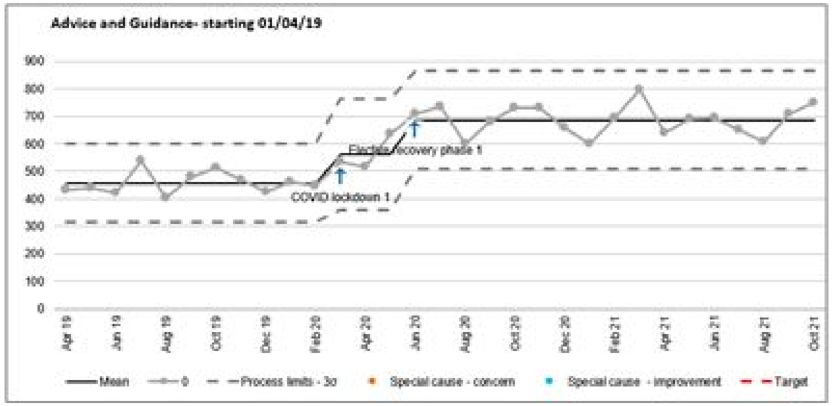
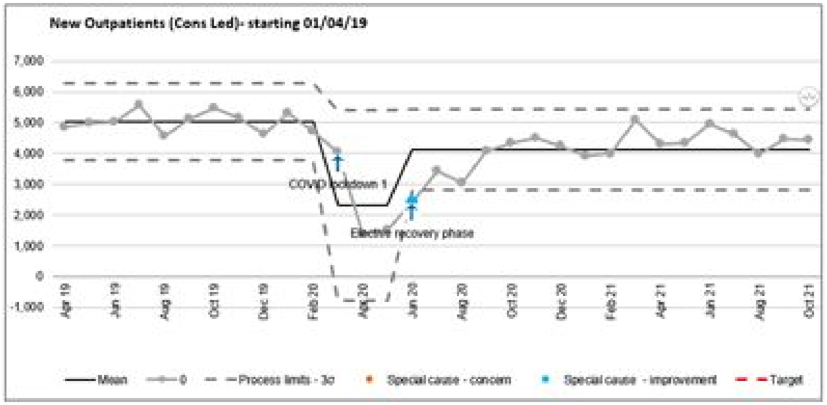
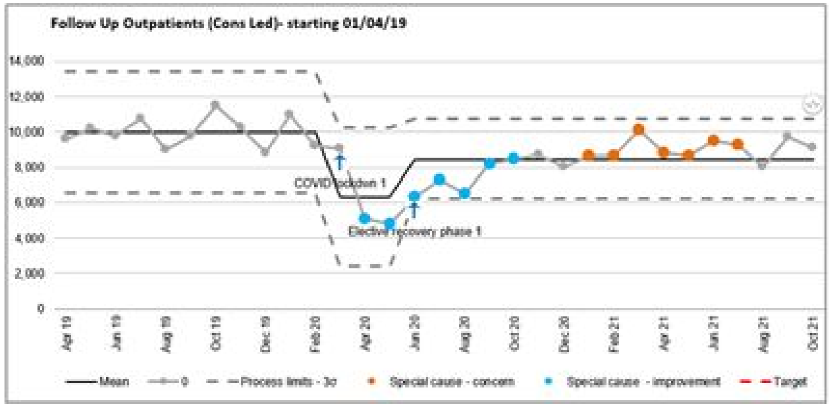
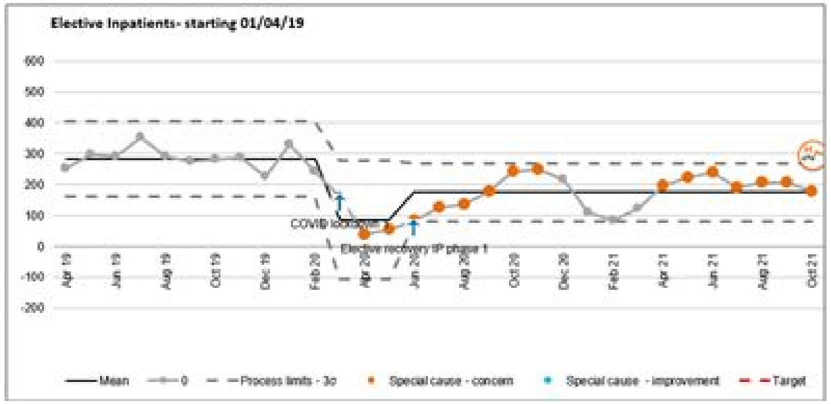
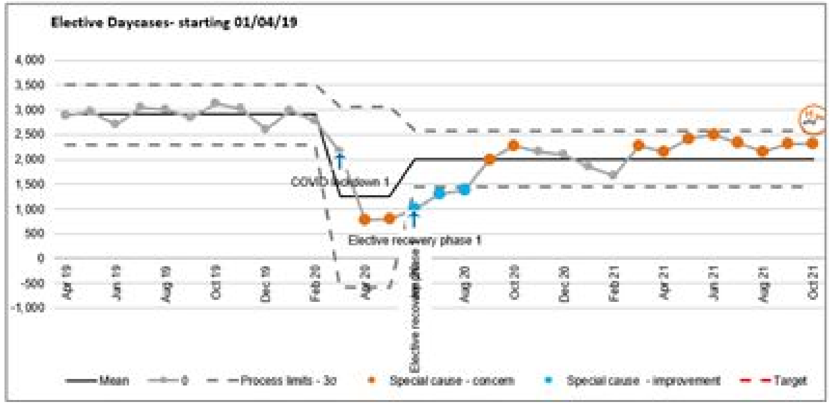

Primary Care Referrals- starting 01/04/19


Advice and Guidance- starting 01/04/19


New Outpatients (Cons Led)- starting 01/04/19


Follow Up Outpatients (Cons Led)- starting 01/04/19


Elective Inpatients- starting 01/04/19


Elective Daycases- starting 01/04/19

Elective Recovery

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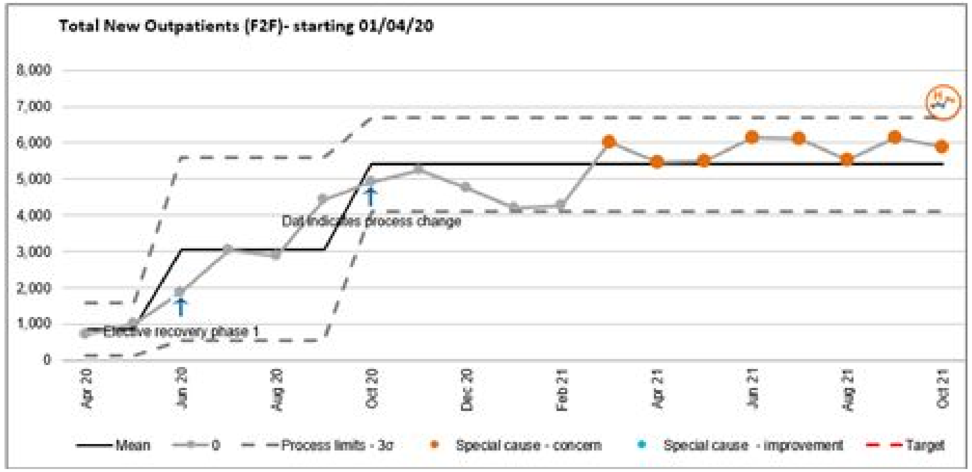
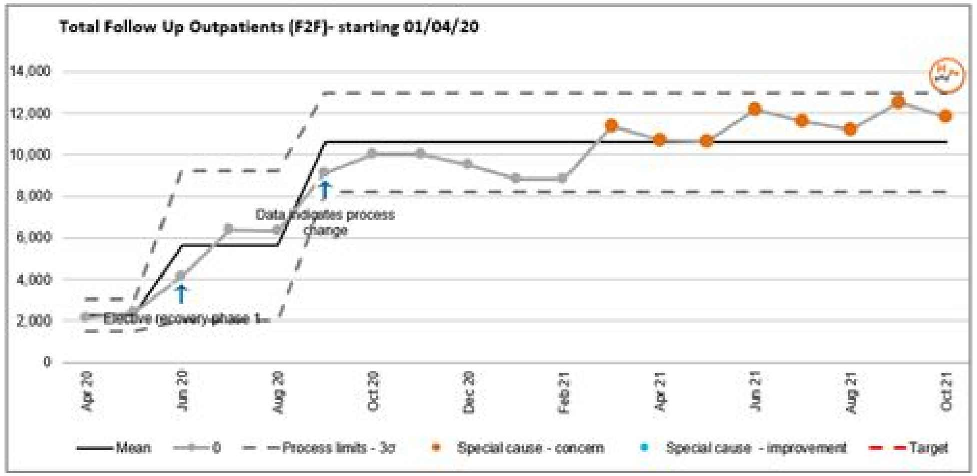
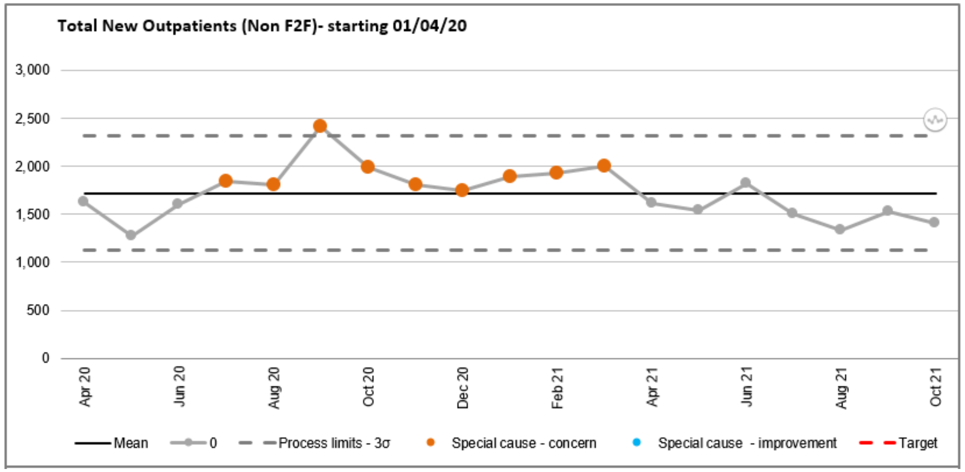
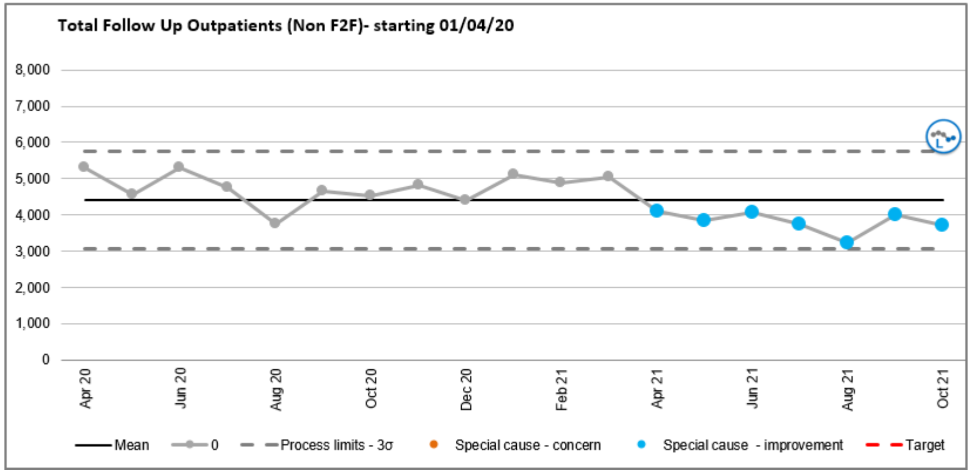

Total New Outpatients (F2F)- starting 01/04/20


Total Follow Up Outpatients (F2F)- starting 01/04/20


Total New Outpatients (Non F2F)- starting 01/04/20


Total Follow Up Outpatients (Non F2F)- starting 01/04/20

- Elective demand continues to be a challenge with GP Referrals and Advice and Guidance requests both remaining above 2019/20 levels, particularly for breast, GI cancer and ECHO.
- Total New and Follow up outpatient attendances reduced in October but remained above the average since the start of the year. The Trust continues to deliver around 90% of 2019/20 attendance levels.
- Elective Inpatients reduced in October and Day cases remained at the same level as September.
- Non face to face first and follow up outpatient contacts have remained below the average since the start of the year, an element of reduction was expected following the change in national guidelines in July. Increasing non face to face contacts remains a focus and is part of the outpatient transformation project. This is discussed in the weekly Access meeting and the Outpatient Transformation Programme is working closely with services to increase where appropriate.
- Elective theatres now fully up and running however staffing remains a significant challenge as a result of vacancies and sickness.
- Focus remains on stepping levels of activity back up to 2019/20 levels whilst reducing > 104 week waiters to zero.

Referral to Treatment (RTT)

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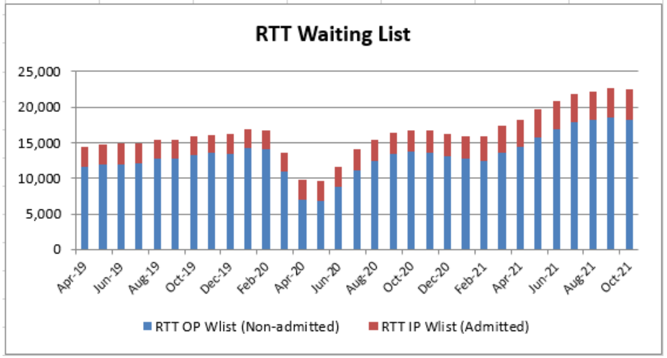
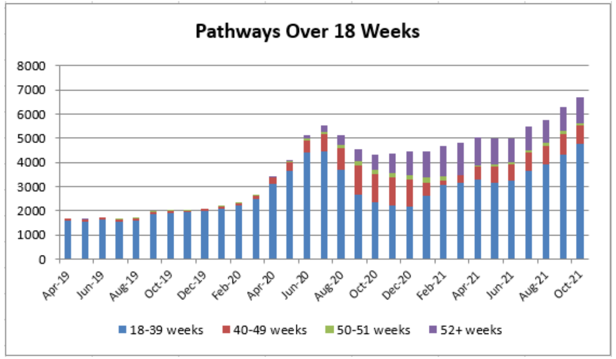
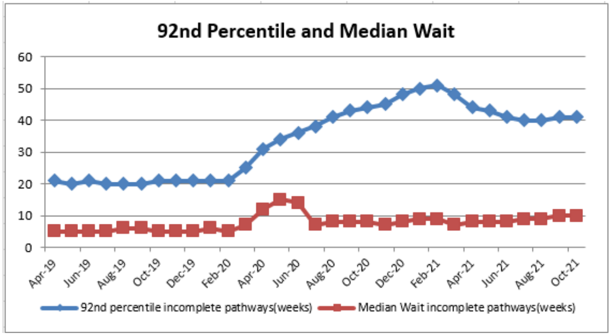
	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21
No. of pathways 18-39 weeks	3,101	3,627	4,418	4,463	3,699	2,674	2,342	2,224	2,185	2,615	3,047	3,173	3,310	3,168	3,255	3,657	3,922	4,336	4,787
No. of pathways 40-49 weeks	270	397	498	709	910	1,216	1,186	1,145	1,120	527	211	299	521	666	644	735	748	820	743
No. of pathways 50-51 weeks	17	32	67	74	106	138	168	208	179	219	155	11	21	62	91	90	127	133	104
No. of pathways 52+ weeks	18	53	139	293	421	524	639	789	974	1,075	1,268	1,345	1,201	1,087	1,006	988	955	1,008	1,070
Total >18weeks	3,406	4,109	5,122	5,539	5,136	4,552	4,335	4,366	4,458	4,436	4,681	4,828	5,053	4,983	4,996	5,470	5,752	6,297	6,704
Total RTT List	9,754	9,593	11,659	14,039	15,345	16,379	16,730	16,733	16,197	15,877	15,878	17,323	18,182	19,746	20,631	21,785	22,168	22,648	22,423





IPDC PTL by Clinical Priority

Weeks Band	Not Rec	P1A	P1B	P2	P3	P4	P5	P6	Total
0-2	50	0	0	329	291	246	0	2	**918**
3-4	2	0	0	54	127	186	0	1	**370**
5-6	4	0	0	20	86	173	0	1	**284**
7-8	2	0	0	16	71	225	0	0	**314**
9-10	0	0	0	5	44	113	0	1	**163**
11-12	0	0	0	3	44	122	0	1	**170**
13-14	0	0	0	3	39	121	0	1	**164**
15+	2	0	0	11	409	2,071	0	7	**2,500**
Total	**60**	**0**	**0**	**441**	**1,111**	**3,257**	**0**	**14**	**4,883**



RTT - The Trust had 22,423 patients waiting at the end of October, this is a reduction of 225 patients on the September position.
There are 1,070 patients waiting over 52 weeks, this is a 6% increase on the September position.
The 92nd centile and median wait in September remained at 41 weeks and 10 weeks respectively.
Of the 4,883 patients waiting for a procedure, 38% are Orthopaedics, 19% General Surgery and 12% Ophthalmology.

Clinical Prioritisation & Review - Clinical prioritisation and review continues for elective patients, 98.8% of patients waiting having been allocated a P1-6 national classification. The majority of those yet to be classified (55/60) have been waiting <=2 weeks and work is progressing to ensure these are rapidly coded. This information is tracked weekly at the Trust Access meeting.

87% of P2 patients have been waiting less than 28-days and there is still a large element of patient choice owing to Covid-19. An RCA is completed for every patient not booked within the required time parameters with a subsequent harm review if a breach.

Urgent Care and Diagnostics

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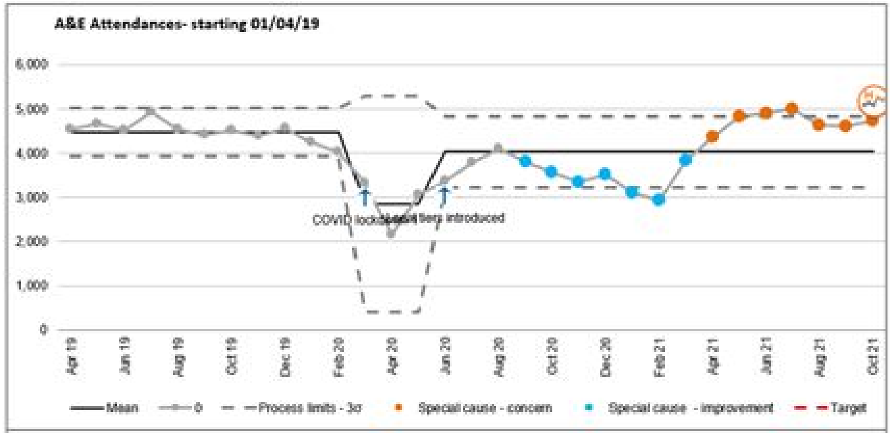

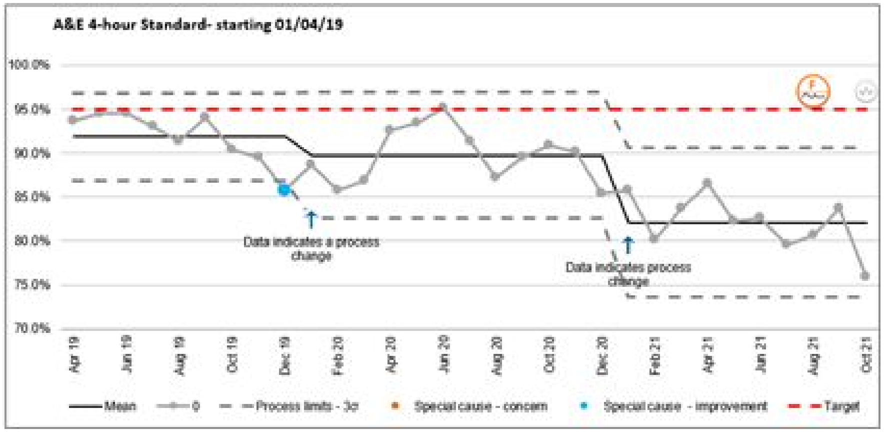

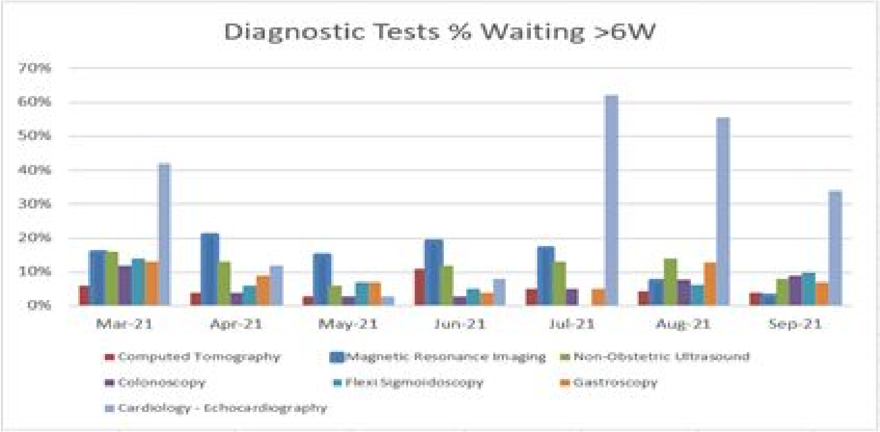

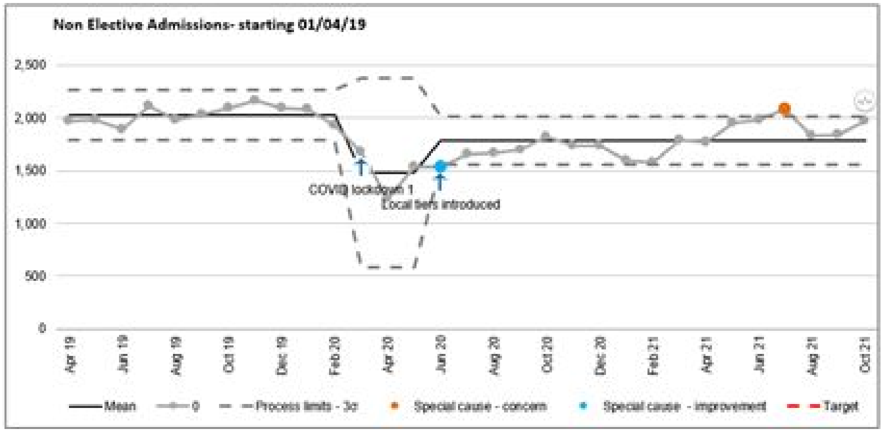

- Performance against the A&E 4-hour standard remained below 95% in October at 75.9%. The 95th percentile wait was 8-hours 27- minutes.
- There were twelve x 12-hour breaches in October → down to 8 after validation → occurred in a very difficult 24 hours at the end of October.
- There were 27 x 30-minute handover breaches, of which 11 x 60-minute ambulance handover breaches in October, in the same 24 hours.
- ED attendances continue to remain above 2019/20 levels, this combined with the high occupancy levels in the hospital makes flow through the department a challenge.
- A UEC and ED Performance meeting dashboard enables monitoring of ED flow and performance to increase visibility and is now published to ED teams.
- Diagnostic waits beyond 6-weeks continue to decrease with focus maintained on reducing the backlog, except for Echocardiography that is currently experiencing staffing challenges, to counter this short term issue increase IS support is now in place.

A&E Performance

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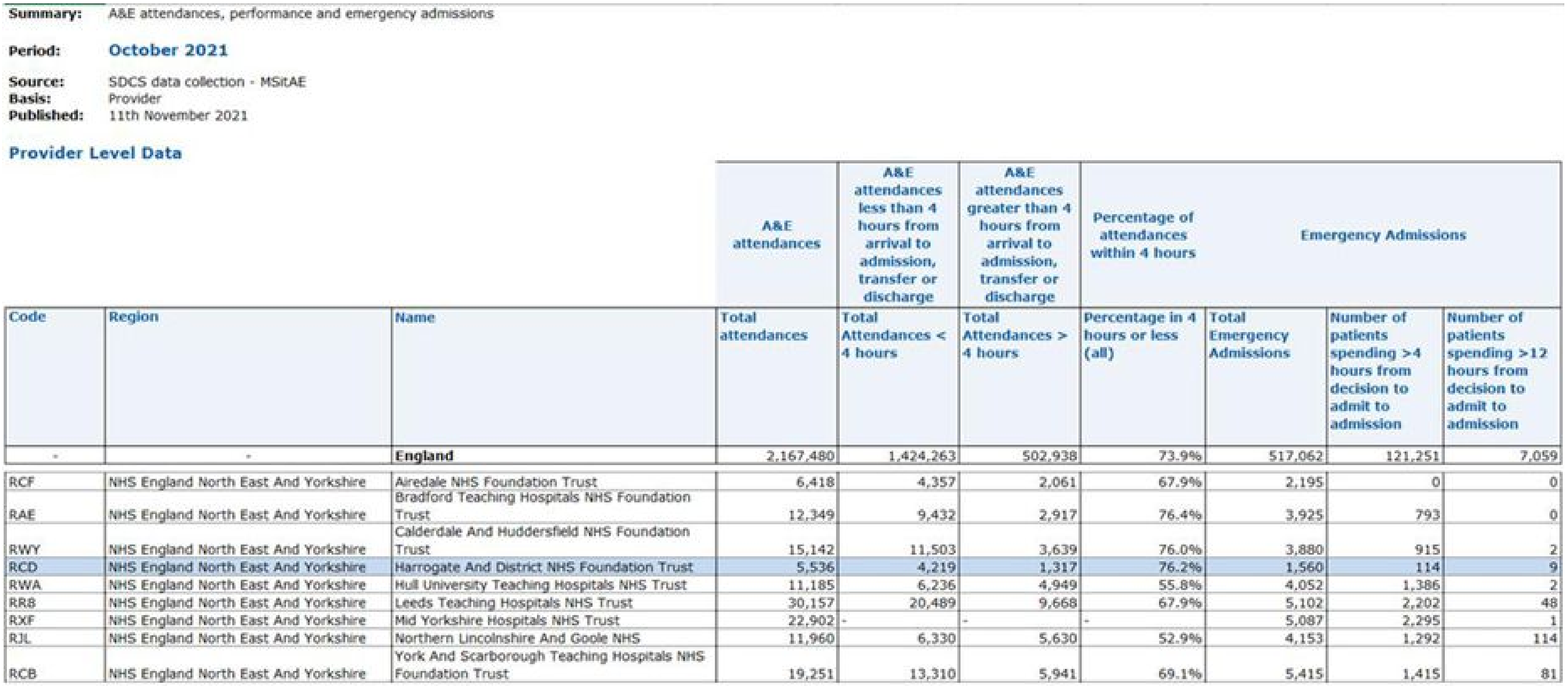

Summary: A&E attendances, performance and emergency admissions

Period: October 2021

Source: SDCS data collection - MSitAE
Basis: Provider
Published: 11th November 2021

Provider Level Data

			A&E attendances	A&E attendances less than 4 hours from arrival to admission, transfer or discharge	A&E attendances greater than 4 hours from arrival to admission, transfer or discharge	Percentage of attendances within 4 hours	Emergency Admissions		
Code	**Region**	**Name**	**Total attendances**	**Total Attendances < 4 hours**	**Total Attendances > 4 hours**	**Percentage in 4 hours or less (all)**	**Total Emergency Admissions**	**Number of patients spending >4 hours from decision to admit to admission**	**Number of patients spending >12 hours from decision to admit to admission**
-	-	**England**	2,167,480	1,424,263	502,938	73.9%	517,062	121,251	7,059
RCF	NHS England North East And Yorkshire	Airedale NHS Foundation Trust	6,418	4,357	2,061	67.9%	2,195	0	0
RAE	NHS England North East And Yorkshire	Bradford Teaching Hospitals NHS Foundation Trust	12,349	9,432	2,917	76.4%	3,925	793	0
RWY	NHS England North East And Yorkshire	Calderdale And Huddersfield NHS Foundation Trust	15,142	11,503	3,639	76.0%	3,880	915	2
RCD	NHS England North East And Yorkshire	Harrogate And District NHS Foundation Trust	5,536	4,219	1,317	76.2%	1,560	114	9
RWA	NHS England North East And Yorkshire	Hull University Teaching Hospitals NHS Trust	11,185	6,236	4,949	55.8%	4,052	1,386	2
RR8	NHS England North East And Yorkshire	Leeds Teaching Hospitals NHS Trust	30,157	20,489	9,668	67.9%	5,102	2,202	48
RXF	NHS England North East And Yorkshire	Mid Yorkshire Hospitals NHS Trust	22,902	-	-	-	5,087	2,295	1
RJL	NHS England North East And Yorkshire	Northern Lincolnshire And Goole NHS	11,960	6,330	5,630	52.9%	4,153	1,292	114
RCB	NHS England North East And Yorkshire	York And Scarborough Teaching Hospitals NHS Foundation Trust	19,251	13,310	5,941	69.1%	5,415	1,415	81

- The table above shows October A&E performance data for HDFT and other Acute Providers in WY&H and HCV ICS'..
- The national performance for the 4-hour standard in October was 73.9%.
- HDFT was the highest performing provider in HCV and second highest performer in WY&H ICS.
- *The source data for this report is an automated daily dataset extracted at 3.00am daily for the previous day and therefore the numbers do not match exactly the validated month end position.*

Cancer

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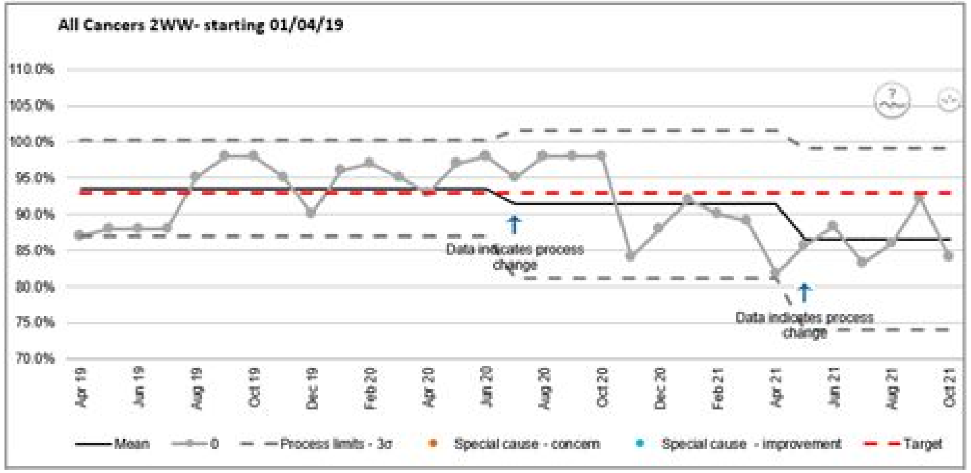
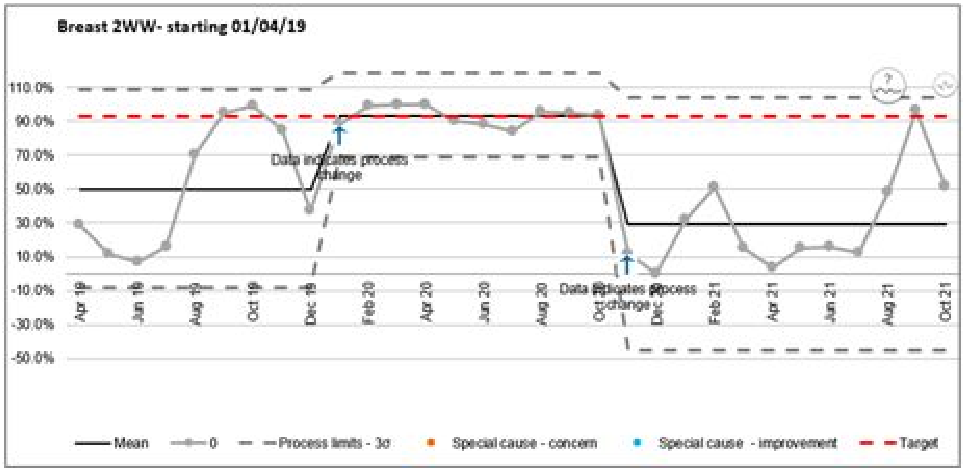
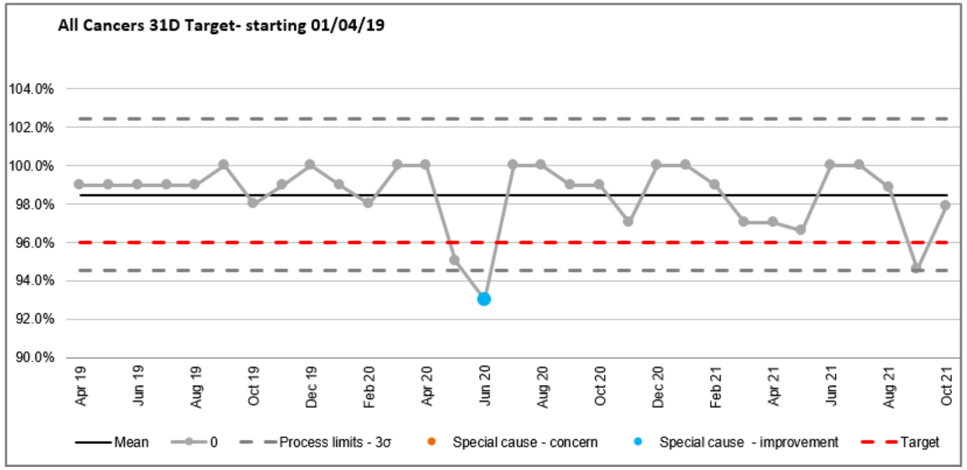
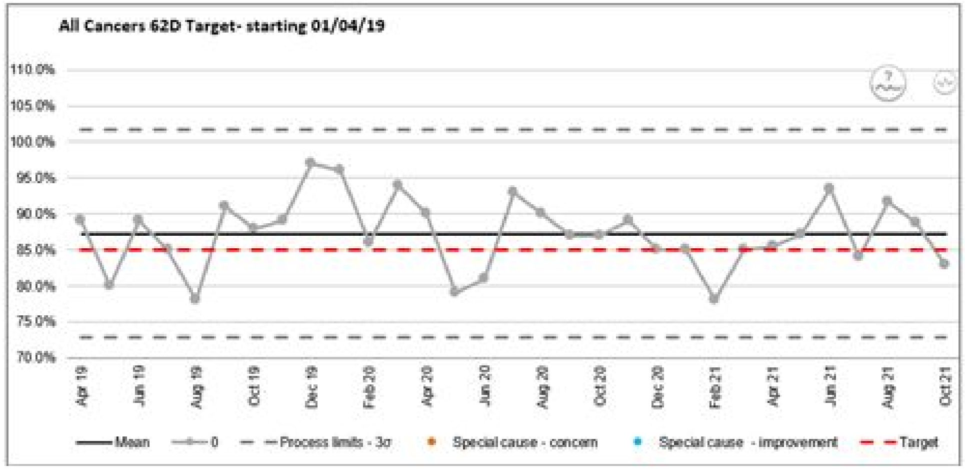




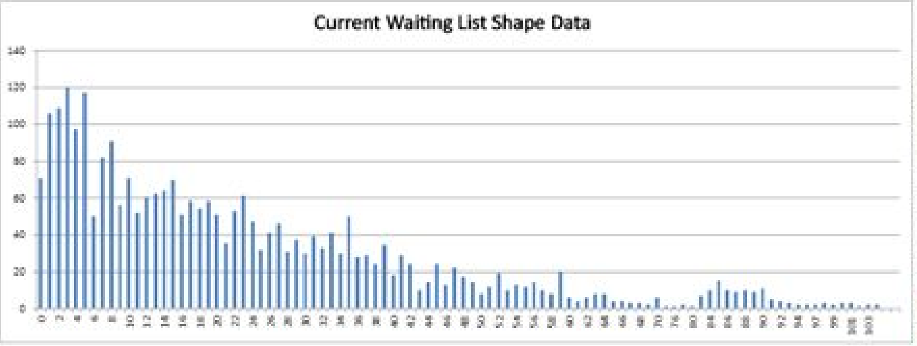


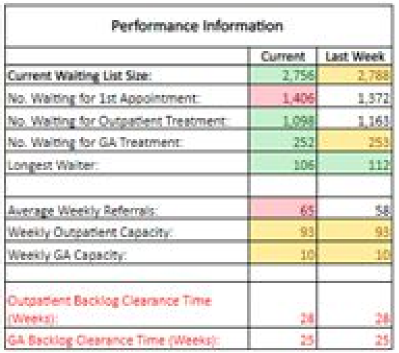


- The 62-day standard was not met in October with a performance of 82%
- The 31-day standard was met in October with a performance of 98%
- The 2-week wait standard was not delivered in October with a performance of 84%
- The 2-week wait breast symptomatic standard was not met with a performance of 51.6%
- At the end of October 41 patients remain on an open cancer pathway over 62 days and 6 patients over 104 days. This has increased since September and remains a key focus, however remains one of the smallest PTL backlogs nationally when adjusted for size. The main tumour site breaching is colorectal; demand and capacity analysis is underway to understand the shortfall. The colorectal pathway has now resumed 'straight to test'.
- The number of breast 2WW and non-cancer related breast symptomatic referrals received continue to be higher than the number of weekly appointment slots available. Additional breast clinic work to improve the position is now underway including outsourcing work to a private service provider with additional clinics in place, taking our capacity above 70 new patients, per week, (of 40 per week, pre-covid).

Children's and Community

Community Dental Services





Performance Information	Current	Last Week
Current Waiting List Size:	2,756	2,788
No. Waiting for 1st Appointment:	1,406	1,372
No. Waiting for Outpatient Treatment:	1,098	1,163
No. Waiting for GA Treatment:	252	253
Longest Waiter:	106	112
Average Weekly Referrals:	65	58
Weekly Outpatient Capacity:	93	93
Weekly GA Capacity:	10	10
Outpatient Backlog Clearance Time (Weeks):	28	28
GA Backlog Clearance Time (Weeks):	25	25

Community 0-19 Services

Performance Indicator Description	Apr	May	Jun	Q1	Jul	Aug	Sep	Q2
Health Visiting – % of infants receiving a new born visit within 14 days of birth - **North Yorkshire**	92.6%	90.3%	92.3%	**91.7%**	94.0%	92.5%	89.1%	**91.9%**
Health Visiting – % of infants receiving a new born visit within 14 days of birth - **Durham**	96.1%	96.0%	96.3%	**96.1%**	97.6%	96.3%	94.3%	**96.1%**
Health Visiting – % of infants receiving a new born visit within 14 days of birth - **Darlington**	91.1%	97.6%	97.2%	**95.3%**	93.8%	98.9%	96.2%	**96.3%**
Health Visiting – % of infants receiving a new born visit within 14 days of birth - **Middlesbrough**	96.4%	97.4%	92.7%	**95.5%**	95.8%	94.3%	92.4%	**94.2%**
Health Visiting – % of infants receiving a new born visit within 14 days of birth - **Stockton**	89.4%	89.7%	92.4%	**90.5%**	93.3%	90.5%	86.4%	**90.1%**
Health Visiting – % of infants receiving a new born visit within 14 days of birth - **Gateshead**	96.5%	96.2%	97.9%	**96.9%**	98.8%	99.3%	98.7%	**98.9%**
Health Visiting – % of infants receiving a new born visit within 14 days of birth - **Sunderland**	98.9%	99.6%	98.3%	**98.9%**	96.2%	99.6%	99.5%	**98.4%**
% of 2-2.5 year reviews completed by the time child turns 2.5 years - **North Yorkshire**	82.6%	85.6%	91.9%	**86.7%**	90.9%	90.1%	90.2%	**90.4%**
% of 2-2.5 year reviews completed by the time child turns 2.5 years - **Durham**	90.1%	87.6%	90.4%	**89.4%**	89.8%	90.0%	87.8%	**89.2%**
% of 2-2.5 year reviews completed by the time child turns 2.5 years - **Darlington**	97.8%	98.9%	98.8%	**98.5%**	94.9%	97.7%	98.8%	**97.1%**
% of 2-2.5 year reviews completed by the time child turns 2.5 years - **Middlesbrough**	97.3%	94.9%	94.1%	**95.4%**	94.2%	96.8%	98.2%	**96.4%**
% of 2-2.5 year reviews completed by the time child turns 2.5 years - **Stockton**	92.9%	94.4%	91.8%	**93.0%**	90.5%	91.9%	93.1%	**91.8%**
% of 2-2.5 year reviews completed by the time child turns 2.5 years - **Gateshead**	95.0%	97.1%	97.2%	**96.4%**	95.5%	98.6%	97.2%	**97.1%**
% of 2-2.5 year reviews completed by the time child turns 2.5 years - **Sunderland**	97.8%	97.7%	94.5%	**96.7%**	95.9%	97.5%	92.4%	**95.3%**
Community Podiatry - % patients seen within 18 weeks	98.9%	99.5%	99.0%	**99.1%**	99.4%	96.9%	92.1%	**96.1%**

October OPEL Level – 3

Adult Community

Service continues to be very pressured due to increased complexity of caseloads and high vacancy rate and sickness
Task and finish group established to progress skill mix review, updated recruitment campaign.

0-19 Service

In line with OPEL 3 level the following actions are being taken:

- Non urgent activity paused, cancelled or re-arranged.
- Flexible approach to timelines for mandated contacts introduced.
- Face to face or virtual contacts based on COVID risk assessment, family health needs assessment and cumulative risk.
- Support required from outside of contract area. Managing across contracts to minimise impact of staffing gaps due to vacancies and absence levels.

Safeguarding

14 staff absent from work within the safeguarding specialist team which is impacting on capacity within the team.
Demand for safeguarding remains high within 0-19 and specialist safeguarding teams.
Statutory responsibilities still being delivered

Community Dental

Plans in place to link with clinical teams across HCV to embed best practise and teams are now looking to schedule WLI sessions to target 80wk waiters (98) to ensure all dated before end of March 22.

Board of Directors Meeting
24th November 2021

Title:	**Director of Workforce & OD Report**
Responsible Director:	Director of Workforce & OD
Author:	Deputy Director of Workforce & OD

Purpose of the report and summary of key issues:	This report details Organisational Development priorities in terms of:- • Major Actions Commissioned and Actions underway • Positive News and Assurance • Any Matters of Concerns and Risks to Escalate	
BAF Risk:	AIM 1: To be an outstanding place to work	
	BAF1.1 to be an outstanding place to work	x
	BAF1.2 To be an inclusive employer where diversity is celebrated and valued	x
	AIM 2: To work with partners to deliver integrated care	
	BAF2.1 To improve population health and wellbeing, provide integrated care and to support primary care	
	BAF2.2 To be an active partner in population health and the transformation of health inequalities	
	AIM 3: To deliver high quality care	
	BAF3.1 and 3.4 To provide outstanding care and outstanding patient experience	
	BAF3.2 To provide a high quality service	
	BAF3.3 To provide high quality care to children and young people in adults community services	
	BAF3.5 To provide high quality public health 0-19 services	
	AIM 4: To ensure clinical and financial sustainability	
	BAF4.1 To continually improve services we provide to our population in a way that are more efficient	
	BAF4.2 and 4.3 To provide high quality care and to be a financially sustainable organisation	
	BAF4.4 To be financially stable to provide outstanding quality of care	
Corporate Risks	As detailed within the report.	
Report History:	October and November SMT	
Recommendation:	The Board of Directors are requested to receive and accept this report.	

Director of Workforce and OD Report

Harrogate and District
NHS Foundation Trust

Matters of concern & risks to escalate

OD Matters

- The appraisal rate in October is 52.78%, which is a small decrease from September which saw an appraisal rate of 54.02%.
- Non-Medical appraisal % = 51.70%   (previous month 53.12%)
- Medical appraisal % = 63.55%   (previous month 63.97%)

- Pressure continues within the Occupational Health Team, due to the inability to recruit to vacancies, absences due to COVID and increased demand on the service – there is currently a 3 week wait for appointments.

Major actions commissioned & work underway

OD Matters

- 2nd Reciprocal mentoring workshop held.
- Steering Group established.
- Staff Survey remains open, currently 30% return rate (05.11) and closes on 26 November. Paper questionnaires being issued w/c 8/11 to those who have not yet returned one.
- Colleague Wellbeing Programme Lead role established at Band 7 to support the on-going and increasing issues regarding colleague health and wellbeing.
- The HCV ICS are aiming to become Menopause Accredited, and HDFT are participating in this workstream, and hope to become accredited by April 2022. This is a positive step for the HDFT, as 87% off our workforce are likely to be impacted by the menopause.
- The HCV ICS are developing a Coaching Strategy and network of coaches. HDFT have signed up to this work, and will be part of the network, which will give our colleagues access to qualified coaching support. It is envisaged that this service will be up and running by April 2022.

Positive news & assurance

OD Matters

- Service Knowledge Analyst role successfully recruited to. Phillipa (Pippa) Croft will be starting in the role in December 2021, and will be a great asset to the Trust. The role will support our aspirating to become a Continuous Learning and Improvement organisation and Pippa will liaise closely with the Quality Governance Team, the Corporate Nursing Team and the Medical Director's team. Additionally she will link with the Research and Pharmacy teams.
- Reciprocal Mentoring preparatory workshops completed – all 12 pairings now ready to commence 1:1's

Decisions made & decisions required of the Board

OD Matters

No decisions required of the Board

Harrogate and District
NHS Foundation Trust

Board Committee Report to the Board of Directors

Committee Name:	Senior Management Team
Committee Chair:	Chaired by Jonathan Coulter, Deputy Chief Executive
Date of meeting:	20th October 2021
Date of Board meeting this report is to be presented	24th November 2021

Summary of key issues

It was confirmed that the NHS Planning Guidance had now arrived. Elective recovery remains the most important area to focus on in order to achieve the 104 week wait list by end of March.

Community Covid rates remain high and community services remain under pressure, particularly for delivery of the booster and 12-15 vaccination programmes.

Key updates were provided by all Executive Directors in relation to work ongoing in their portfolio.

The Strengthening Maternity and Neonatal Safety Report was received and noted.

A demonstration of the Perfect Ward Software was received.

A comprehensive update regarding the Emergency Department was provided including notes on performance and developments within the department.

An update was provided on the development of the Trust Strategy.

As part of the Senior Manager Team development programme a continuing of a recent workshop on becoming an anti-racist organisation was held.

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

None

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

None

Harrogate and District
NHS Foundation Trust

Board Committee Report to the Board of Directors

Committee Name:	Senior Management Team
Committee Chair:	Chaired by Steve Russell, Chief Executive
Date of meeting:	17th November 2021
Date of Board meeting this report is to be presented	24th November 2021

Summary of key issues

Challenges were noted and discussed on current pressures within the local and regional system.

Updates were provided on the clinical governance structure, resources and work required within the central team and within the directorates.

Recent CQC requests for information were highlighted, as were updates on the current complaints and SI position.

The Safer Staffing report was presented. This noted the key aspects of the recent safer staffing audit. The audit was undertaken in June and July 2021. Moving forward this would be conducted on a 6 monthly basis.

A presentation was received on the role of the Matron.

Month 7 financial update was provided. It was noted that the plan was met in M7. H2 plans and allocations have been confirmed. Winter capacity funding was also noted.

Ongoing discussions were being held regarding the development of the Clinical Strategy as well as the Trustwide Strategy.

Operational pressures were noted and the work that was ongoing to reduce 104 week waits.

Each directorate provided an update on the Inpulse survey results and the actions being taken as a result.

Further discussions took place following recent workshops on Becoming an Anti Racist Organisation as well as the development of the Senior Management Team meeting.

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

None

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

None

			2021		2022					
Element	**Item**	**Frequency**	**Sept**	**Nov**	**Jan**	**Mar**	**May**	**Jul**	**Sept**	**Nov**
Opening Items	Patient Story	All	x	x	x	x	x	x	x	x
	Declarations	All	x	x	x	x	x	x	x	x
	Minutes	All	x	x	x	x	x	x	x	x
	Action Tracker	All	x	x	x	x	x	x	x	x
	Chairman Report	All	x	x	x	x	x	x	x	x
Chief Executive	Chief Executive Report	All	x	x	x	x	x	x	x	x
	Corporate Risk Register	All	x	x	x	x	x	x	x	x
Quality & Safety	Quality Committee Chair Report	All	x	x	x	x	x	x	x	x
	IBR Metrics	All	x	x	x	x	x	x	x	x
	Director of Nursing, Midwifery and AHPs	All	x	x	x	x	x	x	x	x
	Freedom to Speak Up	Quarterly	x	x		x	x		x	x
	Strengthening Maternity and Neonatal Safety	All	x	x	x	x	x	x	x	x
	Medical Director Report	All	x	x	x	x	x	x	x	x
	Guardian of Safe Working	Quarterly	x	x		x	x		x	x
	Learning from Deaths	Quarterly	x		X	x	x		x	x
	Statement – Eliminating Mixed Sex Accommodation	Annually					x			
	Quality Accounts	Annually					x			
	National Patient Survey	Annually			X					x
	Safeguarding Annual Report	Annually		X				x		
	Health and Safety Annual Report	Annually		X			x			
	IPC Annual Report	Annually		X			x			
	7 Day Working Framework	As required								
People & Culture	People & Culture Chairs Report	All	x	X	x	x	x	x	x	x
	IBT Metrics	All	x	X	x	x	x	x	x	x
	Workforce Report	All	x	X	x	x	x	x	x	x
	Workforce Race Equality Standards	Annually	x				x			
	Workforce Disability Equality Standards	Annually	x				x			
	Public Sector Equality Duty	Annually	x				x			
	Gender Pay Gap	Annually	x				x			
	Medical Revalidation	Annually	x				x			
	Modern Slavery	Annually			X		x			
	National Staff Survey	Annually				x				x
Strategy & Partnerships	Director of Partnership Report	All	x	x	x	x	x	x	x	x
	Trust Strategy	As required		x		X				
Resources and Finance	Resource Committee Chairs Report	All	x	x	x	X	x	x	x	x
	IBR Metrics	All	x	x	x	X	x	x	x	x
	Director of Finance report	All	x	x	x	X	x	x	x	x
	Chief Operating Officer Report	All	x	x	x	X	x	x	x	x
	Organisational Development Report	All	x	x	x	X	x	x	x	x

			2021		2022					
Element	**Item**	**Frequency**	**Sept**	**Nov**	**Jan**	**Mar**	**May**	**Jul**	**Sept**	**Nov**
Governance	Audit Committee Chairs Report	All	x	x	x	X	x	x	x	x
	SMT Chairs Report	All	x	x	x	X	x	x	x	x
	Board Assurance Framework	All	x	x	x	X	x	x	x	x
	Board Reporting Framework	All	x	x	x	X	x	x	x	x
	Annual Accounts	Annually					x			
	Going Concern Review	Annually					x			
	Audit Letter	Annually					x			
	Annual Report	Annually					x			
	Emergency Preparedness Statement	Annually					x			
	Self certification and statement	Annually				X				
	Fit and Proper Person	Annually					x			
	Standing Orders	As Required								
	Use of Trust Seal	As required								
	Board Effectiveness Review	Annually						x		
	Certification on training for governors	Annually				X				

Board of Directors (Public)
24th November 2021

Title:	**Treasury Management Policy**
Responsible Director:	Director of Finance
Author:	Director of Finance

Purpose of the report and summary of key issues:	The Treasury Management Policy is attached for Approval by Board.	
BAF Risk:	AIM 1: To be an outstanding place to work	
	BAF1.1 to be an outstanding place to work	
	BAF1.2 To be an inclusive employer where diversity is celebrated and valued	
	AIM 2: To work with partners to deliver integrated care	
	BAF2.1 To improve population health and wellbeing, provide integrated care and to support primary care	
	BAF2.2 To be an active partner in population health and the transformation of health inequalities	
	AIM 3: To deliver high quality care	
	BAF3.1 and 3.4 To provide outstanding care and outstanding patient experience	
	BAF3.2 To provide a high quality service	
	BAF3.3 To provide high quality care to children and young people in adults community services	
	BAF3.5 To provide high quality public health 0-19 services	
	AIM 4: To ensure clinical and financial sustainability	
	BAF4.1 To continually improve services we provide to our population in a way that are more efficient	X
	BAF4.2 and 4.3 To provide high quality care and to be a financially sustainable organisation	X
	BAF4.4 To be financially stable to provide outstanding quality of care	X
Corporate Risks	None	
Report History:	The Policy has been approved at the Audit Committee in September 2021.	

Harrogate and District NHS
NHS Foundation Trust

TREASURY MANAGEMENT POLICY

Version	Date	Purpose of Issue/Description of Change	Review Date
1-10	Jun 05 – Sep 14	Initial Issue and 12 monthly review of Policy	Jun 06 – Aug 15
11	Sept 2015	12 month review of Policy	August 2016
12	Sept 2016	12 month review of Policy	August 2017
13	Aug 2017	12 month review of Policy	July 2018
14	Aug 2018	12 month review of Policy	July 2019
15	Aug 2019	12 month review of Policy	August 2020
16	Aug 2020	12 month review of Policy	August 2021
17	Aug 2021	12 month review of Policy	August 2022

Status	Open	
Publication Scheme	Document Library>>Policies	
FOI Classification	Release without reference to author	
Function/Activity	Treasury Management	
Record Type	Policy	
Project Name	**N/A**	
Key Words	Treasury, Management, Policy, Finance	
Standard	**N/A**	
Scope / Location	Trust-wide	
Author	Head of Financial Accounts	**Date 30 August 2019**
Approval and/or Ratification Body	Board of Directors Board of Directors Board of Directors Board of Directors Board of Directors Board of Directors Board of Directors	May 05 – Jan 15 Oct 2015 Sep 2016 Aug 2017 Sep 2018 Oct 2019 Nov 2020

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5 APPROVED INVESTMENT INSTITUTIONS 5
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7 MAXIMUM INVESTMENT PERIOD 6
8 DELEGATION OF RESPONSIBILITY FOR BORROWING 6
9 AUDIT COMMITTEE 6
10 APPENDICES 7

1 INTRODUCTION

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

Treasury Management includes the management of:

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

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

2 AIMS AND OBJECTIVES

The Treasury Management Policy aims and objectives are:

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

3 KEY RESPONSIBILITIES AND CONTROLS

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

The Finance Director is responsible for the following:

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

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

4 INVESTMENTS

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

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

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

5 APPROVED INVESTMENT INSTITUTIONS

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

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

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

6 LIMIT PER COUNTERPARTY

GBS	Unlimited
NLF	Unlimited
HHFM Ltd	Unlimited

7 MAXIMUM INVESTMENT PERIOD

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

8 DELEGATION OF RESPONSIBILITY FOR BORROWING

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

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

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

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

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

9 AUDIT COMMITTEE

The Audit Committee is responsible for:

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

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

10 APPENDICES

Appendix 1: Consultation Summary

10.1 Appendix 1: Consultation Summary

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

teamHDFT
At our best

NHS
Harrogate and District
NHS Foundation Trust

Board of Directors (Public)
24th November 2021

Title:	0-19 Working Group Establishment
Responsible Director:	Chairman
Author:	Chairman

Purpose of the report and summary of key issues:	For review and approval of the creation of a time limited 0-19 working group.	
BAF Risk:	AIM 1: To be an outstanding place to work	
	BAF1.1 to be an outstanding place to work	x
	BAF1.2 To be an inclusive employer where diversity is celebrated and valued	x
	AIM 2: To work with partners to deliver integrated care	
	BAF2.1 To improve population health and wellbeing, provide integrated care and to support primary care	x
	BAF2.2 To be an active partner in population health and the transformation of health inequalities	x
	AIM 3: To deliver high quality care	
	BAF3.1 and 3.4 To provide outstanding care and outstanding patient experience	x
	BAF3.2 To provide a high quality service	x
	BAF3.3 To provide high quality care to children and young people in adults community services	x
	BAF3.5 To provide high quality public health 0-19 services	x
	AIM 4: To ensure clinical and financial sustainability	
	BAF4.1 To continually improve services we provide to our population in a way that are more efficient	x
	BAF4.2 and 4.3 To provide high quality care and to be a financially sustainable organisation	
	BAF4.4 To be financially stable to provide outstanding quality of care	
Corporate Risks	None	
Report History:	none	
Recommendation:	The Board of Directors to note and approve	

HARROGATE AND DISTRICT NHS FOUNDATION TRUST

Board Working Group for 0-19 Services

At the Board workshop on 27 October it was agreed to establish a working group to focus on 0-19 Services. This will essentially consider strategic issues and will not replace operational management or the oversight of performance which will take place through the Trust's management and governance structures.

The purpose of the working group will be to explore the opportunities which the Trust's wide range of 0-19 Services bring to HDFT as a whole and to examine the potential arising from being the largest provider of 0-19 Services in England.

Specific objectives for the Working Group will include:

- Scoping the services across the (current) 8 areas where HDFT is the provider of 0-19 Services
- Seeking the views of commissioners on their priorities and plans for these services
- Seeking the view of colleagues on the issues associated with delivering the services
- Considering the opportunities associated with being the largest provider of 0-19 Services in England
- Developing a strategy for 0-19 Services
- Exploring the opportunities for assessing the impact of the services
- Considering the effects of 0-19 services on the whole of HDFT

The Working Group should not be constrained by these objectives and should be able to redefine its purpose as necessary.

Membership:

- The Chairman of HDFT will chair the Working Group
- Chief Executive
- Medical Director
- Director of Nursing, Midwifery and AHPs
- 3 Non Executive Directors
- Clinical Director, Lead Nurse and Operational Director for CC Directorate
- One Director of Public Health
- One Director of Children's Services

Method of Working.

The Working Group

- will study information about the services provided by HDFT
- may wish to consult with stakeholders, colleagues and external bodies as required.
- may wish to commission studies
- may wish to visit services provided by HDFT and elsewhere
- will meet quarterly

Reporting

The Working Group will produce notes for its own use and for reporting to the Board

Regular feedback will be provided to stakeholders and colleagues

AS/1.11.21