CORPORATE RISK REGISTER

CQC SAFE DOMAIN

Safety is a priority for everyone. People should always be safe and protected from bullying, harassment, avoidable harm, neglect, abuse and discrimination. Their liberty is protected where this is in their best interests and in line with legislation.

- **Learning culture -** We have a proactive and positive culture of safety based on openness and honesty, in which concerns about safety are listened to, safety events are investigated and reported thoroughly, and lessons are learned to continually identify and embed good practices.
- **Safe systems, pathways and transitions -** We work with people and our partners to establish and maintain safe systems of care, in which safety is managed, monitored and assured. We ensure continuity of care, including when people move between different services.
- **Safeguarding -** We work with people to understand what being safe means to them as well as with our partners on the best way to achieve this. We concentrate on improving people's lives while protecting their right to live in safety, free from bullying, harassment, abuse, discrimination, avoidable harm and neglect. We make sure we share concerns quickly and appropriately.
- **Involving people to manage risks -** We work with people to understand and manage risks by thinking holistically so that care meets their needs in a way that is safe and supportive and enables them to do the things that matter to them.
- **Safe environments -** We detect and control potential risks in the care environment. We make sure that the equipment, facilities and technology support the delivery of safe care.
- **Safe and effective staffing -** We make sure there are enough qualified, skilled and experienced people, who receive effective support, supervision and development and work together effectively to provide safe care that meets people's individual needs.
- **Infection prevention and control -** We assess and manage the risk of infection. We detect and control the risk of it spreading and share any concerns with appropriate agencies promptly.
- **Medicines optimisation -** We make sure that medicines and treatments are safe and meet people's needs, capacities and preferences by enabling them to be involved in planning, including when changes happen.

Lead Committee	Quality Committee	**Risk Type**	Clinical	Workforce	**Risk Appetite**	Averse	
Executive Committee	Quality Management Group (QGMG)	**Summary in Month:** This area of the Corporate Risk Register is linked to Safe Domain. Currently there are 3 Corporate Risks within this Domain. Nursing Shortages (CRR5) remains a High Level risk, however mitigation is in place and is actively reducing the risk from a 25 in June 2022 to 16 in July 2022. Health and Safety (CRR70) also remains a High Level risk at 16 in July 2022, however, active recruitment and revised governance arrangements are expected to reduce the risk in the coming months. Finally the Aseptic unit risk also remains a High Level risk at 16, however preparations for the new build continue at pace.					
Initial Date of Assessment	1st July 2022						
Last Reviewed	1st August 2022						

Strategic Ambition	Corporate Risk ID	Principle Risk	Key Targets	Current Position (August 2022)	Plans to Improve Control and Risks to Delivery	Risk Rating Target (CvL)	Risk Rating Current (CvL)
Best Quality, Safest Care	CRR5: Nursing Shortages	Risk to service delivery and patient care due to failure to fill registered nurse vacancies due to the national labour market shortage.	Vacancy Rate Turnover Sickness Covid absences Maternity Leave – including currently commencement at 28 weeks gestation	Successful bid (87k) to NHSE/I to recruit additional CSWs to bring to zero vacancy (inpatient units) Additional focused HCSW recruitment day 26/5/22 and ongoing HCSW recruitment and resulted in 40 offers of posts to HCSWs – on boarding now taking place with total of 36 new recruits remaining in the process Redefining of CSW Development Programme to support new recruits, programme has commenced and evaluating well Clarity of career progression from CSW to RN and points between Agreed 'Home Trust' status with York St John University, have 100% clinical placement capacity at HDFT to support 'growing our own' Additional placement capacity agreed to accommodate additional student numbers. Which would increase the student intake from 186 currently, to 222 in September '22 and a predicted 237 by 2023 International Recruitment and associated funding to increase capacity, continue to review opportunities to increase IR intakes. Expecting 26 new arrivals	Focus on recruitment and retention and effective roster practice	3X3	3X4

<table>
<tr><td></td><td></td><td></td><td></td><td>between June '22 and January '23. There has been a development of 'bootcamp' style courses in preparation for OSCES</td><td></td><td></td><td></td></tr>
<tr><td>An Environment that promotes wellbeing</td><td>CRR70: Health and Safety</td><td>Organisational Risk to compliance with legislative Health and Safety requirements impacting on employees, patients and contractors to HDFT sites due to an absence of infrastructure and associated governance, systems and processes</td><td>Datix reported Health and Safety Incidents

HSE/RIDDOR reporting</td><td>Notification to organisation to cease using the Goods Yard access with immediate effect – reduction in some footfall but not all. Further work required as continued use of this as a cut through has been noted

Work ongoing with plans to section off the yard so access is not possible.

Recruitment: One x Band 8b – Head of Health and Safety interviews to take place 13th July 2022, 2 x Band 7 Health and Safety Managers (one Acute and one Community) interviews to take place 21st July Strong field of applicants for all posts.

Interim Health and Safety Manager in Place for further 6 months to ensure cover during recruitment period.

Revisions to ToR for Health and Safety Committee

Procurement of Datix to support wider risk register roll out, including H&S

Health and Safety walk around due to take place in Mid July 2022 to provide further benchmarking of the acute site.</td><td>Exploration of Tendable as a mechanism for audit programme

Review of contract with SALUS and proposal for alternative provision being drawn up

Contractor meetings with HIF to ensure that H&S requirements of external contractors are adhered to

TNA/GAP Analysis to be commenced to understand training needs and gaps for managers re: H&S responsibilities

Action plan drawn up following external review of H&S compliance, this will be exception reported to revised Health and Safety Committee to capture and monitor ongoing risks

Review and updating of the Ligature Risk procedure

Review of Fire Door compliance across the site

Full site survey for all access control/lockdown to report back on position for improvement</td><td>3x3</td><td>3x4</td></tr>
<tr><td>Best Quality, Safest Care</td><td>CRR67: Pharmacy Aseptic Unit</td><td>Risk to service delivery that the trust is not able to provide some cancer and other treatments because we have to close the Aseptic Unit due to inability to maintain IPC standards

Risk to patient safety because IPC standards for aseptic production of medicines may not be met.

Risk to staff safety due to exposure to substances harmful to health.</td><td>Daily, weekly and quarterly environmental monitoring to ensure Aseptic Unit and products are within specification (indicator data by month is below).</td><td>• Aseptic unit closed at the end of Jun 22 so no further data
<table>
<tr><th>Indicator</th><th>Feb 22</th><th>Mar 22</th><th>Apr 22</th><th>May 22</th><th>Jun 22</th></tr>
<tr><td>Grade A Compliance</td><td>99.07%</td><td>99.69%</td><td>100%</td><td>99.74%</td><td>No further reports</td></tr>
<tr><td>Grade D Weekly Plate</td><td>PASS</td><td>PASS</td><td>PASS</td><td>PASS</td><td>No further reports</td></tr>
<tr><td>End of Session Kits A-D</td><td>PASS</td><td>PASS</td><td>PASS</td><td>PASS</td><td>No further reports</td></tr>
</table>
Business Case for replacement unit approved by Trust Board in Mar 22, with capital funding identified in the 22/23 and 23/24 capital plan.

Aseptic unit shutdown w/c 27 Jun 22.

From w/c 27 Jun 22 aseptic products being sourced from LTHT and private sector, and through mutual aid with YSTHFT (HDFT staff working in YSTHFT aseptics unit to manufacture products)

Aseptics unit replacement project progress:
○ URS and VMP near complete.
○ Feasibility study by HIF in progress.
○ Performance specification by HIF in progress – due for completion mid-August</td><td>Aseptics unit replacement project milestones (subject to completion of procurement process):
○ Development of URS, VMP, performance specification, Mar-Aug 22
○ Procurement process for specialist building contractor, Aug-Oct 22
○ Contractor design, review and mobilisation, Nov 22 – Mar 23
○ Aseptics unit build, Mar-Jun 23
○ Commissioning, Jun-Aug 23
○ Start production of aseptic products, end Aug 23</td><td>3x1</td><td>3x4</td></tr>
</table>

CQC EFFECTIVE DOMAIN

People and communities have the best possible outcomes because their needs are assessed. Their care, support and treatment reflect these needs and any protected equality characteristics. Everyone is supported to see what works well and not so well based on indicators of quality. Continuous improvement is always guided by this insight

- **Assessing needs -** We maximise the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.
- **Delivering evidence-based care and treatment -** We plan and deliver people's care and treatment with them, including what is important and matters to them. We do this in line with legislation and current evidence-based good practice and standards.
- **How staff, teams and services work together -** We work effectively across teams and services to support people. We make sure they only need to tell their story once by sharing their assessment of needs when they move between different services.
- **Supporting people to live healthier lives -** We support people to manage their health and wellbeing so they can maximise their independence, choice and control. We support them to live healthier lives and where possible, reduce their future needs for care and support.
- **Monitoring and improving outcomes -** We routinely monitor people's care and treatment to continuously improve it. We ensure that outcomes are positive and consistent, and that they meet both clinical expectations and the expectations of people themselves.
- **Consent to care and treatment -** We tell people about their rights around consent and respect these when we deliver person-centred care and treatment.

Lead Committee	Quality Committee	**Risk Type**	Clinical	Workforce	Operational	**Risk Appetite**	Cautious
Executive Committee	Quality Management Group (QGMG)	**Summary in Month:** This area of the Corporate Risk Register is linked to the Effective Domain. Currently there is 1 Corporate Risks within this Domain. School Age Immunisation remains a high level risk at 16, however, plans are in place that should reduce this risk in the coming months.					
Initial Date of Assessment	1st July 2022						
Last Reviewed	1st August 2022						

Strategic Ambition	Corporate Risk ID	Principle Risk	Key Targets	Current Position (August 2022)	Plans to Improve Control and Risks to Delivery	Risk Rating Target (CvL)	Risk Rating Current (CvL)
Great Start in Life	CRR 73: School Age Immunisation	Systems and Processes within the School Age Immunisation Service leading to duplicate vaccines being given and vaccination without consent.	This target has been set at 0 incidents	In the period from Oct 21 to March 22 there were 8 children who received duplicate vaccination in error. In the period from Oct 21 to March 22 there were 2 incidents of children vaccinated without consent. Within August 22 there were no incidents school age children receiving a duplicate vaccination in error. Within August 22 there were no indents of school age children being vaccinated without consent. RPIW took place 12-15th April to review / amend current processes and develop SOPs to support reduction in unwarranted variation and practice. Pause and learn event took place with the wider team on the 25th April to share the learning from the RPIW and to progress work streams identified.	Experience Service Manager from 0-19 team seconded to support Clinical Lead with review and transformation of service. Band 7 Leadership capacity increased to support capacity to deliver change. Bi weekly Governance Meeting lead by CC DCD. Weekly CAG lead by HON/Head of Safeguarding Switched program from HPV 2 to HPV 1 while process reviewed (simpler check so lower risk).	3X1	3X4

CQC CARING DOMAIN

People are always treated with kindness, empathy, and compassion. They are supported to live as independently as possible. Their privacy and dignity are respected. Every effort is made to take their wishes into account and respect their choices, to achieve the best possible outcomes for them.

- **Kindness, compassion and dignity -** We always treat people with kindness, empathy and compassion and we respect their privacy and dignity. We treat colleagues from other organisations with kindness and respect.
- **Treating people as individuals -** We treat people as individuals and make sure their care, support and treatment meets their needs and preferences. We take account of their strengths, abilities, aspirations, culture and unique backgrounds and protected characteristics.
- **Independence, choice and control -** We promote people's independence, so they know their rights and have choice and control over their own care, treatment and wellbeing.
- **Responding to people's immediate needs -** We listen to and understand people's needs, views and wishes. We respond to these in that moment and will act to minimise any discomfort, concern or distress.
- **Workforce wellbeing and enablement -** We care about and promote the wellbeing of our staff, and we support and enable them to always deliver person centred care.

Lead Committee	Quality Committee (Clinical Risk) People and Culture (Workforce Risk)	**Risk Type**	**Clinical**	**Workforce**		**Risk Appetite**	Minimal
Executive Committee	Quality Management Group (QGMG) (Clinical) Workforce Committee (Workforce)	**Summary in Month:** This area of the Corporate Risk Register is linked to the Caring Domain. Currently there is 1 Corporate Risks within this Domain. Wellbeing of Staff (CRR6) remains a High Level risk at 15. Mitigation is in place to reduce this risk and a range of wellbeing packages are in place with further being developed.					
Initial Date of Assessment	1st July 2022						
Last Reviewed	1st August 2022						

Strategic Ambition	Corporate Risk ID	Principle Risk	Key Targets	Current Position (August 2022)	Plans to Improve Control and Risks to Delivery	Risk Rating Target (CvL)	Risk Rating Current (CvL)
At Our Best – Developing People, Building Teams	CRR6: Wellbeing of Staff	Risk to patient care and safety due to current staffing levels and poor morale due to increased workload, post pandemic burn-out and poor working environment. Risk of: - both short and long term mental health impacts on staff - potential increase in lapses in delivery of safe and effective care to patients and service users	Inpulse engagement scores National Staff survey scores: Engagement, morale, Sickness absence levels Turnover Vacancy rate	Winter 2022 preparedness: Nursing and midwifery safer staffing project in place including a robust assurance framework Planning combined Flu and Covid Vaccine programme for all colleagues to commence October 2022. Recruitment and Retention groups being established to ensure significant programmes of work underway on both topics. Task & Finish Group established to review and address Trust-wide feedback arising from national staff survey Continued roll out of Healthroster to ensure wards appropriately staffed and purchase of SaferStaffing module underway Operational Leadership Management Restructure consultation process underway, which will create more dedicated time to leadership and management in the clinical environment Board of Directors Workshop held on 29 June 2022 – SMT workshop to follow this up and agree actions	• IPC guidelines under review for workers who are 28+ weeks pregnant, as this will relieve staffing pressures. • Progress with Operational Leadership & Management Restructure	3X2	3X5

CQC RESPONSIVE DOMAIN

People and communities are at the centre of how care is planned and delivered at all times. Their health and care needs are understood and they are actively involved in planning care that meets these needs. Care, support, and treatment are easily accessible, including physical access. People can access care in ways that meet their circumstances and protected equality characteristics

- **Person-centred care -** We make sure people are at the centre of their care and treatment choices and we decide, in partnership with them, how to respond to any relevant changes in their needs.
- **Care provision, integration, and continuity -** We understand the diverse health and care needs of people and our local communities, so care is joined-up, flexible and supports choice and continuity.
- **Providing information -** We provide appropriate, accurate and up-to-date information in formats that we tailor to individual needs.
- **Listening to and involving people -** We make it easy for people to share feedback and ideas or raise complaints about their care, treatment and support. We involve them in decisions about their care and tell them what's changed as a result.
- **Equity in access -** We make sure that everyone can access the care, support and treatment they need when they need it.
- **Equity in experiences and outcomes -** We actively seek out and listen to information about people who are most likely to experience inequality in experience or outcomes. We tailor the care, support and treatment in response to this.
- **Planning for the future -** We support people to plan for important life changes, so they can have enough time to make informed decisions about their future, including at the end of their life.

Lead Committee	Resource Committee	**Risk Type**	**Clinical**	**Operational**		**Risk Appetite**	Cautious
Executive Committee	Operational Management Group (OMG)	**Summary in Month:** This area of the Corporate Risk Register is linked to the Responsive Domain. Currently there are 3 Corporate Risks within this Domain. Autism Assessment (CRR34) remains a High Level risk at 12 and working is ongoing to determine future needs of the service. RTT (CRR41) remains a High Level risk at 12 due to performance against the national standards. However, a wide range of mitigation in place and zero 104 week waits are noted. Finally ED 4 hour standards also remains a High Level risk at 15 due to the continued failure to meet the target. A wide range of mitigation is in place including a pilot of new streaming pathways.					
Initial Date of Assessment	1st July 2022						
Last Reviewed	1st August 2022						

Strategic Ambition	Corporate Risk ID	Principle Risk	Key Targets	Current Position (August 2022)	Plans to Improve Control and Risks to Delivery	Risk Rating Target (CvL)	Risk Rating Current (CvL)
Great Start in Life	CRR34: Autism Assessment	Risk to quality of care by not meeting NICE guidance in relation to the commencement of autism assessment within 3 months of referral. Risk that children may not get access to the right level of support without a formal diagnosis and that this could lead to deterioration in condition.	Need to reduce the backlog of referrals back to the NICE standard of 3 months (reduce the waiting list to approximately 120)	Due to continuing higher referral numbers & assessment model (which is in line with NICE recommendations) we are predicting we would end the year with a waiting list of 743 children with a 19 month wait to commence assessment. The Service is working with commissioners who have consulted with children, young people and their parents about the current model and proposals around a revised approach. We understood their intention was to have one model across North Yorkshire from April 2023 which may involve giving notice and putting out to tender.	Determine future needs	**3X2**	**3X4**
Person Centred, Integrated Care, Strong Partnerships	CRR41: RTT	Risk to patient safety, performance, financial performance, and reputation due to increasing waiting times across a number of specialties, including as a result of	92% 18 week incomplete performance standard 52+ Waits 78+ Waits (zero by March 23)	Elective recovery work continues to be a major focus, and the Trust continues to, where possible, increase elective admissions to reduce the gap to pre-COVID levels. The trust have implemented and resourced dedicated project support in theatres that commenced in October 2021 to aid elective 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 have increased beds on the Elective Surgical Unit; these remain in place to help mitigate increased activity levels over the winter period.	Internally the Trust continue to review all patients on the Admitted pathway over 60 weeks and have initiated a weekly PTL meeting. With the service manager, admissions manager and 18-week lead each patient is reviewed to ensure that there are clear plans in place. **Additional theatre lists at a weekend** Significant progress has been made in engaging with clinicians to undertake additional work on a weekend, with lists now being booked for Community Dentistry Paediatric	**3x2**	**3x4**

		the impact of Covid 19 (added 13/03/2020)	104+ Waits (zero by July 22)	Ring fencing of orthopaedic elective capacity is underway alongside a pilot of an LLP model to re-engage weekend and evening lists (commenced 11th June 2022 with lists alternate weekends since) The 5th room to support capsule endoscopy remains operational and Endoscopy lists are available seven days per week. Clinical prioritisation and review continue for elective patients with 99% of patients waiting having been allocated a P1-6 national classification. The majority of those yet to be classified have been waiting <=2 weeks and work is progressing to ensure these are rapidly coded. **104+ week waiters** Through Quarter 3 and 4, the Trust have been working collectively with our partner Trusts across WYAAT to understand how each Trust could support pressures on waiting lists, redesigning pathways and agreeing governance for identifying capacity to support the treatment of long waiting patients and ensuring consistent communication. The community dental over 104 weeks is now zero. The 1 remaining reported >104 week patient is a orthopaedic patient who is unavailable for surgery until(P6) September – there has been a number of long waiting patients cancelling due to new COVID infection which so far we have been able to mitigate. All patients over 93 weeks have a date for surgery.	sessions, General Surgery and Urology. The first theatre lists went ahead on Saturday the 15th January, with another two subsequent lists post. Staffing in theatres continues to be challenging with vacancies gaps and covid related sickness but there is now a greater up take for covering additional theatre lists in the evening and at weekends and there are currently 22 new starters in the workforce pipeline. 22-23 plans are now confirmed. Additional capacity will become available for treating patients through the wharefdale theatres (TIF1 Scheme)- however the timelines for this opening have slipped into 23-24. The independent sector support is being increased with circa 1000 cases being delivered in this way. The LLP for trauma & orthopaedics is being piloted as a vehicle for weekend and evening working to further increase treatment capacity (and reduce RTT waiting lists)		
Best Quality, Safest Care	CRR61: ED 4-hour Standard	Risk of increased morbidity/ mortality for patients due to failure to meet the 4 hour standard.	A&E 4 hour standard (below 95% in June 2022) 12 hour DTA breaches (15 in June 2022) Ambulance Handovers (1 x 60 min breach in June 2022)	&E 4 hour standard remains below the 95% standard in June 2022 but with a continued improvement and the highest reported performance since January 2022. 6 hour harm indicator (1,030 >6 hour stays total for June) equates to 10 harms due to longer stay in June. **12 hour DTA breaches** – RCAs undertaken indicating no harm **June 2022** | **May 2022** | **April 2022** 15 | 18 | 43 **Ambulance handover breaches** Continue to be in top quartile for national performance for Ambulance delays but 1 x 60 min ambulance hand over breach - RCA undertaken indicating no harm Continuing improvement in 4 hour standard (highest since Jan 22). Supporting system pressures with diverts from York. Reduced flow secondary to 45+ patients not meeting right to reside waiting for NH/RH/POC. System partners (York and Scarborough) at Opel 4 most days	Minor streaming model being implemented with recruitment underway Hospital flow RPIW w/c 9 May with actions managed via UEC Board Capital works ongoing to centralise acute services at front door and provide enhanced access to diagnostics. Community 2 hour response to reduce admissions/attendances over next 6 months. Recovery in performance as COVID numbers / staff absence / COVID IP measures (and extended stays) reduce. The plan for improvement in performance are likely to take 3-6 months to address the different elements contributing to poor performance.	**3x2**	**3x5**

CQC WELL_LED DOMAIN

There is an inclusive and positive culture of continuous learning and improvement. This is based on meeting the needs of people who use services and wider communities. There are effective governance and management systems in place. Leaders proactively support staff and collaborate with partners to deliver care. This care is safe, integrated, person-centred and sustainable care and helps reduce inequalities.

- **Shared direction and culture:** We have a shared vision, strategy and culture. This is based on transparency, equity, equality and human rights, diversity and inclusion, engagement, and understanding challenges and the needs of people and our communities in order to meet these.
- **Capable, compassionate and inclusive leaders:** We have inclusive leaders at all levels who understand the context in which we deliver care, treatment and support and embody the culture and values of their workforce and organisation. They have the skills, knowledge, experience and credibility to lead effectively. They do so with integrity, openness and honesty.
- **Freedom to speak up:** We foster a positive culture where people feel that they can speak up and that their voice will be heard.
- **Governance, management and sustainability:** We have clear responsibilities, roles, systems of accountability and good governance. We use these to manage and deliver good quality, sustainable care, treatment and support. We act on the best information about risk, performance and outcomes, and we share this securely with others when appropriate.
- **Partnerships and communities :**We understand our duty to collaborate and work in partnership, so our services work seamlessly for people. We share information and learning with partners and collaborate for improvement.
- **Learning, improvement and innovation:** We focus on continuous learning, innovation and improvement across our organisation and the local system. We encourage creative ways of delivering equality of experience, outcome and quality of life for people. We actively contribute to safe, effective practice and research.
- **Environmental sustainability – sustainable development:** We understand any negative impact of our activities on the environment and we strive to make a positive contribution in reducing it and support people to do the same.
- **Workforce equality, diversity and inclusion:** We value diversity in our workforce. We work towards an inclusive and fair culture by improving equality and equity for people who work for us."

Lead Committee	Trust Board	**Risk Type**	**Clinical**	**Workforce**	**Operational**	**Risk Type**	Cautious
Executive Committee	Senior Management Committee (SMT)	**Summary in Month:** This area of the Corporate Risk Register is linked to the Well-Led Domain. Currently there are no Corporate Risks that link to this domain.					
Initial Date of Assessment	1st July 2022						
Last Reviewed	1st August 2022						

Strategic Goal	Corporate Risk ID	Principle Risk	Key Targets	Current Position (August 2022)	Plans to Improve Control and Risks to Delivery	Risk Rating Target (CvL)	Risk Rating Current (CvL)

USE OF RESOURCES

Use of resources area Key lines of enquiry (KLOEs)

- **Clinical services -** How well is the trust using its resources to provide clinical services that operate as productively as possible and thereby maximise patient benefit?
- **People**- How effectively is the trust using its workforce to maximise patient benefit and provide high quality care?
- **Clinical support services** - How effectively is the trust using its clinical support services to deliver high quality, sustainable services for patients?
- **Corporate services, procurement, estates and facilities** - How effectively is the trust managing its corporate services, procurement, estates and facilities to maximise productivity to the benefit of patients?
- **Finance** - How effectively is the trust managing its financial resources to deliver high quality, sustainable services for patients?

Lead Committee	Resource Committee	**Risk Type**	Financial	Workforce	Operational	**Risk Appetite**	Minimal
Executive Committee	Operational Management Committee (OMG)	**Summary in Month:** This area of the Corporate Risk Register is linked to the Use of Resources Domain. Currently there are 2 Corporate Risks that are link to this domain. Agency Usage (CRR71) remains a High Level risk at 15, however it is noted that this risk is being used to off set CRR5 Nursing Shortages and CRR6 Staff Wellbeing. In addition the Operational Financial Position (CRR72) also remains a High Level risk at 12.					
Initial Date of Assessment	1st July 2022						
Last Reviewed	1st August 2022						

Strategic Ambition	Corporate Risk ID	Principle Risk	Key Targets	Current Position (August 2022)	Plans to Improve Control and Risks to Delivery	Risk Rating Target (CvL)	Risk Rating Current (CvL)
Overarching	CRR 71: Agency Usage	The Trust is currently in breach of regulatory obligation regarding agency price caps, is incurring premium costs for staffing where vacancies exist, and in some circumstances this results in an adverse impact to quality and safety. Breach of IR35 regulations and potential fine from HRMC.	Monthly financial performance Performance against indicative agency ceiling Weekly reporting regarding cap compliance	The Trust is current spending in excess of the agency ceiling. The Trust breaches the agency cap for a number of roles. No agency medical staff are engaged below agency cap rates. It should be noted that this risk is mitigating some of the other risks currently raised on the Trust risk register. In particular nurse staffing, work around ED/flow and elective recovery. This clearly is not ideal but is accepted whilst those other risks persist.	Substantive recruitment and retention schemes Clear escalation on cascades where appropriate and available	**3X3**	**3X5**
Overarching	CRR 72: Operational Financial Position	Risk to financial sustainability and regulatory impacts as a result of not achieving breakeven. Risk of providing value for money to taxpayer.	Monthly financial performance Savings programme performance Various procurement indicators Monthly budgetary reporting at directorate level Various benchmarking information – eg Model Hospital	The Trust is currently at risk of managing within resources available. There were two factors contributing to this – 1. Performance in relation to Savings Programme As reported in June, £5.2m has been actioned in month 3 against the £8.3m target required to achieve this year's plan. Risk adjusted forecasts still outline a £1m risk to the programme and the Trust position. 2. Inflation As can be seen in the wider economy there are a number of material impacts in relation to inflation. The two most notable for the Trust relate to Cost of Capital and Energy prices, which impact the Trust by £1.7m and £1.6m respectively. Previously we were awaiting guidance on these elements, which has now been received. The Trust has received funding to support this non recurrently.	Delivery of directorate savings programme Management of monthly budget position across all areas, from cost centre to trustwide Clear link between business planning, prioritisation and strategy Strong local vacancy control processes Maximising procurement savings through consolidation and collaboration Negotiation with wider system	**4x1**	**4x3**

				Following the support received for funding inflation from NHS England, the HNY ICS had a residual financial issue. To support the ICS the Trust is in a position where we are being asked to support the ICS by £3.5m, £2.2m of which is already in the previous planning assumptions. There are currently no plans on achieving the £1.3m but it has been agreed in principle with some wider incentives being discussed.	Potential non recurrent support would be adjusting annual leave process to pre pandemic policy.		

Integrated Board Report - June 2022

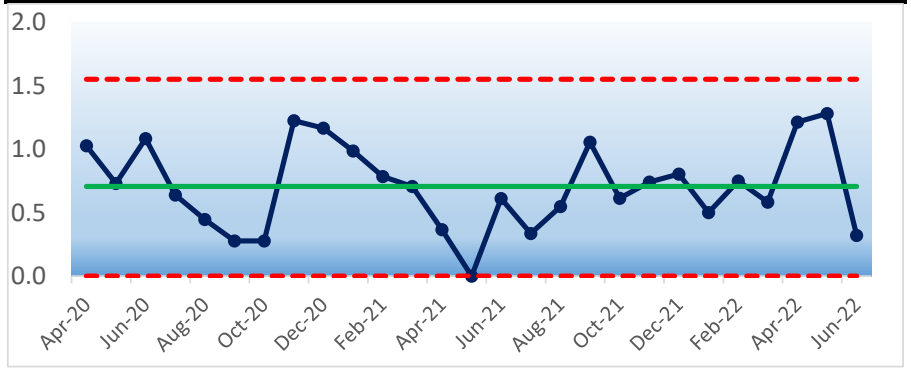
Domain 1 - Safe

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	Jun-22
Value / RAG rating	0.32

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

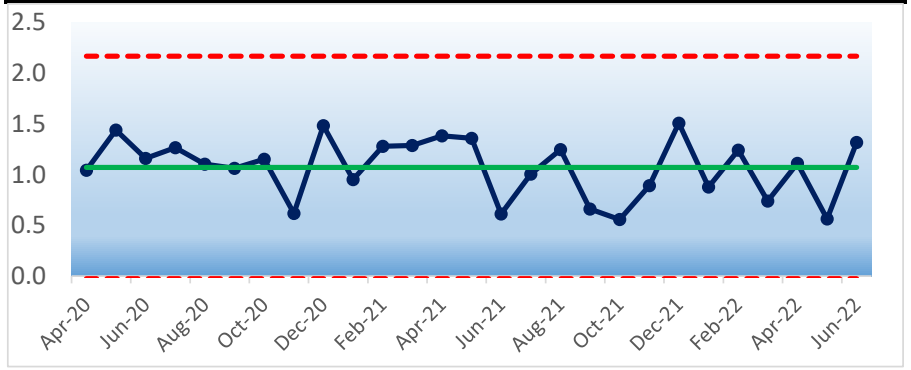
Reduction in hospital acquired pressure ulcers noted in June - intensive support to ward areas from TVN team in supporting the correct categorisation of skin damage and appropriate reporting.

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	Jun-22
Value / RAG rating	1.32

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

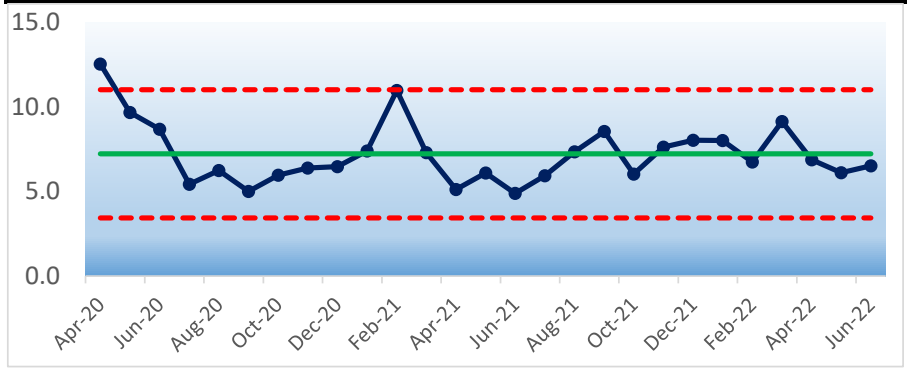
Increase in community acquired pressure ulcers. Likely due to challenges of patients not always being able to receive the desired frequency of repositioning due to gaps in social care provision (ie; home care). Adult community services have recently declared OPEL 4 and have been required to prioritise visits based on level of need.

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	Jun-22
Value / RAG rating	6.5

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

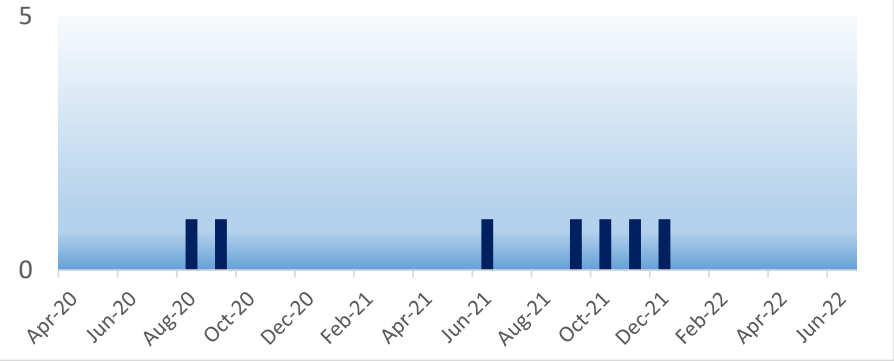
Slight increase in inpatient falls per 1,000 bed days. All escalation beds open and staffing challenges remain. Length of stay remains longer than necessary due to gaps in social care provision and therefore patients in ward areas for longer. Lack of falls nurse at present - returning from maternity leave mid July.

Indicator	**1.4 - Infection control - Hospital acquired C.difficile cases, lapse in care identified**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Jun-22
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 2022/23 is a maximum of 40 hospital acquired cases - including avoidable, unavoidable and indeterminable causes.

Trend chart



Narrative

There were no hospital acquired cases of C.difficile reported in June, with the year to date total remaining at 11. RCAs have been completed and agreed with the CCG for 9 of the 11 cases - 8 cases were deemed to be unavoidable and 1 case was deemed to be indeterminable.

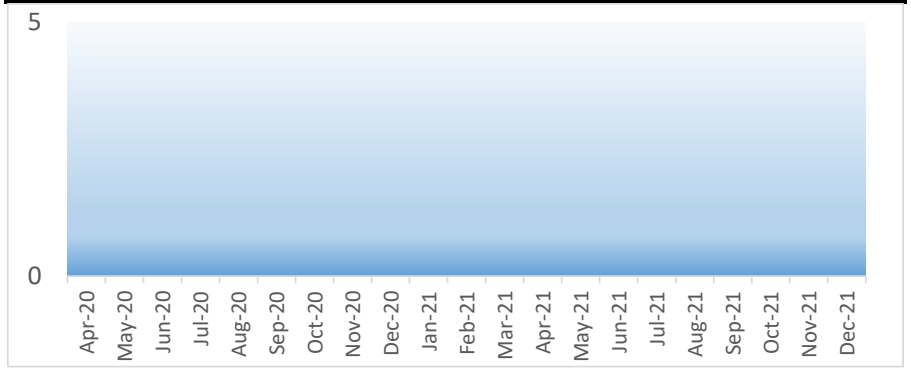
The Trust has now received confirmation from NHS England that its C. difficile trajectory for 2022/23 is a maximum of 40 hospital acquired cases - including avoidable, unavoidable and indeterminable causes.

Indicator	**1.5 - Infection control - Hospital acquired MRSA cases, lapse in care identified**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Jun-22
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

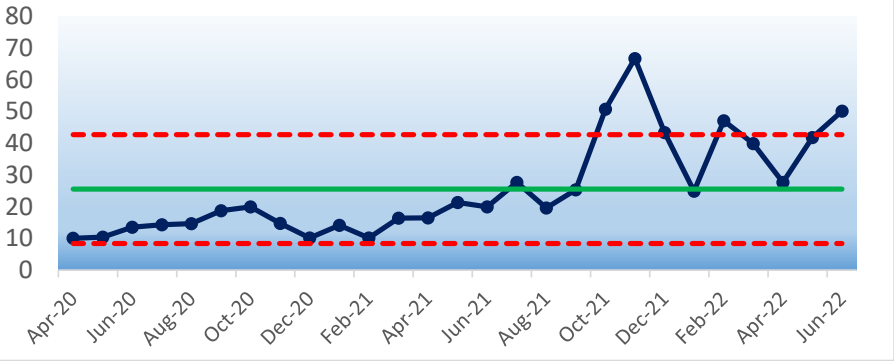
No hospital acquired MRSA cases where lapses in care identified for June.

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	Jun-22
Value / RAG rating	50.1

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

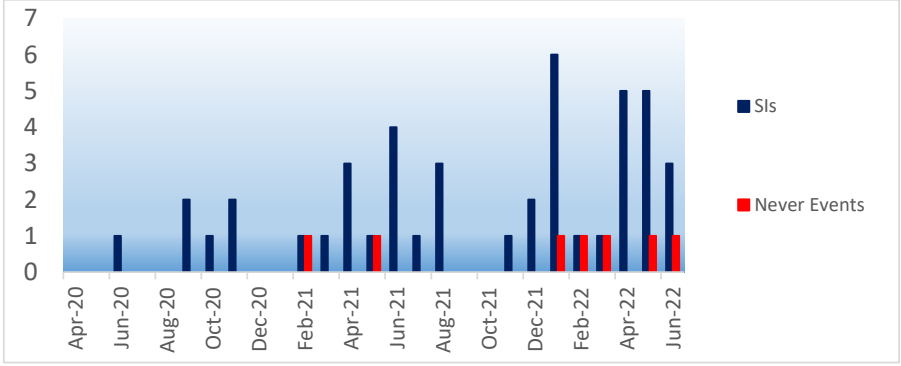
The number of low harm incidents reported in June has increased resulting in a level of reporting that positively exceeds the upper control limit of the SPC chart. In June 2022, the top 5 categories of incidents reported were:
Pressure Ulcers & Other Skin Damage (29%)
Records & Consent (10%)
Appointments, Admission, Transfer & Discharge (10%)
Slips, Trips & Falls (Patients) (7%)
Workload & Staffing (7%)

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	Jun-22
Value / RAG rating	3 (SI), 1 (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

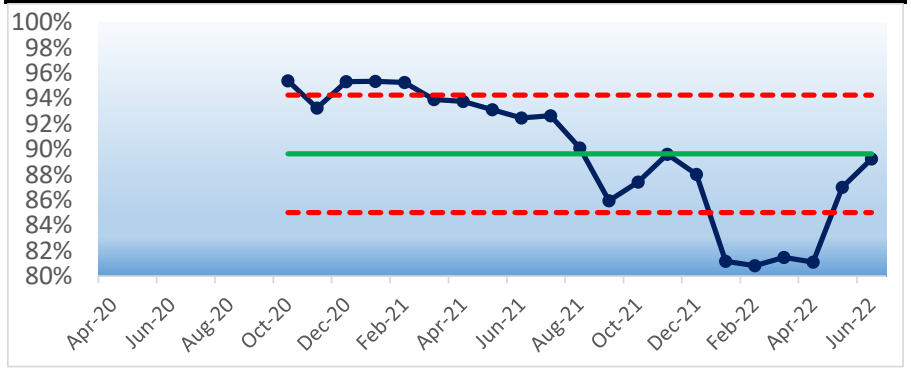
In June 2022, three serious incidents were declared, including one Never Event.
The SI Committee has strong oversight of current SI investigations with closure reports being produced and shared into Learning Summit.

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	Jun-22
Value / RAG rating	89.2%

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

The data presented identifies that fill rates have improved. This could possibly be aligned to:

- The newly recruited CSW's starting their roles
- Harlow escalation closing and Wensleydale moving to Harlow at reduced beds.
- Incentive payments have been extended to 4th September.

Recruitment events continue to be planned and band 4 project officers have been recruited for:

1) Recruitment
2) Retention
3) International Recruitment

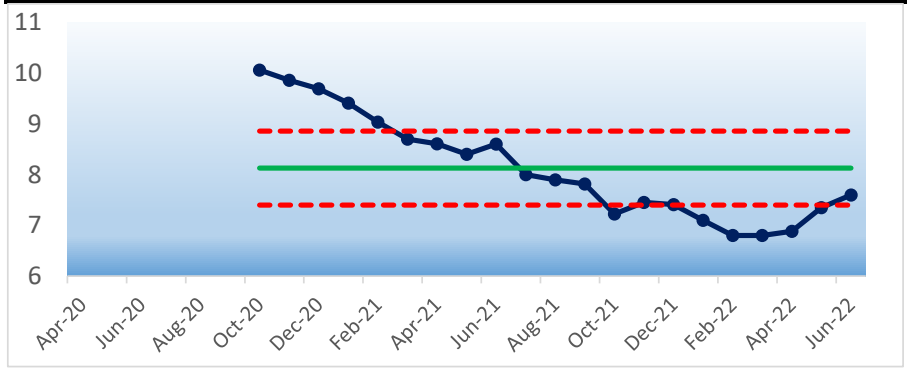
Recruitment and Retention groups have now been introduced feeding in to the Nursing, Midwifery and AHP Workforce Governance meetings.

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	Jun-22
Value / RAG rating	7.6

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

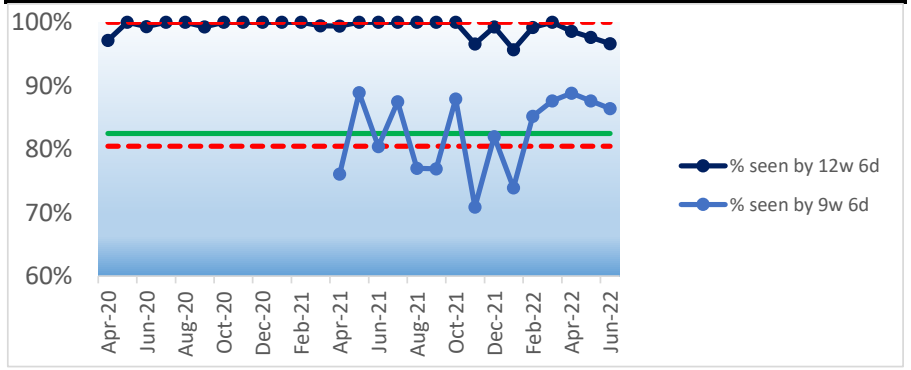
CHPPPD has increased over the last few months. However CHPPPD is not in line with fill rate. To note, calculations of nurse fill from Fountains are being based on 28 beds when they are mostly 15. Data is being reviewed to ensure accuracy of reporting staffing fill rates against changing operational position.

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	Jun-22
Value / RAG rating	96.6%

Indicator description

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

SPC chart



Narrative

Performance against this standard remains good.

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

We continue to submit 0% compliance with this model, as we are providing continuity during the antenatal and postnatal periods but not intrapartum care to women. This is due to reduced midwifery staffing levels and the need to maintain safe staffing levels across the unit.

Agreement at previous Trust Board meeting to continue with risk assessed plans for continuity of carer implementations which were re-assessed following the publication of the final Ockenden Report.

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	Jun-22
Value / RAG rating	3.7%

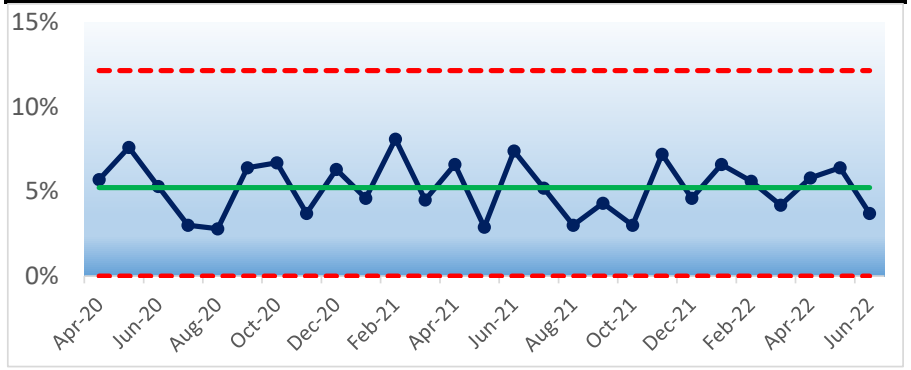
Indicator description

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

Narrative

Performance against this standard remains good.

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	Jun-22
Value / RAG rating	81.8%

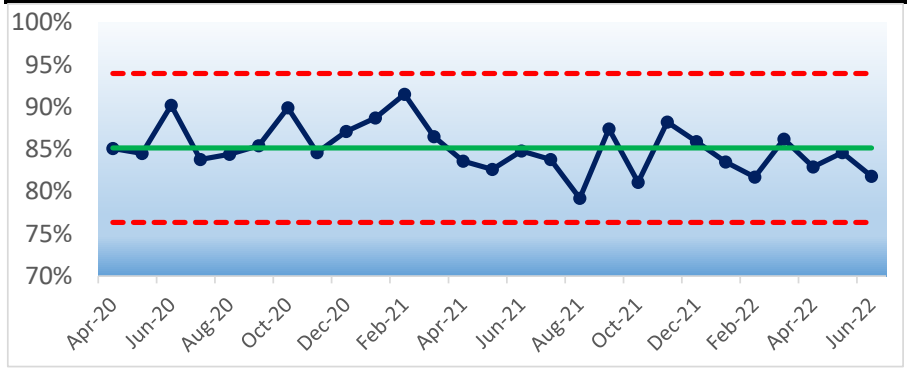
Indicator description

The % of women initiating breastfeeding

Narrative

Performance against this standard remains good

SPC chart

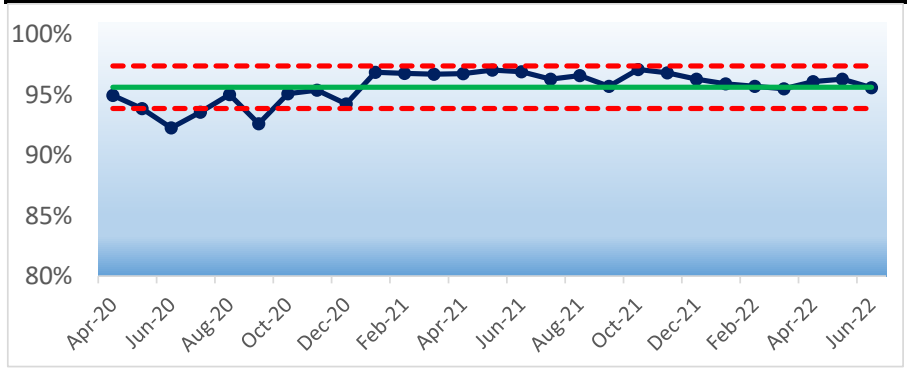


Indicator	**1.13 - VTE risk assessment - inpatients**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Jun-22
Value / RAG rating	95.6%

Indicator description

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

SPC chart



Narrative

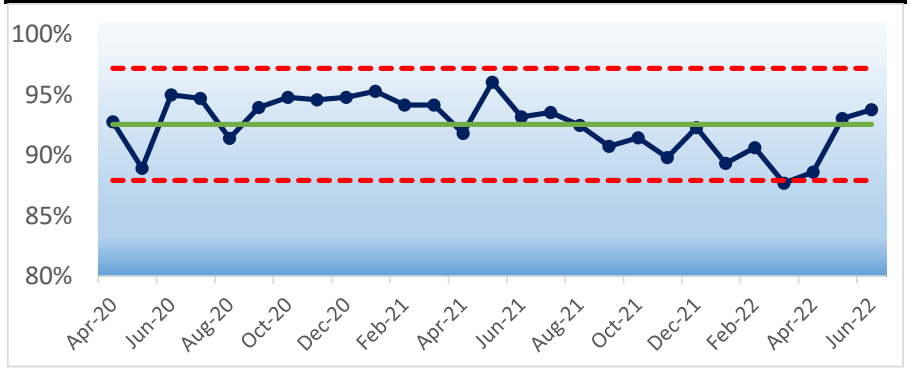
VTE risk assessment compliance continues to slowly improve, wards are reminded of the monitoring of this, remaining above the 95% standard.

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	Jun-22
Value / RAG rating	93.8%

Indicator description

The percentage of eligible inpatients who were screened for sepsis.

SPC chart



Narrative

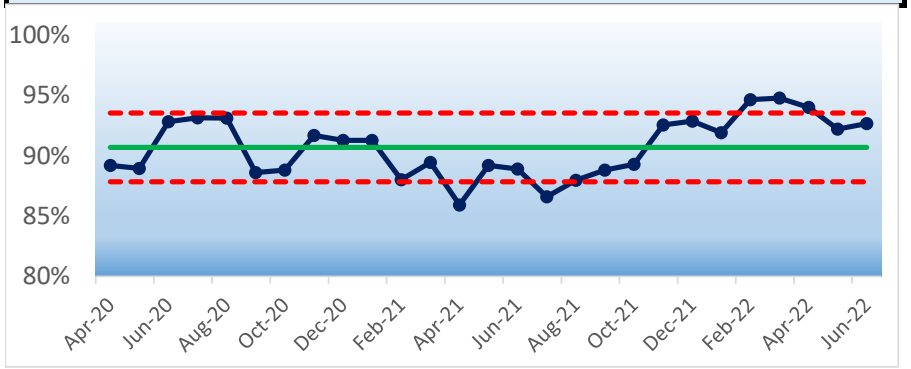
Improvement noted due to systems in place and monitoring from matrons.

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	Jun-22
Value / RAG rating	92.6%

Indicator description

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

SPC chart



Narrative

Lead Nurse and Matron continue to monitor the compliance against this standard, slightly improved position since last month.

Integrated Board Report - June 2022

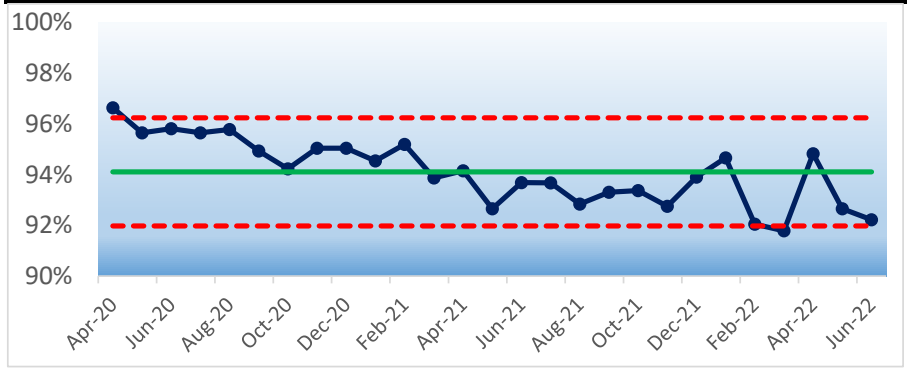
Domain 2 - Caring

Indicator	**2.1.1 - Friends & Family Test (FFT) - All Patients**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Jun-22
Value / RAG rating	92.2%

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

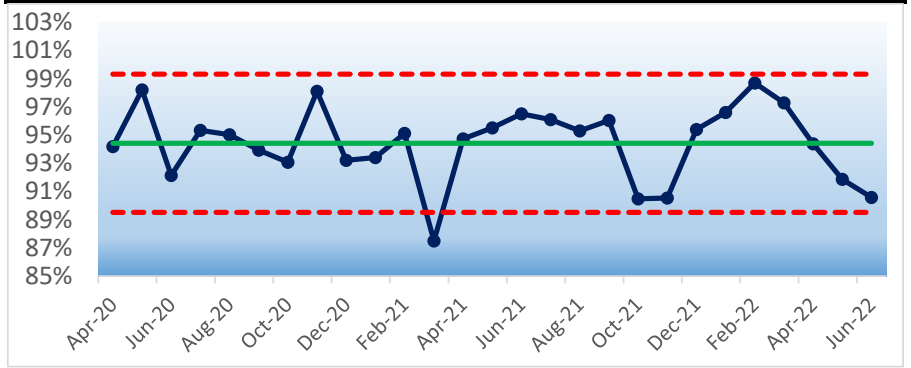
Performance against this standard continues to fluctuate but overall remains over 90% which is positive.

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	Jun-22
Value / RAG rating	90.6%

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

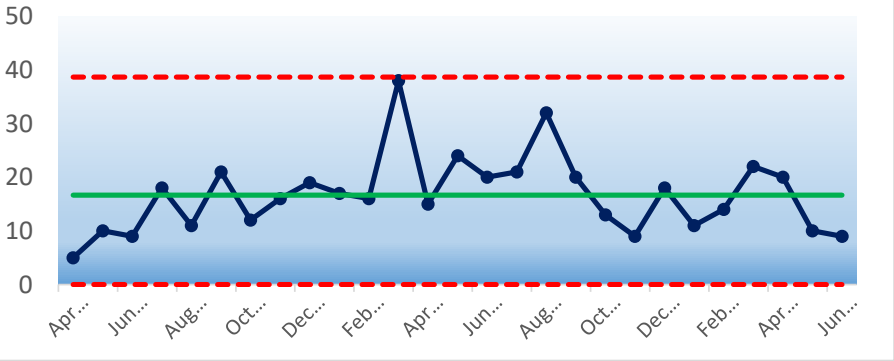
Performance against this standard continues to fluctuate but overall remains over 90% which is positive.

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	Jun-22
Value / RAG rating	9

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

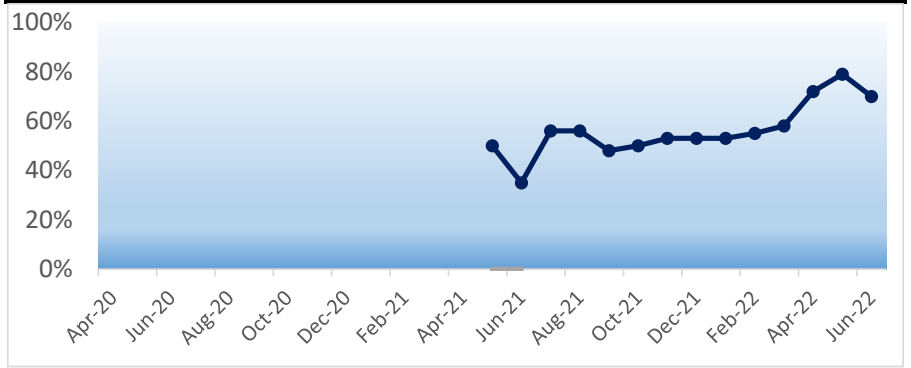
In June, there were 9 standard complaints received into the organisation that required a response within the 25 working day KPI. There were a further 2 multiagency complaints. There were 6 standard complaints in PSC, 1 in LTUC and 2 in Children's and Community. Some themes noted for complaints during June 22 by sub-subject: Appointment cancellations, Attitude of nursing staff/other staff, Cleanliness of Non Clinical and Clinical Areas, Communication with relatives and Delay/Failure in Treatment or procedure.

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	Jun-22
Value / RAG rating	70%

Indicator description

The number of complaints responded to within 25 days, shown as the year to date position. The Trust's improvement trajectory for 2021/22 is to respond to 95% of non-multi-agency complaints on time by December 2021.

Trend chart



Narrative

During the month of June 2022, 70% of complaints were responded to within the Trust standard of 25 working days. This level of performance shows a slight dip from May 2022 when the Trust achieved 79%. PSC Directorate have had reduced capacity within their Quality Assurance Lead team and have also received the greatest number of complaints. In June 2022, the breakdown by Directorate is as follows; 22% C&C, 11% LTUC and 67% PSC.

Integrated Board Report - Juney 2022

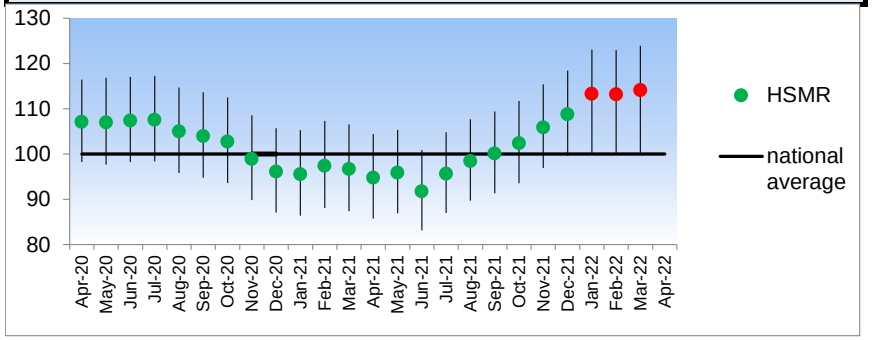
Domain 3 - Effective

Indicator	**3.1 - Hospital Standardised Mortality Ratio (HSMR)**
Executive lead	Jacqueline Andrews, Medical Director
Board Committee	Quality Committee
Reporting month	Mar-22
Value / RAG rating	114.09

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

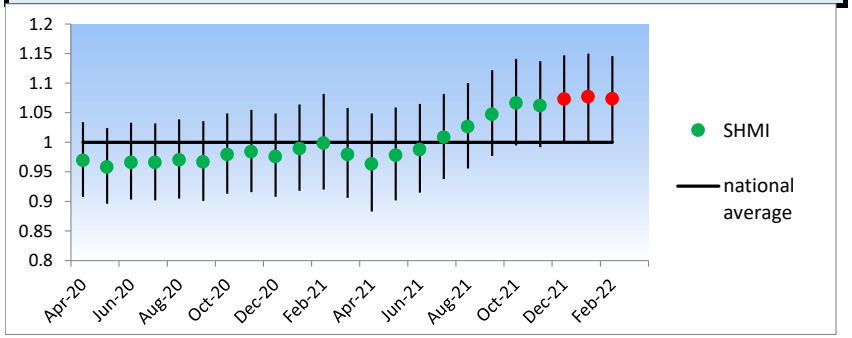
National average is 100. HDFT remains above the expected range. The funnel plot below shows HDFT as the diamond compared to similar Trusts (shown as a cross) and all other Trusts. The Deputy Medical Director (Quality and Safety) has performed a deep dive into the rise in our mortality indicators, details of which are submitted as a board paper. Mortality indicators are triangulated with ME scrutiny, Structured Judgement Reviews, national mortality alerts, incidents, complaints and claims and no concerns have been identified via these additional indicators.

Indicator	**3.2 - Summary Hospital Mortality Index (SHMI)**
Executive lead	Jacqueline Andrews, Medical Director
Board Committee	Quality Committee
Reporting month	Feb-22
Value / RAG rating	1.07

Indicator description

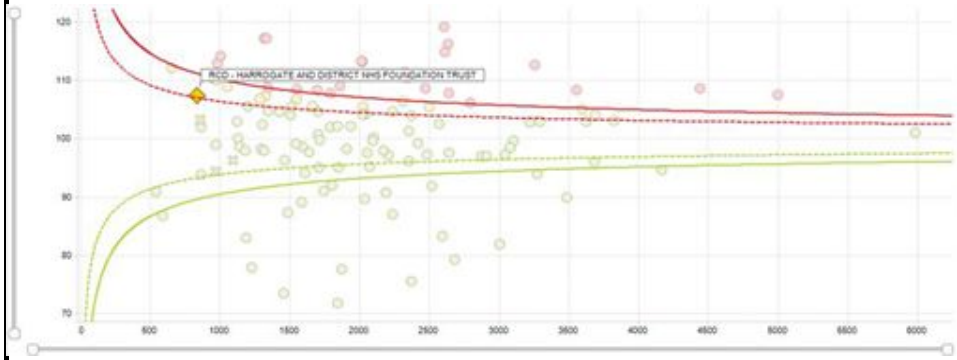
The SHMI looks at the mortality rates for all diagnoses and standardises against various criteria including age, sex and comorbidities. The measure does not make an adjustment for palliative care.

Trend chart



Narrative

National average is 1. HDFT remains at the upper limit of the expected range. The funnel plot below shows HDFT as the diamond compared to similar Trusts (shown as a cross) and all other Trusts. See section 3.1 for more details on out mortality indices.

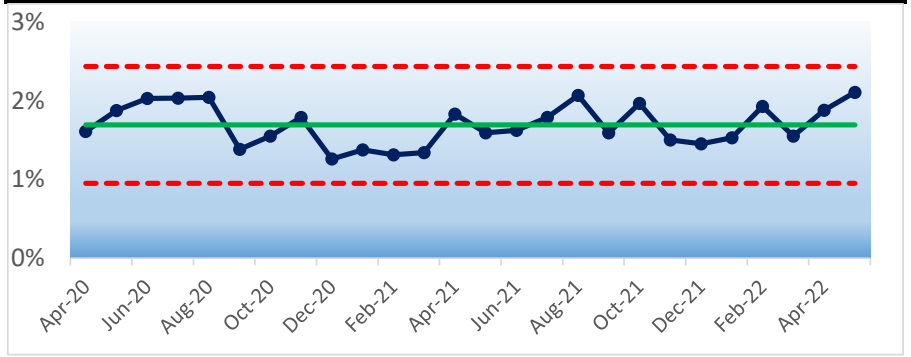


Indicator	**3.3.1 - Readmissions to the same specialty within 30 days - following elective admission**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	May-22
Value / RAG rating	2.1%

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

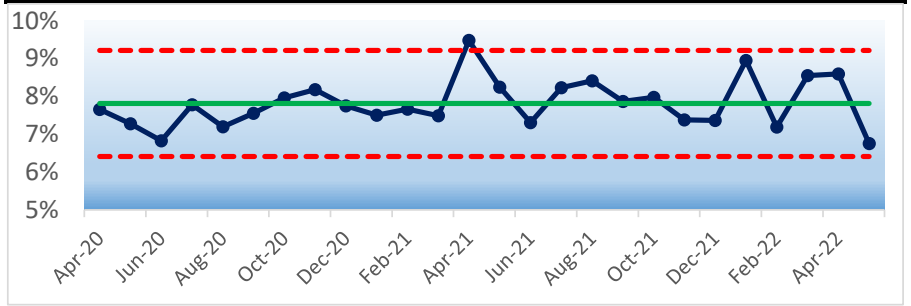
Readmissions following an elective admission increased to 2.1% in May but remain within control limits and less than national average.

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	May-22
Value / RAG rating	6.8%

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 to 6.8% in May, remaining within the control limits.

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

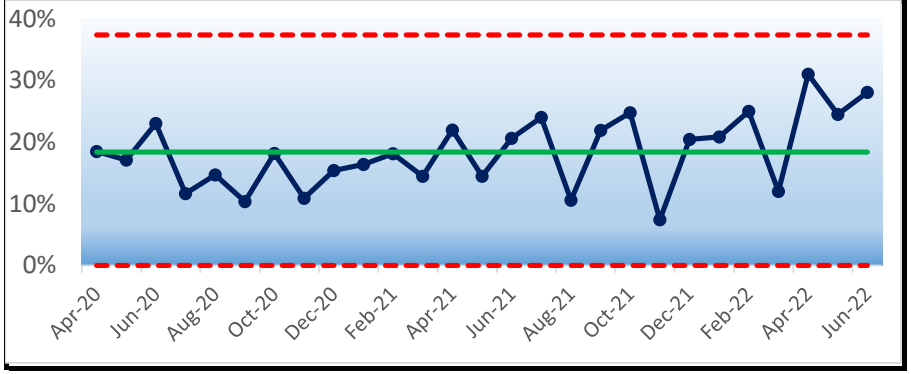
Narrative

Indicator	**3.5 - Delayed transfers of care**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Jun-22
Value / RAG rating	28.1%

Indicator description

The percentage of inpatients not meeting the criteria to reside as reported on the daily discharges sitrep. This is a snapshot position as reported on the last Thursday of the month.

SPC chart



Narrative

28% of inpatients did not meet the criteria to reside when the snapshot was taken in June. The Trust have now purchased a system using funding from NHSE that allows the ward teams to electronically capture the criteria to reside of every patient. This is now rolled out across all adult wards and provides real-time information.

However the major blockage with hospital outflow remains the social care crisis. 66% of MFFD (medically fit for discharge) patients are waiting for PoC or Care home placements. The key issue is a lack of capacity in POC due to staffing issues in the care market. Staffing issues are also impacting on capacity in care homes both of which are leading to more patients meeting the critera to reside remaining in hospital. The reduction seen in the metric this month reflects higher acuity of patients, thus more meeting criteria to reside, rather than a significant change in 'delays'.

TRUST BOARD (Public)
28th September 2022

Title:	**Patient Safety Incident Response Framework (PSIRF)**
Responsible Director:	Executive Director of Nursing, Midwifery and AHPs / Deputy Chief Executive
Author:	Associate Director of Quality and Corporate Affairs

Purpose of the report and summary of key issues:	The report provides the Trust Board with an update on the national publication of the Patient Safety Incident Response Framework (PSIRF) and HDFTs approach to implementation.	
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	
	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:	None	
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.	

TRUST BOARD (PUBLIC)

Patient Safety Incident Response Framework (PSIRF)
28th September 2022

1.0 INTRODUCTION

The Patient Safety Incident Response Framework (PSIRF) sets out the NHS's approach to developing and maintaining effective systems and process for responding to patient safety incidents, for the purpose of learning and improving patient safety. Its aim is to support one of the key aims of the NHS Patient Safety Strategy: *to help the NHS improve its understanding of safety by drawing insight from patient safety incidents.* PSIRF will replace the Serious Incident Framework, with all organisations expected to transition to PSIRF within 12 months (by Autumn 2023).

2.0 BACKGROUND

The PSIRF is a contractual requirement under the NHS Standard Contract and as such is mandatory for services provided under that contract, including acute, ambulance, mental health, and community healthcare providers.

Its intention is to support the development and maintenance of an effective patient safety incident response system that integrates four key aims:

- Compassionate engagement and involvement of those affected by patient safety incidents.
- Application of a range of system-based approaches to learning from patient safety incidents.
- Considered and proportionate responses to patient safety incidents.
- Supportive oversight focused on strengthening response system functioning and improvement.

As part of this change, organisations are required to develop a thorough understanding of their patient safety incident profile, ongoing safety actions (in response to recommendations from investigations) and established improvement programmes.

A patient safety incident response planning exercise is used to inform what the organisation's proportionate response to patient safety incidents should be. The PSIRF approach is designed to be flexible and adapt as organisations learn and improve, so they explore patient safety incidents relevant to their context and the populations they serve.

3.0 ENGAGING, INVOLVING AND IMPROVING

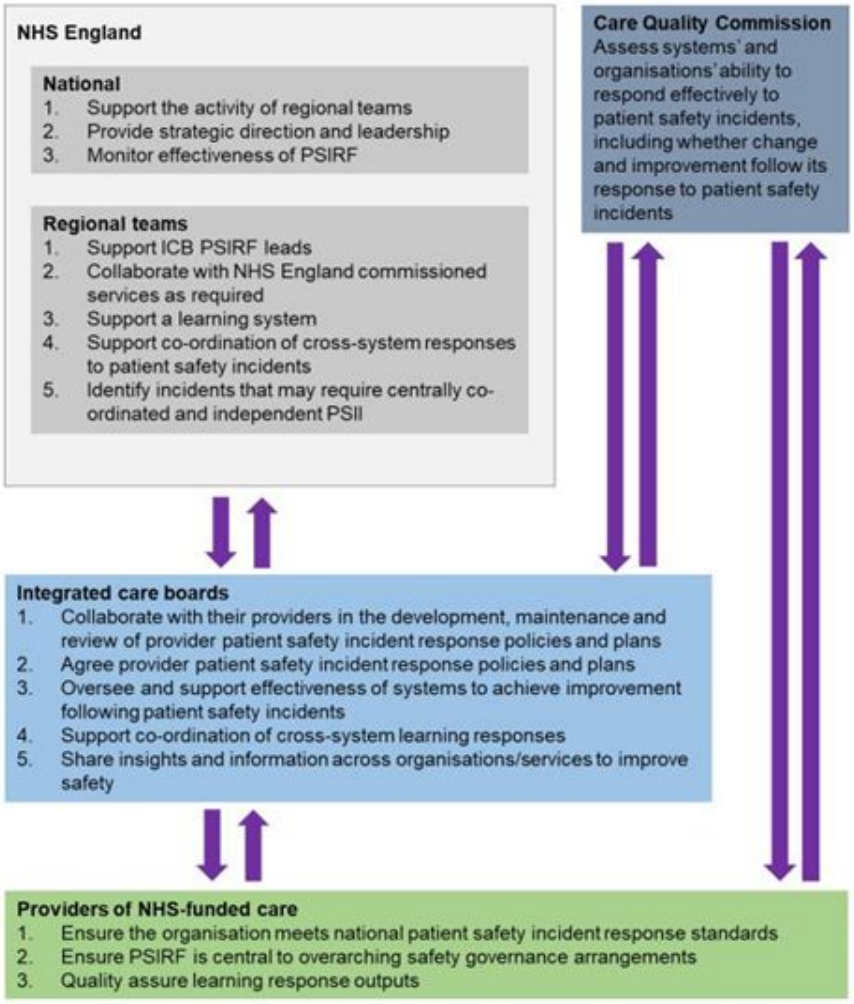
The following 'mindset' principles should underpin the oversight of patient safety incident response:

1. Improvement is the focus: PSIRF oversight should focus on enabling and monitoring improvement in the safety of care, not simply monitoring investigation quality.
2. Blame restricts insight: Oversight should ensure learning focuses on identifying the system factors that contribute to patient safety incidents, not finding individuals to blame.
3. Learning from patient safety incidents is a proactive step towards improvement: Responding to a patient safety incident for learning is an active strategy towards continuous improvement, not a reflection of an organisation having done something wrong.

4. Collaboration is key: A meaningful approach to oversight cannot be developed and maintained by individuals or organisations working in isolation – it must be done collaboratively.
5. Psychological safety allows learning to occur: Oversight requires a climate of openness to encourage consideration of different perspectives, discussion around weaknesses and a willingness to suggest solutions.
6. Curiosity is powerful: Leaders have a unique opportunity to do more than measure and monitor. They can and should use their position of power to influence improvement through curiosity. A valuable characteristic for oversight is asking questions to understand rather than to judge.

4.0 GOVERNANCE STRUCTURES

The following diagram describes the organisational responsibilities in relation to PSIRF oversight:

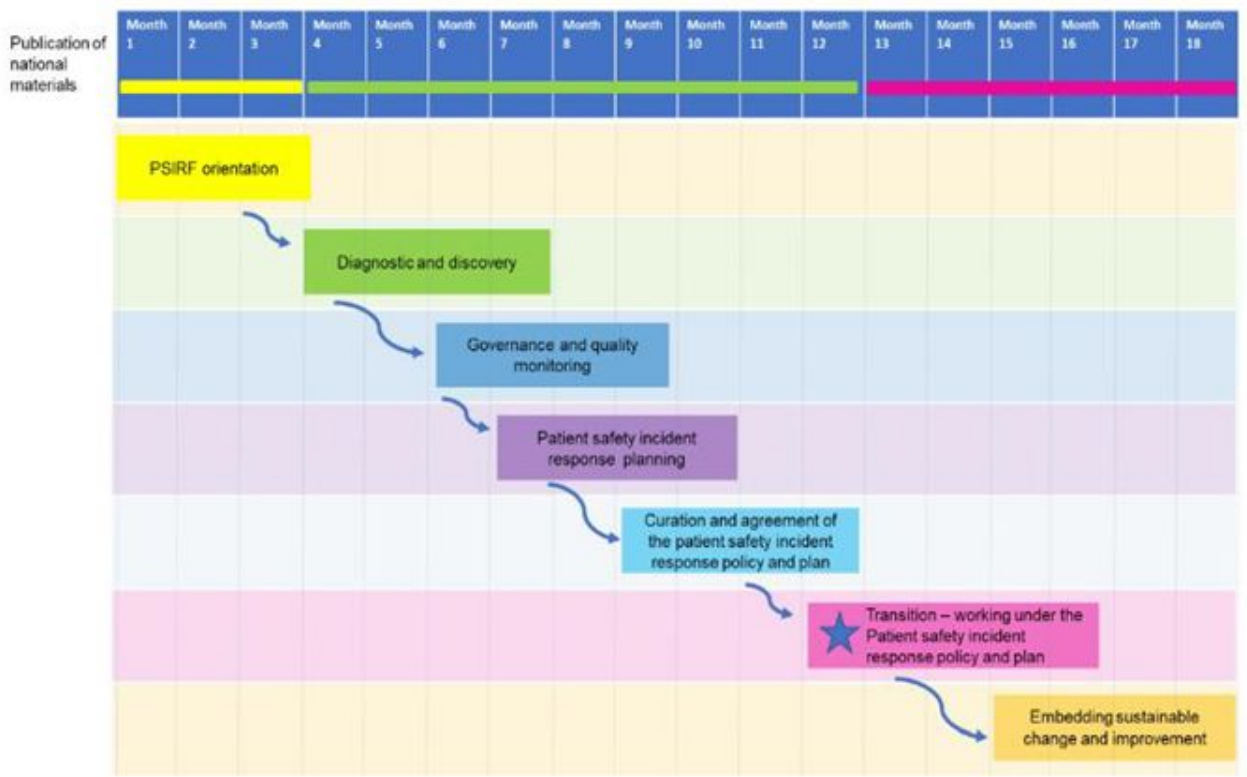


5.0 PSIRF PREPARATION

PSIRF shifts how the NHS responds to patient safety incidents for learning and improvement. PSIRF is not an investigation framework that prescribes what to investigate, instead, PSIRF:

- advocates a co-ordinated and data-driven approach to patient safety incident response that prioritises compassionate engagement with those affected
- embeds patient safety incident response within a wider system of improvement
- prompts a significant cultural shift towards systematic patient safety management.

Implementation of PSIRF will not be achieved by a change in policy alone, and it cannot be implemented in days or weeks as it requires work to design a new set of systems and processes. NHS E/I have developed a preparation guide using insight from 17 early adopters. The guide aims to support those leading PSIRF implementation across the NHS during 2022/23. The Figure below gives an overview of the phases that those leading PSIRF will need to work through, but not necessarily in sequence, to deliver the new way of working.



Phase	Duration	Purpose
PSIRF orientation	Months 1–3	To help PSIRF leads at all levels of the system familiarise themselves with the revised framework and associated requirements. This phase establishes important foundations for PSIRF preparation and subsequent implementation.
Diagnostic and discovery	Months 4–7	To understand how developed systems and processes already are to respond to patient safety incidents for the purpose of learning and improvement. In this phase strengths and weaknesses are identified, and necessary improvements in areas that will support PSIRF requirements and transition are defined.

Phase	Duration	Purpose
Governance and quality monitoring	Months 6–9	Organisations at all levels of the system (provider, ICB, region) begin to define the oversight structures and ways of working once they transition to PSIRF.
Patient safety incident response planning	Months 7–10	For organisations to understand their patient safety incident profile, improvement profile and available resources. This information is used to develop a patient safety incident response plan that forms part of a patient safety incident response policy.
Curation and agreement of the policy and plan	Months 9–12	To draft and agree a patient safety incident response policy and plan based on the findings from work undertaken in the preceding preparation phases.
Transition	Months 12+	Organisations continue to adapt and learn as the designed systems and processes are put in place.

6.0 NEXT STEPS

Following publication of the national PSIRF guidance in August 2022, HDFT are now in the process of developing our own implementation plan. This will be created to the timescales detailed in section 5 of this report.

At an operational level this will be managed through the Quality Governance Management Group and overseen at a strategic level by the Quality Committee.

Kate Southgate
Associate Director of Quality and Corporate Affairs

September 2022

Harrogate and District NHS Foundation Trust

4

Board Meeting Held in Public
28th September 2022

Title:	Learning from Deaths Quarterly Report 1: April-June 2022
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 has risen since mid-2021 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:	Paper scrutinised at Patient Safety Forum, Quality Governance Management Group and Quality Committee	
Recommendation:	The board is asked to note the contents of the report, including the metrics and methodology used.	

Harrogate and District NHS Foundation Trust

Board Meeting Held in Public

28th September 2022

Learning from Deaths Quarterly Report 1

Executive Medical Director

1.0 Executive Summary

Crude mortality rates for the trust continue to oscillate around national trends.

Standardised mortality rates have been rising since mid-2021. Possible reasons for this are discussed in Appendix A. A change in the demographics of our inpatient population is the most likely cause.

19 structured judgement reviews have been undertaken since the last report. Median score for overall care was “good”, with no episodes of poor care identified in this selection.

There continues to be a significant number of patients testing positive for Covid-19, with the majority of deaths after a positive test occurring in the over 75s.

The HDFT Medical Examiner team continues to perform well when benchmarked against regional data.

Harrogate and District NHS Foundation Trust

2.0 Introduction

Standardised mortality indices in Q1 2022/23 continue to rise despite a decline in crude mortality rates. A detailed examination of this is undertaken in Appendix A.

3.0 Findings

3.1 Crude Mortality Data

The crude mortality rate for admissions gives a long-term view of trust mortality. In total, 191 deaths were recorded in Q1, down from 203 in the preceding Q4. This represents a small fall as a percentage of activity. 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.

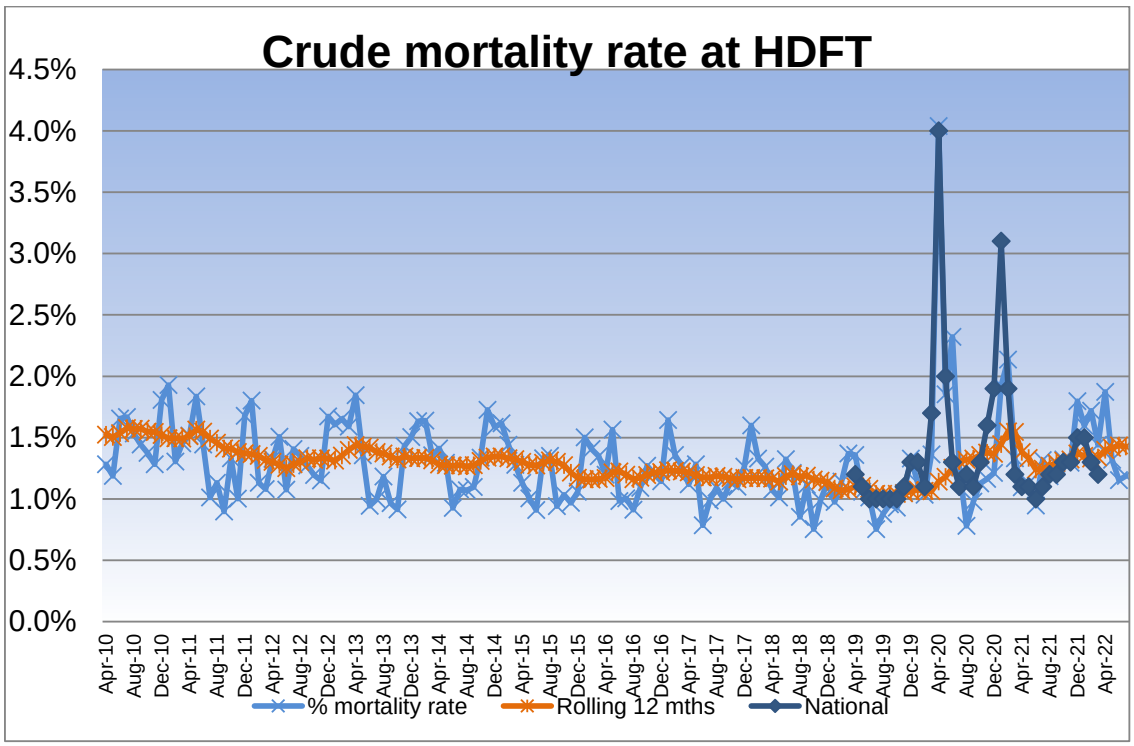


Figure 1: Crude mortality rates over the last 12 years (%deaths per qualifying episode)

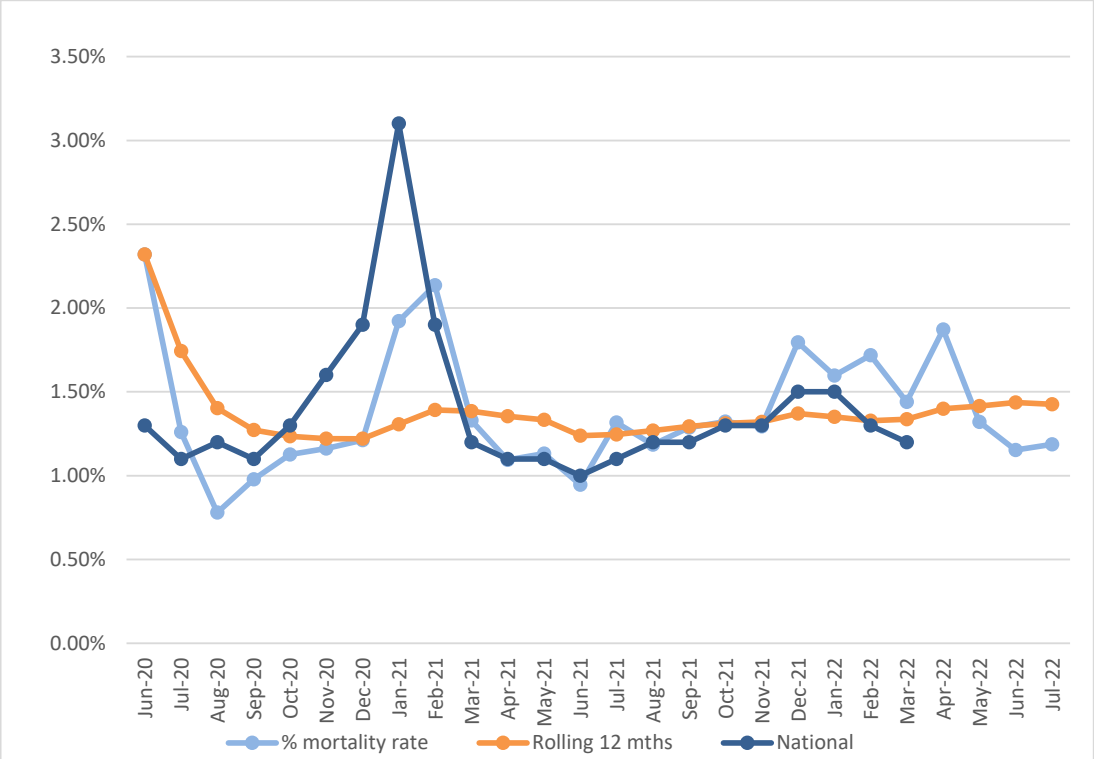


Figure 2: Expanded crude mortality rates over the last 2 years (%deaths per hospital episode)

3.2 Standardised Mortality Rates (HSMR and SHMI)

Figures 3-10 show the most recent data available for HSMR and SHMI. Overall, our results from both indices have slowly increased since mid-2021. Please note that Figures 3 to 10 show 12 month rolling data, with the exception of Figure 5 which shows the monthly swings in mortality.

3.2.1 HSMR

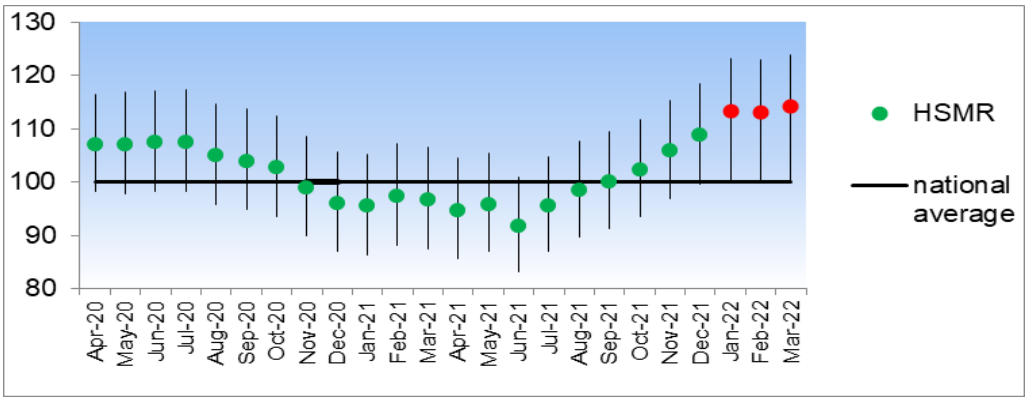


Figure 3: HSMR. Dots show the recorded values with error bars showing possible range of true values.

Harrogate and District NHS Foundation Trust

Figures 4, 5 and 6 show our most recent HSMR data in comparison to national and regional peers. Figure 5 demonstrates the significant monthly variation in HSMR, including the unexplained spikes at HDFT in July 2021 and November 2021. HDFT is shown as a black diamond icon.

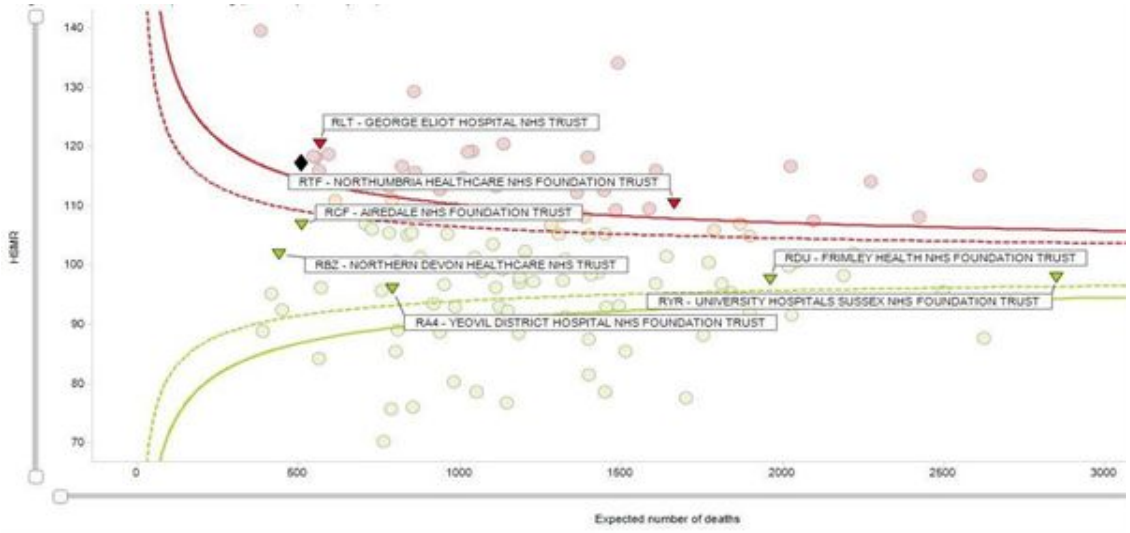


Figure 4: HSMR data for national peer organisations

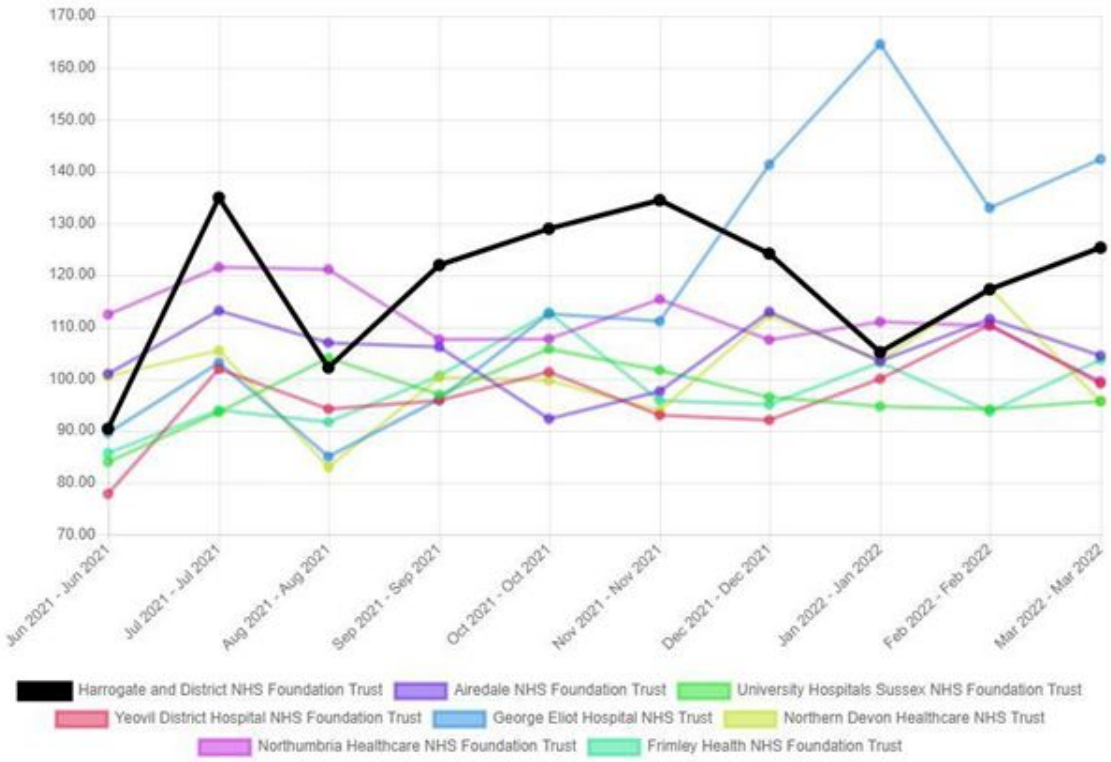


Figure 5: Monthly HSMR for national peer organisations

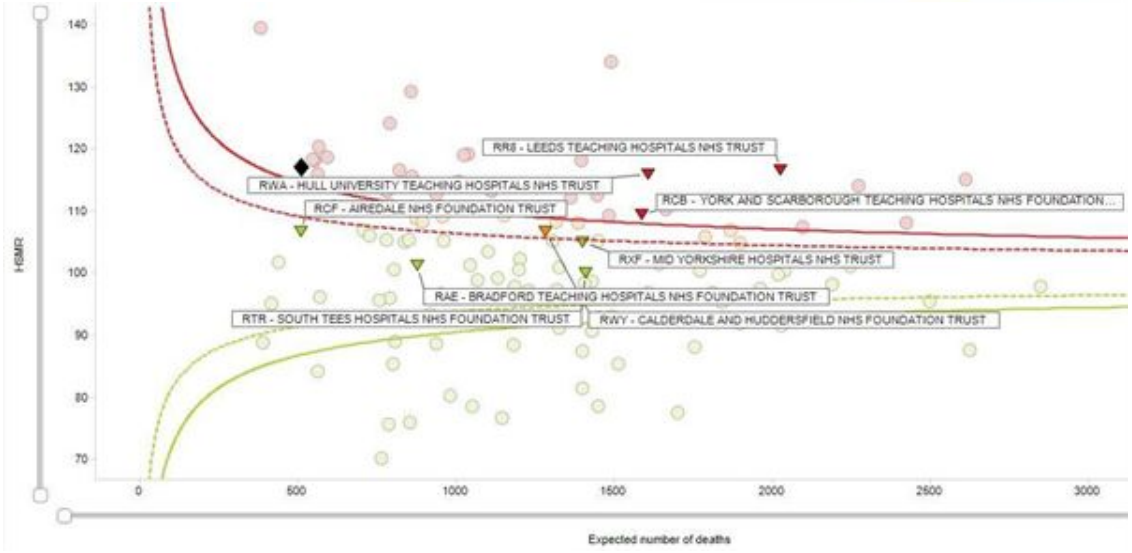


Figure 6: HSMR data for regional organisations

3.2.2 SHMI

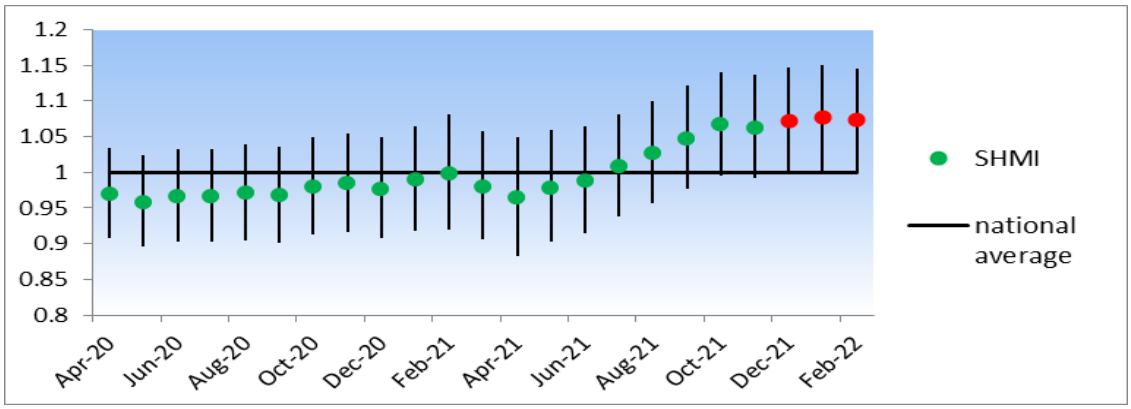


Figure 7: SHMI Dots show the recorded values with error bars showing possible range of true values.

Figures 8, 9 and 10 demonstrate our SHMI against that of peer and regional trusts. Again, HDFT is marked as a black diamond icon.

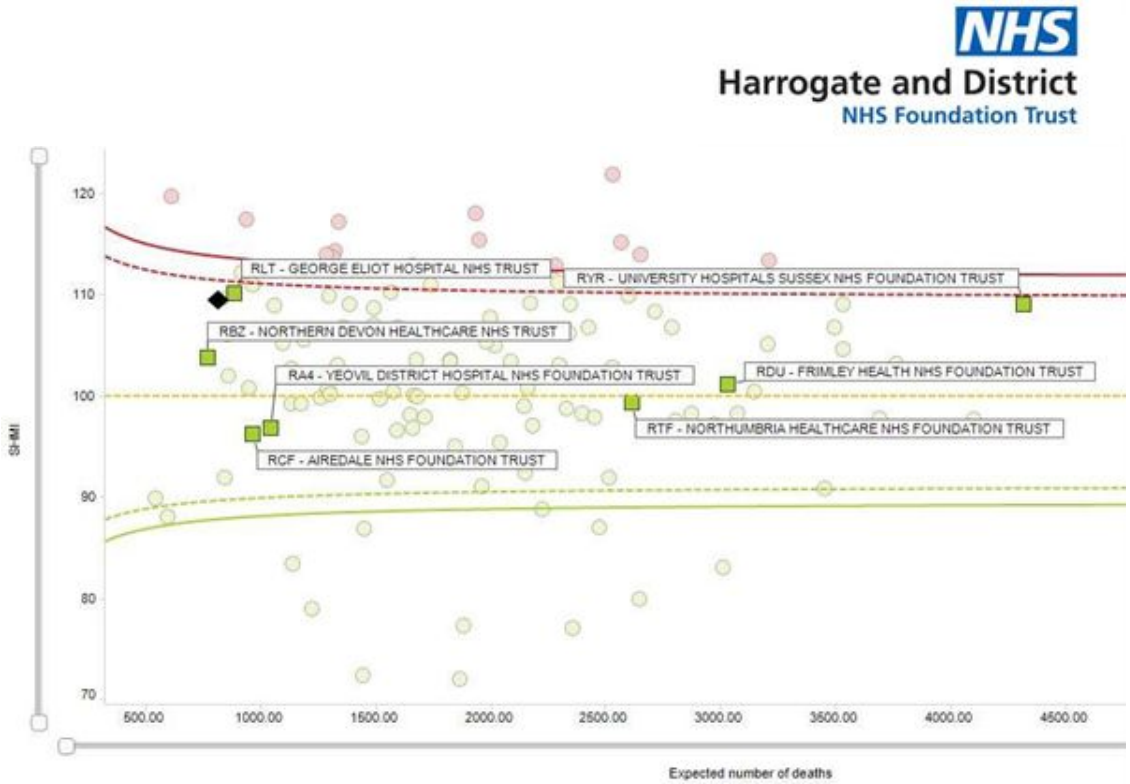


Figure 8: SHMI data for national peer organisations

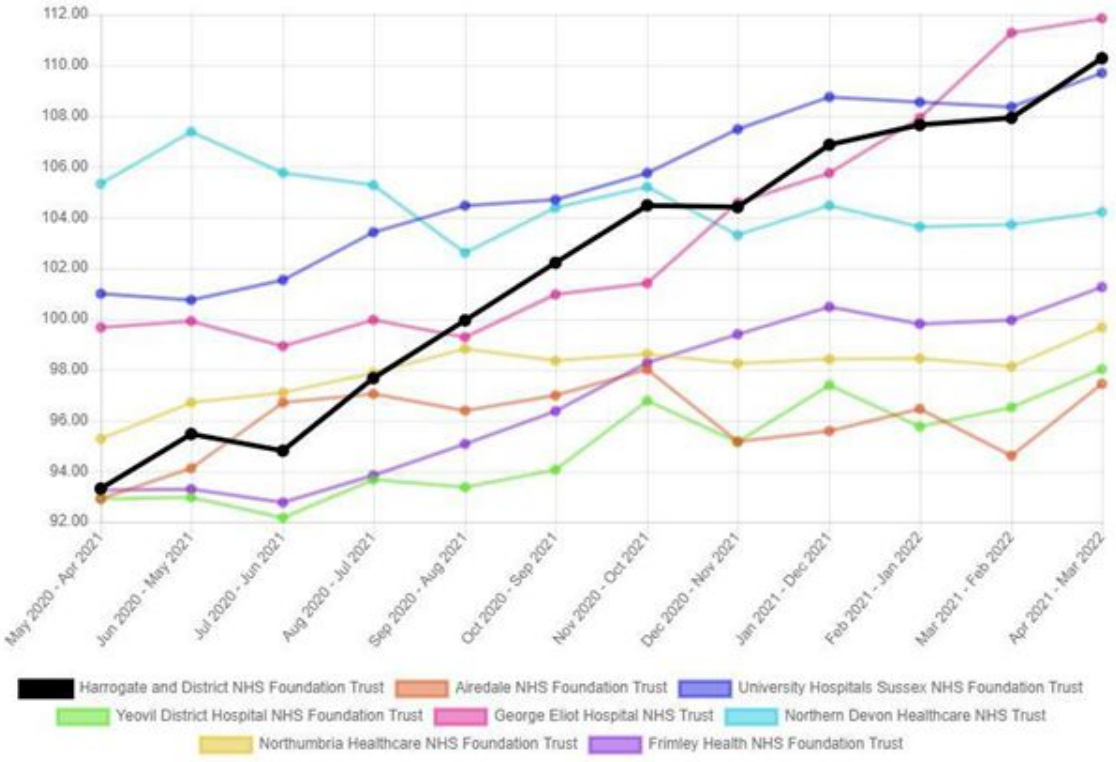


Figure 9: SHMI monthly data for national peer organisations

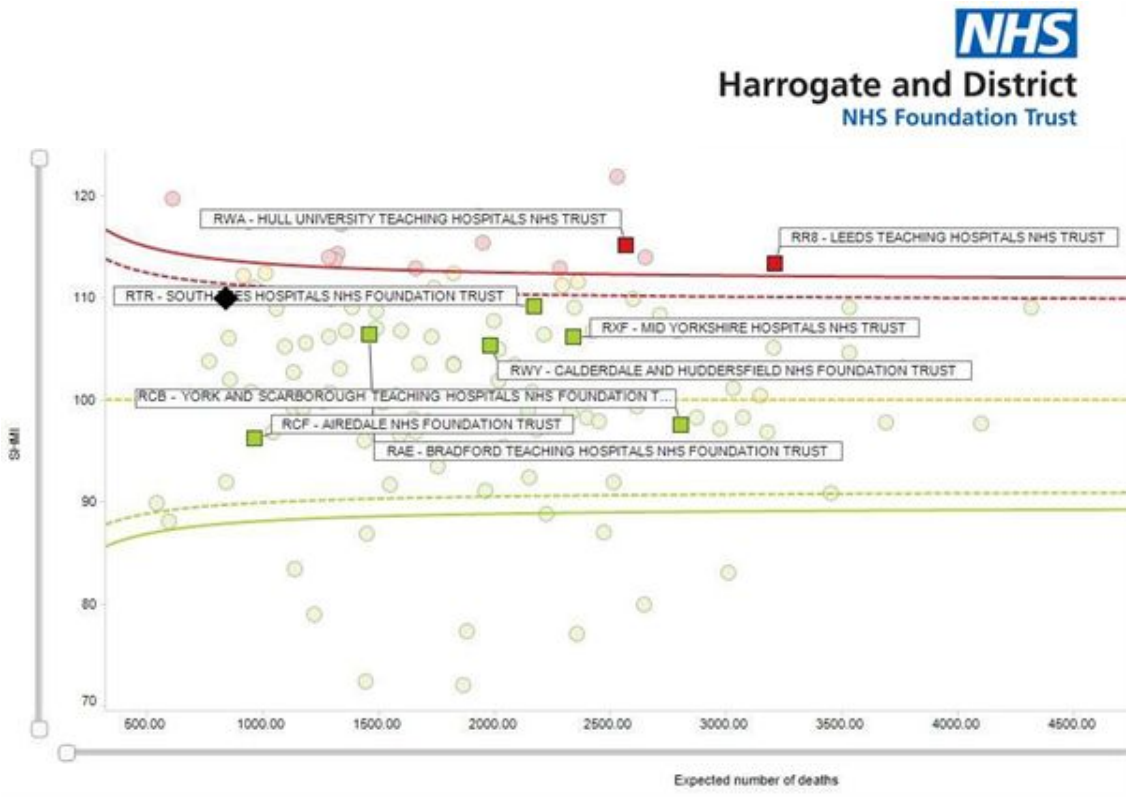


Figure 10: SHMI data for regional organisations

Both the HMSR and SHMI have risen over the last 6-9 months. The exact causes for this are unclear. The SJRs over this period (section 3.3 in this and previous reports) have not highlighted any thematic lapses in care.

3 diagnostic areas have triggered alerts around this period:

Aspiration pneumonitis (HSMR-CUSUM)

Open wounds of head, neck and trunk (SHMI)

“Other” gastrointestinal disorders (SHMI)

SJRs have been performed on a selection of deaths in the latter group and no concerns or themes identified. Further cases from this and the other 2 categories will be undertaken over the coming months.

Harrogate and District NHS Foundation Trust

3.3 Structured judgement reviews (SJR)

19 cases have been reviewed in this quarter with 6 relating to deaths in this quarter, 11 from Q3 and 2 from Q4. Cases are chosen following recommendation from a Medical Examiner, diagnoses marked as areas for concern on mortality data or randomly selected for assurance. 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	May 22	No	No	4	4	4	**4**	4
2	Jan 22	No	No	4	3	3	**3**	-
3	Jan 22	No	No	5	4	5	**4**	5
4	Dec 21	No	No	4	4	4	**3**	4
5	Nov 21	No	No	5	5	5	**5**	5
6	Jun 22	No	Yes	3	4	4	**4**	4
7	Nov 21	No	No	4	4	4	**4**	4
8	Oct 21	No	No	3	4	5	**3**	4
9	Jun 22	No	No	4	N/A	N/A	**4**	4
10	Nov 21	No	No	4	3	N/A	**3**	3
11	Jun 22	No	No	4	N/A	4	**4**	3
12	Nov 21	No	No	3	4	4	**4**	4
13	May 22	No	No	4	4	5	**4**	5
14	Dec 21	No	No	4	4	3	**4**	5
15	Nov 21	No	No	4	4	4	**4**	4
16	Oct 21	No	No	4	4	3	**5**	4
17	Dec 21	No	No	4	4	-	**4**	3
18	Oct 21	No	No	4	N/A	4	**4**	3
19	May 22	Yes	No	4	4	4	**4**	4
Median Score				4	4	4	**4**	4

Table 1: Structured Judgemental Reviews (SJR) conducted in Q1 2022-2023

No recurrent themes have been identified in these reviews. 3 cases died soon after admission, so ongoing care beyond 24 hours was not available. One case was a death soon after hospital discharge where the reviewer did not have access to the notes from the last days of life.

No cases had any episode of their care scored as poor.

1 case was identified as having a Learning Disability. This will be subject to an external review as part of the LeDeR process, and feedback from that will be provided in a future report.

Overall, the quality of care being delivered during this period remained of a good standard. This is despite the previously noted rise in both HSMR and SHMI. As previously explained at a board workshop, SJRs are a more reliable method of detecting poor quality clinical care and provide assurance that the rising mortality indices, although warranting further investigation, have not been mirrored by concerns in the subjective case reviews.

The relaunched Mortality Review Group held its formation meeting in July, with the first monthly working meeting scheduled for September. This will allow greater sharing of learning, and should help identify any common themes or areas for concern.

Harrogate and District NHS Foundation Trust

3.4 Covid-19 Deaths

Table 2 shows the hospital's Covid-19 mortality for Q3 2021/22 to Q1 2022/23. This data gives an overview of current Covid-19 infection rates, but a number of significant caveats should be noted. The total number of Covid admissions relates to any patient who has had a positive PCR at/during admission (for diagnostic or surveillance indications) or patients admitted with a known positive PCR in the community within the previous 14 days. This means that a significant proportion of patients admitted in this time period were asymptomatic from a Covid perspective and were admitted for other reasons, and many did not receive specific treatment for Covid-19. This is further complicated by the fact that some patients who test positive at/during admission are later known to have had Covid within the previous 90 days and therefore the positive test reflects previous infection. Preliminary analysis has confirmed that in many cases, the Covid infection was not thought to have had any contribution to the patient's death.

Confirmed Covid-19 inpatient discharges (Oct-Dec 2021)				% (of patients)	
Age category	Total	Death within 28 days	Death in hospital	% Death within 28 days	% Death in hospital
0-5	13	0	0	0.0%	0.0%
6-17	15	0	0	0.0%	0.0%
18-24	4	0	0	0.0%	0.0%
25-34	3	0	0	0.0%	0.0%
35-44	19	0	1	0.0%	5.3%
45-54	17	0	1	0.0%	5.9%
55-64	33	0	3	0.0%	9.1%
65-74	39	1	8	2.6%	20.5%
75-84	38	1	6	2.6%	15.8%
85+	39	3	6	7.7%	15.4%
Total	220	5	25	2.3%	11.4%

Confirmed Covid-19 inpatient discharges (Jan-March 202				% (of patients)	
Age category	Total	Death within 28 days	Death in hospital	% Death within 28 days	% Death in hospital
0-5	50	0	0	0.0%	0.0%
6-17	21	0	0	0.0%	0.0%
18-24	10	0	0	0.0%	0.0%
25-34	15	0	0	0.0%	0.0%
35-44	19	0	1	0.0%	5.3%
45-54	15	0	0	0.0%	0.0%
55-64	30	0	1	0.0%	3.3%
65-74	55	7	1	12.7%	1.8%
75-84	97	5	13	5.2%	13.4%
85+	121	7	22	5.8%	18.2%
Total	433	19	38	4.4%	8.8%

Confirmed Covid-19 inpatient discharges (Apr-Jun 2022)				% (of patients)	
Age category	Total	Death within 28 days	Death in hospital	% Death within 28 days	% Death in hospital
0-5	28	0	0	0.0%	0.0%
6-17	5	0	0	0.0%	0.0%
18-24	13	0	0	0.0%	0.0%
25-34	9	0	0	0.0%	0.0%
35-44	9	0	1	0.0%	11.1%
45-54	17	0	2	0.0%	11.8%
55-64	3	1	0	33.3%	0.0%
65-74	48	1	5	2.1%	10.4%
75-84	69	2	7	2.9%	10.1%
85+	96	1	20	1.0%	20.8%
Total	**269**	**5**	**35**	**1.9%**	**13.0%**

Table 2: Covid19 deaths for admissions in Q3, Q4 and Q1 either whilst still an inpatient or after discharge but within 28 days of positive test.

3.5 Medical Examiner Service

The Medical Examiner service has now been expanded to look at deaths in the community, irrespective of any previous care from HDFT. By the end of Q1, all deaths in the community are being scrutinised in the Harrogate Borough Council footprint, with the exception of deaths occurring at St Michael's Hospice and Ripon Hospital. These 2 areas will soon be included once the logistics of note transfer and attending doctor's availability is finalised. In September we plan to involve 7 practices in Richmondshire, which will complete the roll out well ahead of the April 2023 deadline. We are scheduled to become the first ME office in the north of England to achieve this target.

Table 3 below shows our current rates compared to the North of England region for acute site deaths (data for community deaths, in particular the denominator, is not yet available).

	Q2		Q3		Q4		Q1	
	HDFT	Regional	HDFT	Regional	HDFT	Regional	HDFT	Regional
Deaths Scrutinised	**179/179 (100%)**	**6772/9527 (71%)**	**213/213 (100%)**	**8355/10932 (76%)**	**214/214 (100%**	**8117/10372 (78%)**	**185/185 (100%)**	**7865/9794 (80%)**
Death certificate takes longer than 3 days	**2 (1%)**	**650 (10%)**	**17 (8%)**	**1048 (13%)**	**18 (8%)**	**1006 (18%)**	**25 (13%)**	**1376 (17%)**
Death certificate rejected by Registrar	**034 (0.7%)**	**24 (0.7%**	**044 (0.5%)**	**0**	**1**	**19**	**0**	**37**

Table 3: Performance of HDFT Medical Examiner team compared to the Regional Average

4.0 Recommendation

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

Harrogate and District NHS Foundation Trust

Appendix A – Detailed look into HSMR and SHMI

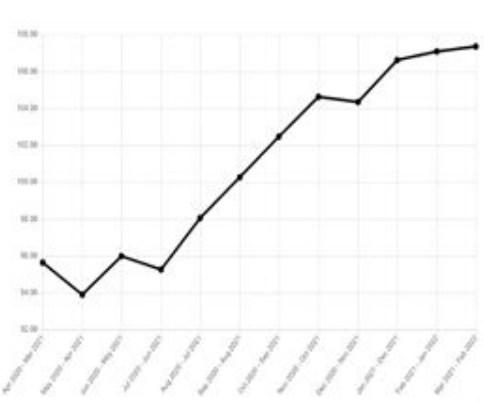
As demonstrated in the Integrated Board Report and the quarterly Learning from Deaths report, there has been a steady rise in both standardized mortality indices for the trust – SHMI and HSMR. This has been particularly true for the latter, which has risen outside the predicted range.

A deep dive into the changes in our mortality indictors was commissioned via QGMG (Quality Governance Management Group), to report back to QGMG and onward to Quality Committee and Board for assurance as required.

This paper aims to investigate, analyse and report on the possible reasons for this change in our mortality indices.

HSMR and SHMI over the last 12 Months

Figures 11 and 12 show that the trend in both indices has been upwards since July 2021. It should be noted that these graphs (and those presented in the IBR) show rolling 12 month data – each month's data represents the total mortality index for that month plus the previous 11 months data. Hence if one month has an unusually high rate, this will be included in all data points for a 12 month period.



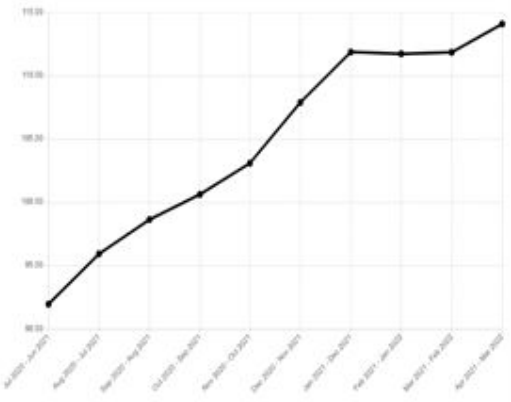


Figure 11: 12 month rolling SHMI for HDFT **Figure 12:** 12 month rolling HSMR for HDFT

Figure 13 shows each month's individual HSMR. Because the number of deaths in HDFT are relatively small, the month-to-month variation in HSMR can be dramatic. This graph shows we had a particularly high rate in July and November 2021.

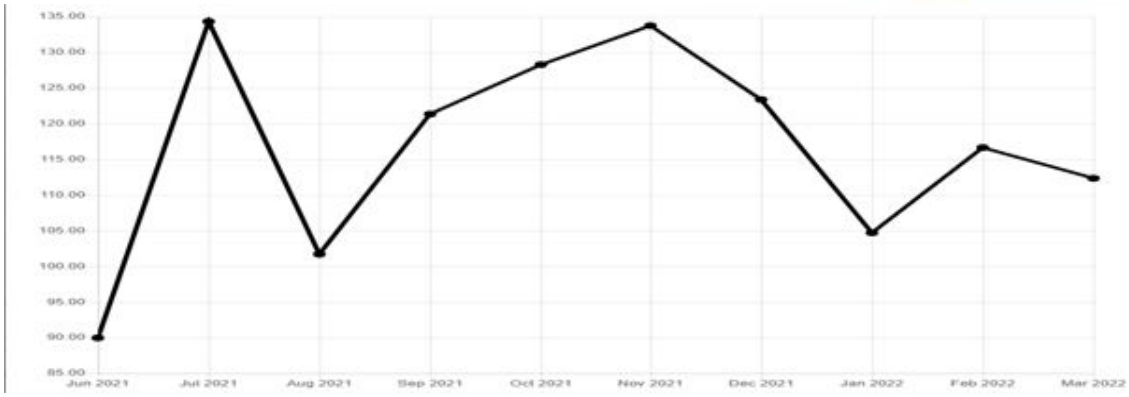


Figure 13: Monthly HSMR for HDFT

Association between Mortality Indices and Quality of Care

Academic investigation has revealed no correlation between mortality indices and avoidable deaths, as shown the in graphs below (Figure 14 - from Hogan et al BMJ 2015;351:h3239). The authors comment that "any metric based on mortality is unlikely to reflect the quality of a hospital". NHS Digital state that "a higher than expected SHMI should not immediately be interpreted as indicating bad performance", but should be viewed as a "smoke alarm" to trigger further investigation.

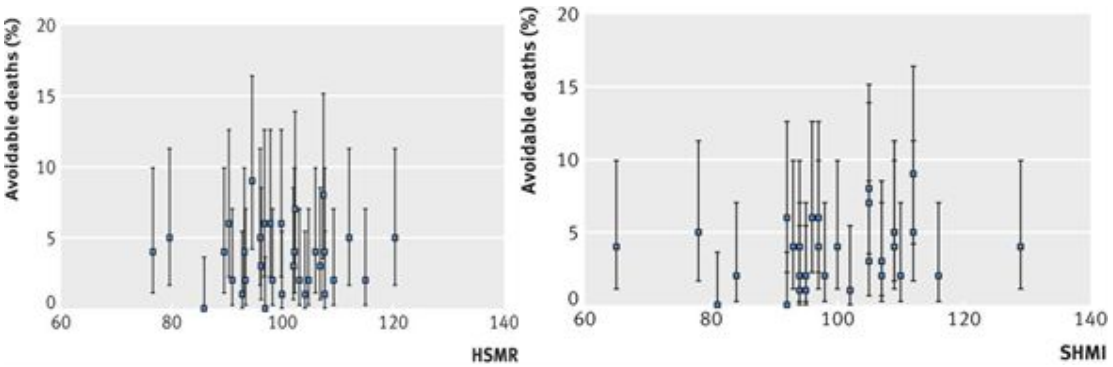


Figure 14: Lack of association between mortality indices and avoidable deaths

The recognized process for examining quality of care following death in the NHS is the use of Structured Judgement Reviews (SJRs). We have undertaken 59 notes reviews from July 2021-June 2022. Only 1 case had the overall care described as poor (and had already been declared a Serious Incident by the time of review). 7 cases were described as "adequate care", 49 as "good" and 3 as "excellent".

The majority of the cases chosen for investigation related to diagnostic areas highlighted by these indices as having higher than expected numbers of death. These were deaths due to stroke, pneumonia, septicemia and non-specific gastrointestinal diseases. No lapses of care were found in any of these groups.

Harrogate and District NHS Foundation Trust

Possible Causes for High Indices

Both HSMR and SHMI use the same principle in their calculation:

Number of observed deaths / Number of expected deaths

A rise would therefore be seen in the following circumstances:

a) More deaths are occurring than previously (eg due to a fall in quality of care provided)
b) Fewer deaths are expected than previously (eg the characteristics of the hospital population has changed)
c) A combined change in both of the above

a) - More deaths are occurring than previously

There are a number of reasons why option a) might seem possible. The hospital has been under significant pressure over the last twelve months, as demonstrated in IBR data on Emergency Department activity, hospital bed occupancy and ward staffing levels (fill rate and care hours per patient per day). But if these were significantly impacting on care, we would expect to see a significant deterioration in other aspects of care. Although we have seen an increase in pressure ulcers (which may reflect the change in population), infection control data remains good, suggesting that quality of care has not significantly deteriorated. There have been no significant changes to clinical pathways around July 2021, and this was before the new intake of junior doctors (whose training will have been impacted by the pandemic). The SJR data reflecting quality of care also makes option a) less likely as the main explanation for the change seen.

Figure 15 shows the rolling 12 monthly percentage crude mortality per hospital episode over the last year. As can be seen, the crude mortality percentage has fallen. This could be due to less deaths or higher hospital episodes of care (which would include very low risk procedures such as endoscopy and day case surgery). However Figure 16 shows that the actual number of deaths (in hospital and within 30 days of discharge) has also fallen. This therefore does not support option a).

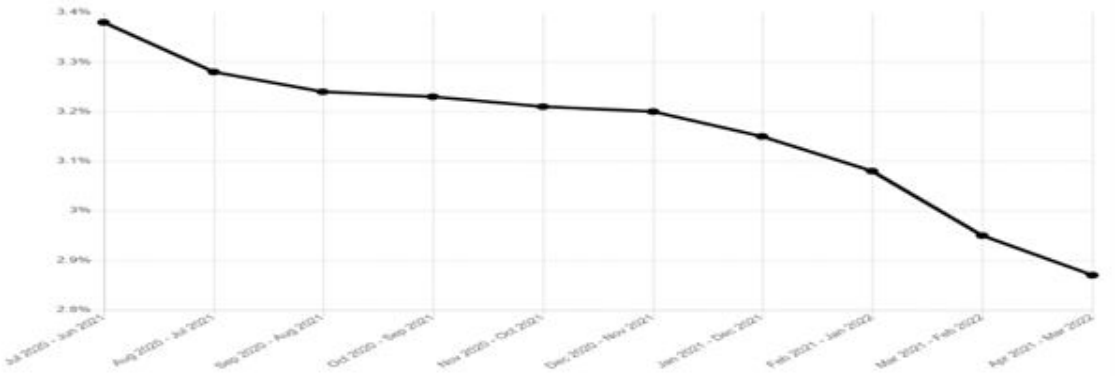


Figure 15: 12 month rolling mortality as a percentage of hospital episodes of care

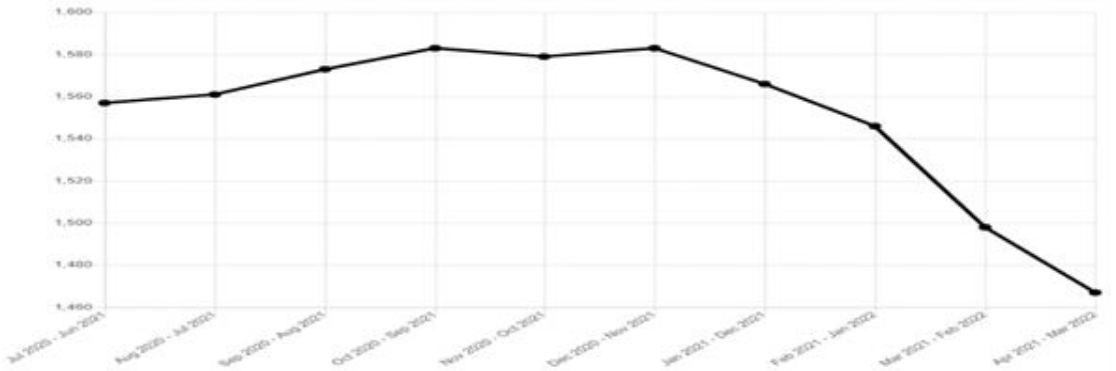


Figure 16: 12 month rolling mortality numbers for patients admitted to HDH. Note that numbers in the last few months may be subject to change pending ONS updates

b) - Fewer deaths are expected than previously

Option b) would suggests that the hospital population has changed in such a way that fewer deaths would be expected. A simple explanation would be that the population served by HDFT has become healthier. This is clearly unlikely to have occurred over such a short timescale. An alternative explanation is that the hospital population has changed in a manner that is not easily reflected in the current risk modelling.

One of the most apparent changes to the in-patient population over the last year has been the rise in patients who are deemed “fit for medical discharge”, but remain in hospital due to delays in ensuring adequate social care is provided. Figure 17 shows the number of patients (on a 12 monthly rolling basis) classed as “super-stranded”, which is defined as a length of stay over 21 days. This shows a substantial rise over this last year.

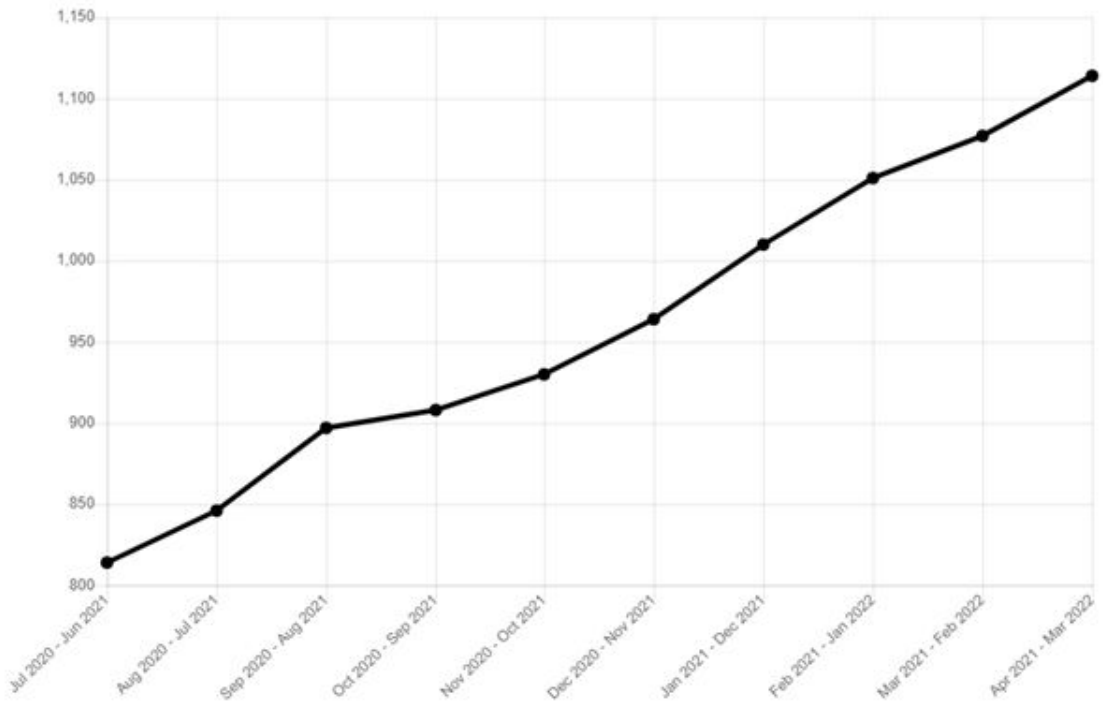


Figure 17: 12 month rolling data on the number of “super stranded” patients

There is more supportive evidence that the change in in-patient population is influencing the indices. Figures 15 and 16 show that the number of deaths has not risen, and may even have declined. However there has been a change in the location of where deaths are occurring. Figure 18 shows that the number of patients dying whilst still an inpatient has risen, and Figure 19 shows that the number of patients dying in the community has fallen. HSMR looks only at in-patient deaths, so these changes would likely cause an increase in HSMR greater than that for SHMI, which is what we have observed.

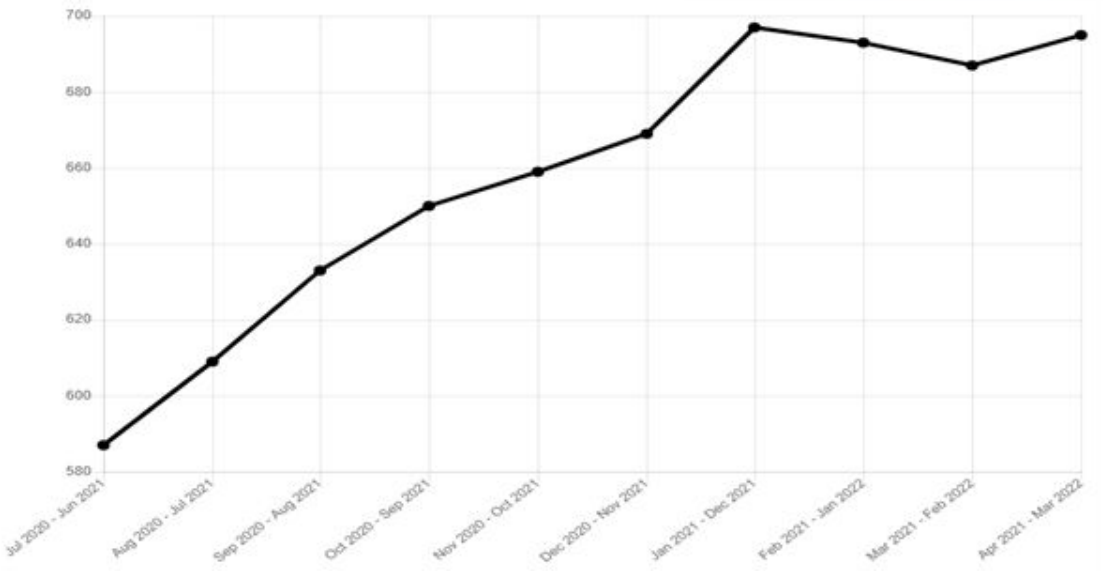


Figure 18: 12 month rolling mortality for inpatients

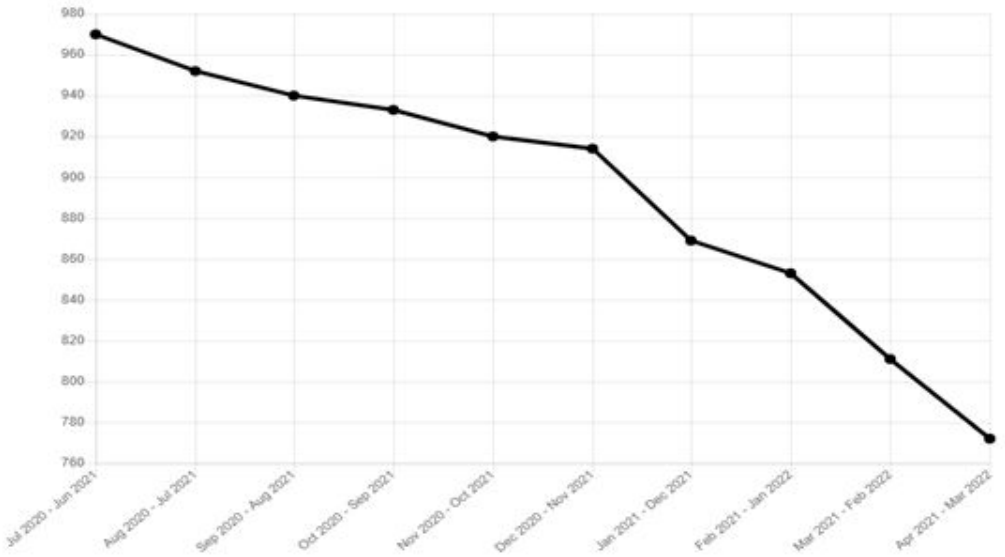


Figure 19: 12 month rolling mortality in the community following an admission. Note that numbers in the last few months may be subject to change pending ONS updates

SHMI records all deaths which occur in hospital plus those that occur in the 30 days following discharge. If it is true that the number of overall deaths has not risen, but the timing and location has been brought forward, then on first inspection the SHMI should not have changed, whereas HDFT's has risen. A possible explanation for this is that we are now recording deaths in a frail population over a longer time period than previously. For example, we may admit an elderly patient with a urinary tract infection. In previous years they may have required 5 days medical inpatient treatment and 7 days to formulate a care package. In this circumstance, the total period for SHMI monitoring would be 42 days (12 in hospital plus 30 in the community). The same patient admitted now would still need 5 days treatment, but could require 21 days

for a care package. Their SHMI period would now be 56 days, so that if they were to die of an unrelated condition between days 43 and 56, they would now be recorded on SHMI as a death related to their original urinary tract infection, whereas previously the connection would not have been made. Unfortunately our frail elderly population do have a significant risk of mortality post-discharge, so this scenario as described would not be uncommon.

Conclusion

In summary it appears that the excess time to discharge our frail elderly patients is the most likely reason for our changing data. We are planning to increase the number of SJR undertaken and are training increasing number of colleagues to undertake the reviews, as evidence shows this is the optimal way to detect any quality of care concerns. Mortality indictors will continue to be reported through our quality and safety framework and via the quarterly Learning from Deaths report.

Classification: Official

Publications approval reference: B0614

A framework of quality assurance for responsible officers and revalidation

Annex D – annual board report and statement of compliance

Version 1, July 2021

Contents

Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and seven annexes A – G.

In 2019 a review of the Annual Organisational Audit (AOA), Board Report template and the Statement of Compliance concluded with a slimmed down version of the AOA (Annex C) and a revised Board Report template (Annex D), which was combined with the Statement of Compliance (previously listed as Annex E) for efficiency and simplicity.

Annual Organisational Audit (AOA):

At the end of April 2021, Professor Stephen Powis wrote to Responsible Officers and Medical Directors in England letting them know that although the 2020/2021 AOA exercise had been stood down, organisations will still be able to report on their appraisal data and the impact of adopting the Appraisal 2020 model, for those organisations who have, in their annual Board report and Statement of Compliance.

Board Report template:

Following the revision of the Board Report template in June 2019 to include the qualitative questions previously contained in the AOA, the template has been further updated this year to provide organisations with an opportunity to report on their appraisal data as described in the letter from Professor Stephen Powis.

A link to the letter is below:

https://www.england.nhs.uk/coronavirus/publication/covid-19-and-professional-standards-activities-letter-from-professor-stephen-powis/

The changes made to this year's template are as follows:

Section 2a – Effective Appraisal

Organisations can use this section to provide their appraisal information, including the challenges faced through either pausing or continuing appraisals throughout and the experience of using the Appraisal 2020 model if adopted as the default model.

2 | Annex D – annual board report and statement of compliance

Section 2b – Appraisal Data

Organisations can provide high level appraisal data for the period 1 April 2021 – 31 March 2022 in the table provided. Whilst a designated body with significant groups of doctors (e.g. consultants, SAS and locum doctors) will find it useful to maintain internal audit data of the appraisal rates in each group, the high-level overall rate requested is enough information to demonstrate compliance.

With these additional changes, the purpose of the Board Report template is to help the designated body review this area and demonstrate compliance with the responsible officer regulations. It simultaneously helps designated bodies assess their effectiveness in supporting medical governance in keeping with the General Medical Council (GMC) handbook on medical governance.[1] This publication describes a four-point checklist for organisations in respect of good medical governance, signed up to by the national UK systems regulators including the Care Quality Commission (CQC). The intention is therefore to help designated bodies meet the requirements of the system regulator as well as those of the professional regulator. Bringing these two quality strands together has the benefits of avoiding duplication of recording and harnessing them into one overall approach.

The over-riding intention is to create a Board Report template that guides organisations by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time. Completion of the template will therefore:

a) help the designated body in its pursuit of quality improvement,

b) provide the necessary assurance to the higher-level responsible officer, and

c) act as evidence for CQC inspections.

[1] Effective clinical governance for the medical profession: a handbook for organisations employing, contracting or overseeing the practice of doctors GMC (2018) [https://www.gmc-uk.org/-/media/documents/governance-handbook-2018_pdf-76395284.pdf]

Statement of Compliance:

The Statement Compliance (in Section 8) has been combined with the Board Report for efficiency and simplicity.

Designated Body Annual Board Report

Section 1 – General:

The board / executive management team – [*delete as applicable*] of [*insert official name of DB*] can confirm that:

1. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Yes

2. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes

3. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

Yes

4. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Yes – The RO and Head of Resourcing and Revalidation actively review the processes in line with the policy. The Trust's internal audit department also review and monitor the policies.

5. A peer review has been undertaken (where possible) of this organisation's appraisal and revalidation processes.

Actions from last year: Peer review to be completed in 21/22 cycle Comments: Due to Covid-19 recovery, peer review was paused to ensure colleagues were focused on the HDFT recovery plan. Action for next year: Peer review to be completed in 22/23 cycle.

6. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Yes Comments: Locum doctors are expected to follow the same process as our permanent doctors with reference to their continuing professional development, appraisal, revalidation, and governance. Locums are able to access resources within this organisation during their period of employment.

Section 2a – Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes. For organisations that have adopted the Appraisal 2020 model, there is a reduced requirement for preparation by the doctor and a greater emphasis on verbal reflection and discussion in appraisal meetings. Organisations might therefore choose to reflect on the impact of this change. Those organisations that have not yet used the Appraisal 2020 model may want to consider whether to adopt the model and how they will do so.

Action from last year: None Comments: The organisation implemented a 3-stage process to support colleagues in completing an appraisal every 12 months. The trust has engaged with and shared the appraisal 2020 model with our colleagues across the Trust.

Action for next year: Ensure the new 3-stage process is embedded and being effective to improvement compliance across the Trust

2. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year: No action from previous year

Comments: The 3-stage process has been implemented to improve compliance and identify colleagues who may need additional assistance to support in completing timely appraisals.

Action for next year: Ensure compliance is improved

3. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Yes

4. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Yes

Comments: We are looking to recruit more appraisers as a number of senior appraisers have recently retired.

Action for next year: Ensure we continue to have sufficient number of trained appraisers.

5. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[2] or equivalent).

Yes

Comments: Bi-annual appraiser forums take place and the RO continually shares relevant correspondence with all our appraisers.

[2] http://www.england.nhs.uk/revalidation/ro/app-syst/

6. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Yes

Section 2b – Appraisal Data

1. The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below.

Name of organisation:	
Total number of doctors with a prescribed connection as at 31 March 2022	262
Total number of appraisals undertaken between 1 April 2021 and 31 March 2022	219
Total number of appraisals not undertaken between 1 April 2021 and 31 March 2022	38
Total number of agreed exceptions	5

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Yes

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Yes

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

Yes

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Yes

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Yes

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors.[3]

Yes

[3] This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.[4]

Yes – the Trust uses MPIT forms

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Yes

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Yes

Section 6 – Summary of comments, and overall conclusion

Please use the Comments Box to detail the following:

- **General review of actions since last Board report: Due to Covid recovery plans, the Trust has 1 outstanding actions from the previous year which is the peer to peer review, this will be complete in the 22 /23 cycle.**
- **New Actions: Imbed the 3-stage process to ensure increase in compliance is achieved.**

[4] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

Section 7 – Statement of Compliance:

The Board / executive management team – [*delete as applicable*] of [*insert official name of DB*] has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: **Harrogate and District NHS Foundation Trust**

Name: David Lavalette Signed: _ _ _ _ _ _ _ _ _ _

Role: Responsible Officer

Date: 26th August 2022

NHS England and NHS Improvement
Skipton House
80 London Road
London
SE1 6LH

This publication can be made available in a number of other formats on request.

Publication approval reference: PAR614

Trust Board (PUBLIC)

September 2022

Title:	**Infection Prevention & Control Annual Report 2021/22**
Responsible Director:	Jackie Andrews, Medical Director
Author:	Sonya Ashworth, Matron Infection Prevention and Control Lauren Heath, Infection Prevention and Control Doctor

Purpose of the report and summary of key issues:	Harrogate and District NHS Foundation Trust recognises that effective prevention of healthcare associated infections (HCAI) is essential to ensure that patients using our services receive safe and effective care. Effective infection prevention and control must be an integral part of everyday practice and applied consistently to ensure the safety of our patients. This annual report covers the period 1st April 2020 to 31st March 2021 and has been written in line with the ten criteria outlined in the Health and Social Care Act 2008 Code of Practice in the Prevention and Control of infection (updated 2015). The ten criteria outlined in the code are used by the Care Quality Commission to judge a registered provider on how it complies with Cleanliness and Infection Prevention & Control requirements detailed in the legislation.	
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	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	
	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		
Report History:		

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

INFECTION PREVENTION & CONTROL ANNUAL REPORT

2021/22

Contents

Abbreviations

HCAI	Healthcare associate infection
IPCT	Infection Prevention and Control Team
DIPC	Director Infection Prevention Control
IPCC	Infection Prevention Control Committee
QGMG	Quality Governance Management Group
QC	Quality Committee
SMT	Senior Management Team
IBR	Integrated Board Report
APSG	Antimicrobial Prescribing Sub-Group
APC	Area Prescribing Committee
CEF	Clinical Effectiveness Forum
MRSA	Meticillin Resistant Staphylococcus Aureus
MSSA	Meticillin Sensitive Staphylococcus Aureus
UKSHA	UK Security Heath Agency
NHSE	National Health Service Executive
LTUC	Long Term Unscheduled Care
HiF	Harrogate Integrated Facilities
CC	Children and County Wide
PSC	Planned and Surgical Care

1.0 Introduction

Harrogate and District NHS Foundation Trust recognises that effective prevention of healthcare associated infections (HCAI) is essential to ensure that patients using our services receive safe and effective care. Effective infection prevention and control must be an integral part of everyday practice and applied consistently to ensure the safety of our patients.

This annual report covers the period 1st April 2020 to 31st March 2021 and has been written in line with the ten criteria outlined in the Health and Social Care Act 2008 Code of Practice in the Prevention and Control of infection (updated 2015). The ten criteria outlined in the code are used by the Care Quality Commission to judge a registered provider on how it complies with Cleanliness and Infection Prevention & Control requirements detailed in the legislation.

The ten criteria of the Health Act are below and will be discussed in more detail in the next section of this report.

Criterion	Detail
1	There are systems to monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other may pose to them
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections
3	Ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events of antimicrobial resistance
4	Provide suitable accurate information on infections to service user, their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion
5	Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people
6	Systems to ensure that all care workers including contractors and volunteers are aware of and discharge their responsibilities in the process of preventing and controlling infection
7	Provide or secure adequate isolation facilities
8	Secure adequate access to laboratory support as appropriate
9	Have and adhere to policies designed for the individuals care and provider organisations that will help to prevent and control infections
10	Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection

2.0 Criterion 1

There are systems to monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other may pose to them

Infection Prevention and Control Team

The Infection Prevention and Control Team (IPCT) provided advice on all aspects of infection prevention and control (IPC) to the Trust Directorates, wards and departments. The team continued to support and prioritise IPC issues relating to the COVID-19 pandemic and the shift to the “Living with COVID” agenda.

The Director of Infection Prevention and Control (DIPC) has overall responsibility for the IPC team, this role is undertaken by the Medical Director. The DIPC is supported by the Deputy DIPC, this role is undertaken by the Deputy Chief Nurse. The Matron for IPC manages the IPC team. A Consultant Microbiologist works for the IPC team on a part-time basis as the Infection Prevention and Control Doctor (IPCD). In addition to the IPCD, two other Consultant Microbiologists continue to provide support to the IPC team.

The structure for the IPCT is shown in Appendix 1.

External Reviews

There have been no external reviews of the IPCT during the 2021/22 period.

Infection Prevention and Control Committee

The Trust Infection Prevention and Control Committee (IPCC) is held monthly and is chaired by the DIPC. (Appendix 2 – meeting record for 2021/22). The IPCC is responsible setting the Trusts IPC strategy, maintaining the IPC Board Assurance Framework and the IPC risk register. The IPCC is responsible for the monthly review of IPC performance across the Trust.

The IPCC reports to the Quality Governance Management Group (QGMG), which is co-chaired by the Medical Director and the Director of Nursing and Allied Health Professionals. Infection Prevention and Control is a standing agenda item at this committee, IPC are represented at this committee by both the DIPC and IPCD. QGMG has responsibility for obtaining assurance that the Trusts IPC service is meeting the Standards set out in the Code of Practice. QGMG receives assurance from the IPCC that adequate and effective policies and systems of work are in place. This assurance is provided through the monthly IPC report and the Trusts Integrated Board Report (IBR). QGMG can escalate matters of concern to the Quality Committee (QC) which has overarching responsibility for managing the organisational quality risks.

The IPC service is provided through a structured annual programme of work (Appendix 3), which includes expert advice to staff, patients and visitors, audit, education, training, surveillance, policy development and review. The annual programme is agreed by the IPCC.

The COVID-19 pandemic has continued to cause significant pressures to the IPC team. The IPC team has been actively involved in the constant evolution of the trust strategy for managing patients with COVID-19. This has required continuous training of staff and updating written guidance.

Trust Board

The code of practice requires that the Trust Board has a collective agreement recognising its responsibilities for Infection Prevention and Control. The Chief Executive has overall responsibility for the control of infection at the Trust. The Trust has a designated DIPC and this role in undertaken by the Medical Director who attends Trust Board meetings with detailed updates on IPC performance and matters.

Antimicrobial Prescribing Sub-Group (APSG)

The Antimicrobial Prescribing Sub-Group (APSG) is a multidisciplinary group responsible for the monitoring and review of good antimicrobial stewardship within the Trust. The group meets bi-monthly and is Chaired by the Trust Lead for Antimicrobial Stewardship. The Antimicrobial Medicines Code describes the Trusts policy for antimicrobial stewardship. APSG is responsible for monitoring and auditing compliance with prescribing guidance and post-prescribing reviews. The group reports to the Area Prescribing Committee (APC), which in turn reports into the Trusts Clinical Effectiveness Forum (CEF).

Decontamination Committee

The Trusts Decontamination Lead is the Chief Operating Officer. The management of Decontamination and compliance is overseen by the Decontamination Committee which reports into the Health and Safety Forum.

Water Safety Group

The Trust has a multi-disciplinary Water Safety Group. It is chaired by the Deputy Director of Estates and meets bi-monthly. The IPCD represents the IPCT on this group.

Ventilation Safety Group

The Trust is in the process of establishing a Ventilation Safety Group.

Harrogate Integrated Facilities (HiF): Cleanliness and Estate Services

Harrogate Integrated Facilities is a wholly owned subsidiary of Harrogate and District HNS Foundation Trust (HDFT). Cleaning and maintenance of the patient environment is the responsibility of HiF. The Trust is working towards the implementation of the National Standards for Cleanliness.

Infection Prevention and Control Assurance

To demonstrate compliance with the Trust IPC policies there is an IPC programme of audit in place. The audits are undertaken by both the clinical and IPC teams and are summarised in the table below.

Table 1.0

Audit	**Completed**	**Overall score April 2021 – March 2022**
General IPC Inspection IPC QAT (including hand hygiene)	Monthly	97.1%
Commode	Monthly	99.3%
Cannula Insertion	Monthly	91.1%
COVID-19	Weekly	69.7%

Audit results are reviewed at the monthly IPC team meeting. Where issues are identified an action plan is devised by the IPCT and fed-back to the Matron and Ward/Department manager. Wards/Departments of concern are escalated to the IPCC.

A COVID-19 audit was developed in December to monitor compliance on the wards with the use of the plastic curtains, ventilation- window opening and visitor mask wearing. The audit was undertaken weekly, the overall result was 69.7%. The audit result is low the key issues were windows not being opened 10 minutes every hour as patients felt cold even though blankets were provided and visitors were not adhering to appropriate mask wearing.

Using Tendable to undertake IPC environmental audits was due to commence in October with the IPC Team undertaking the audits for 6 months to establish a baseline. Unfortunately due to technical issues with Tendable this was not commenced until June with the IPCQAT audits continuing.

Hand Hygiene Audits

Hand hygiene audits are included in the monthly IPC QAT which includes staff and patient hand hygiene, the overall score from April 2021 – March 2022 was 98.4%

Healthcare Associated Infection Surveillance (including mandatory reporting)

The IPC team monitors all alert organisms (defined as organisms of IPC significance). This is currently a very manual and time consuming process, involving daily lists generated by the Microbiology

Laboratory which are emailed to the IPC team. The Trust does not have an automated surveillance system which would be a more efficient system for tracking patients and infections across the Trust.

There has been an increase in all healthcare associated infections during this year. Incidence was artificially low last year due to the pandemic and national lockdowns however incidence in 2021/22 is above the pre-pandemic year of 2019/20. The reasons for this are likely to be multi-factorial and it is a picture seen across the whole region not just in our trust. It is likely this is an effect of cessation of normal healthcare for the much of the previous year but could also be a reflection of a system working beyond its capacity.

COVID-19

COVID-19 has been an unprecedented challenge for the IPC team. The IPC team has attended multi-disciplinary meetings about COVID-19 via Microsoft Teams in order to support the Trust dealing with the operational challenges the pandemic has presented. A weekly IPC-operations meeting was set up in order to make real-time decisions in response to bed pressures generated by COVID-19 outbreaks. The IPC team have worked closely with the site management team and attended the daily flow meetings to help with the placement of patients in order to reduce the risk of cross infection.

Other work the IPC have undertaken in relation to COVID-19 includes:

- Frequent update of the Trust COVID-19 (and now respiratory virus) guideline. This was required in response to the frequent updates issued by UKSHA and NHSE. This was challenging as inevitably national updates would arrive late on a Friday evening and need to be operationalise within a matter of days. The guideline evolved into a manual describing the patient pathways within the trust in order to segregate infected, exposed and uninfected patients.
- PPE training and FIT testing continued. In January the Trust recommended FFP3 masks to be worn by staff in clinical areas / patient facing roles as a result of the increased incidence of COVID-19 and in line with other Trusts. Due to the large number of community staff now requiring Fit Testing, a 'train the trainer' approach via MS Teams was implemented with the use of a video produced by the IPC Team. All results of fit testing are sent to ESR so there is an electronic record.
- Support and advice to individual services and departments to help them implement the COVID-19 guidance according to their specific needs.
- Support and advice to Line Managers and Staff in order to reduce the risk of cross infection between staff.

Clostridioides difficile

Clostridioides difficile (C.difficile) is a bacterium found in the gut which can cause diarrhoea after receiving antibiotics, particularly broad spectrum antibiotics. It can rarely cause a severe and life-threatening inflammation of the gut called pseudo-membranous colitis. The bacterium is capable of forming spores which are very resistant and can survive in the environment for prolonged periods of time. The spores require effective (sporicidal) cleaning products to remove them from the environment and prevent transmission to others.

The Trust reports all cases of C.difficile diagnosed in the laboratory to Public Health England via the national Data Capture System (DCS). Every Trust is given a threshold level which it should not exceed over the course of one year. The Harrogate threshold level for C.difficile in 2021/22 was 29.

At the end of March 2022 there were 37 cases of C.difficile apportioned to the Trust. This means we breached our threshold level by 8 cases. All 37 cases were subject to a post-infection review (PIR). Despite breaching our threshold, the majority of cases (89%) were deemed to be unavoidable. PIR's are presented to the CCG on a monthly basis. It is the role of the CCG to determine if there have been any lapses in care. There are two types of lapses in care, 1. Contributory lapse in care, this is where as a result of inappropriate action (usually inappropriate antimicrobial prescribing or patient placement) the patient has acquired C.difficile. 2. Non-contributory lapse in care, this is where our action has not directly resulted in the acquisition of C.difficile infection but it did not represent "best" care.

Table 2.0

CCG Decision	Number (%)
Avoidable	4 (11%)
Unavoidable	33 (89%)

Table 3.0

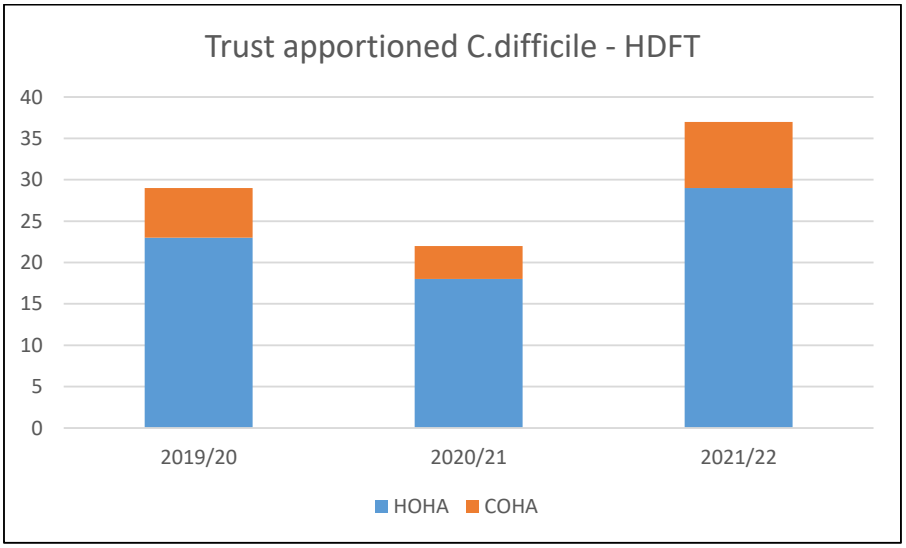
Lapse in care (avoidable cases)	Number (%)
Inappropriate antibiotic prescribing	4 (100%)

Table 4.0

Lapse in care (unavoidable cases)	Number (%)
Delay in stool sampling	13 (38%)
Delay in isolation	10 (29%)
Delay in starting C.diffiicle treatment	2 (6%)

*some cases have more than one type of lapse in care.

Figure 1.0



There is continuous work by the IPC team to reduce the cases *of C.difficile*. This relies on the prompt identification, sampling and isolation of patients with loose stools and the appropriate use of antimicrobials. *C.difficile* diagnosis has been a major focus of the IPC education programme this year.

Implementation of the National Standards for Cleanliness is also key in providing assurance that the patient environment is being cleaned effectively.

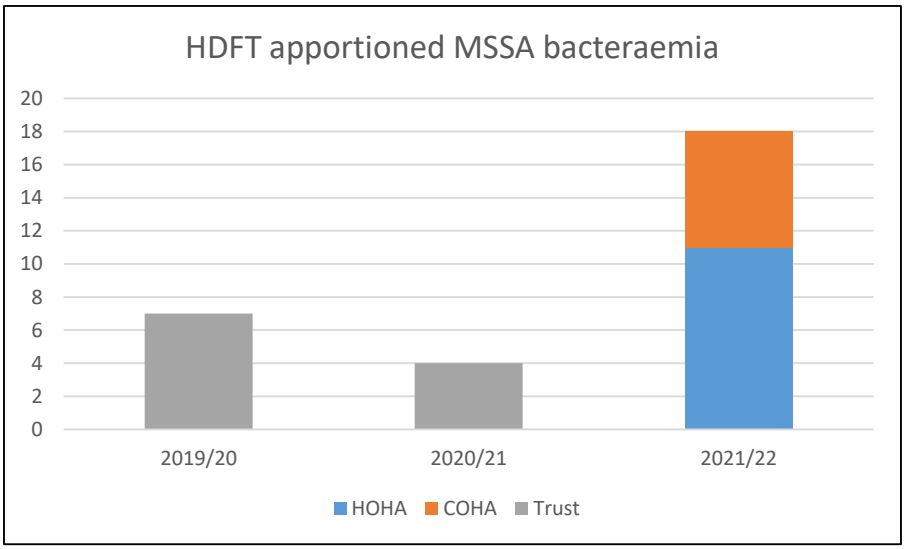
MRSA bacteraemia

In 2021/22 there was a single trust apportioned MRSA bacteraemia. The threshold level for MRSA bacteraemia for all Trusts in England is zero. Although we did not achieve this target, this is the first trust apportioned case since 2016. Root cause analysis was undertaken and reviewed by the CCG. No contributory lapses in care were identified.

MSSA bacteraemia

MSSA (methicillin sensitive Staphylococcus aureus) is the much more common and antibiotic sensitive version of Staphylococcus aureus and less likely to be hospital acquired. 18 MSSA bacteraemia's were apportioned to the Trust in 2021/22. There is no national threshold for MSSA bacteraemia.

Figure 2.0



Gram negative bloodstream infections

There are three Gram negative organisms that are monitored. E.coli, Klebsiella sp and Pseudomonas aeruginosa. Thresholds for Gram negative bacteraemia were introduced for the first time this year.

Figure 3.0

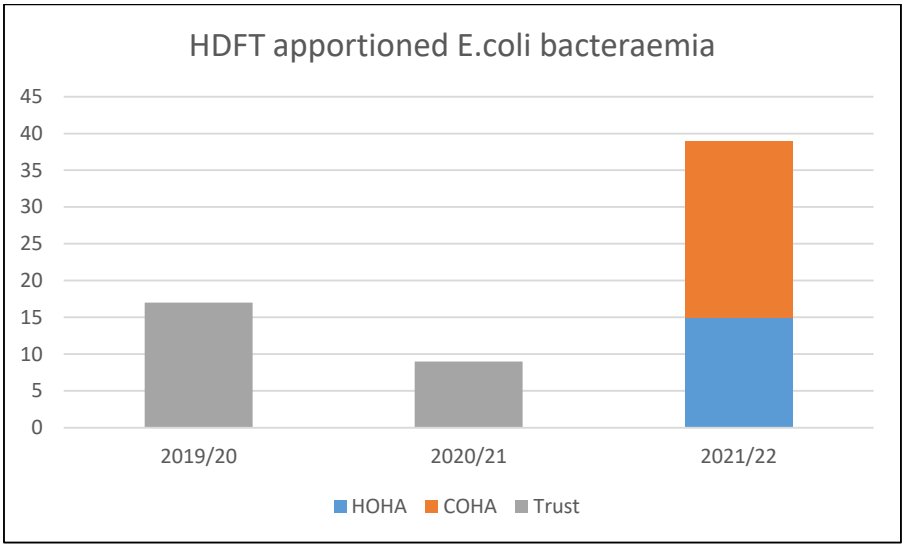


Figure 4.0

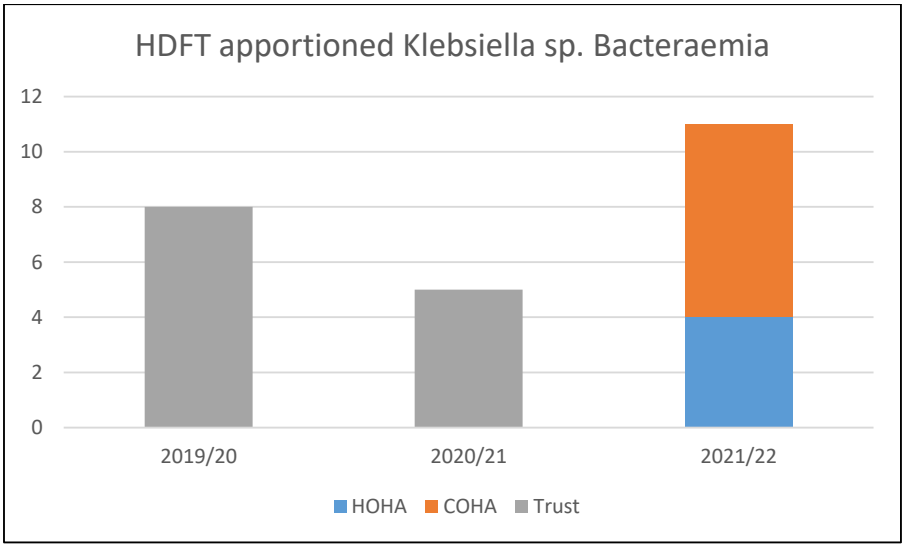
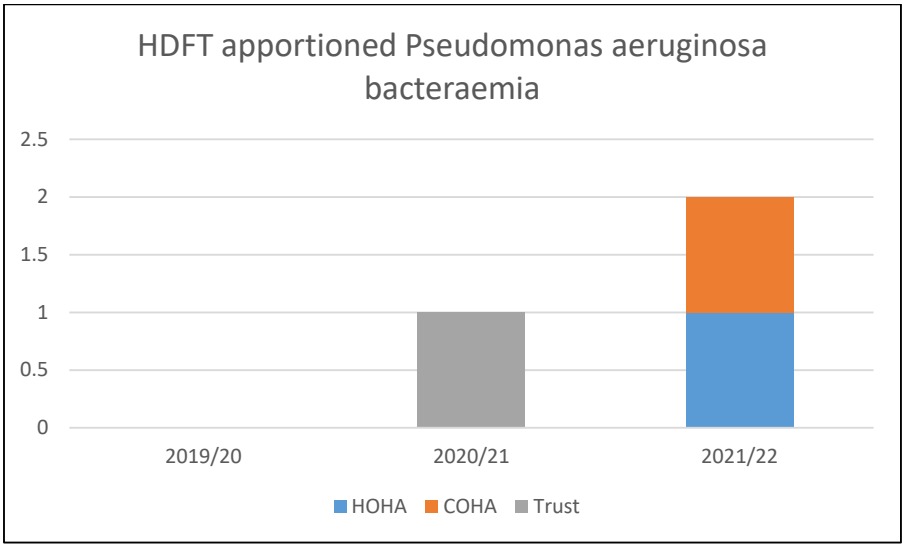


Figure 5.0



Carbapenemase producing Enterobacteriaceae (CPE) cases

CPE are Gram negative bacteria which are so resistant to antibiotics that even our last line of defence, carbapenem antibiotics are ineffective. It is therefore extremely important to detect patients carrying these bacteria and prevent spread through isolation and cleaning. The Trust has a policy on the screening and management of patients with CPE which reflects the guidance produced by Public Health England. A new CPE toolkit was launched in Autumn 2021, due to the pressures of the pandemic the team has not yet been able to implement the updated toolkit. This will be a priority for the 2022/23 work plan. HDFT has a very low incidence of CPE and zero new cases were detected in 2021/22.

3.0 Criterion 2

Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections

The cleaning provided at HDFT for all clinical and non-clinical areas is completed by the in-house Domestic Services team. Domestics are responsible for ensuring that cleaning is performed in accordance with standard operating procedures. All Domestic staff play an essential role in ensuring the Trust reduces hospital acquired infections

Cleanliness assurance

Role of the Domestic Supervisor –The Domestic Supervisors undertake weekly quality monitoring of the hospital wards and departments. The Matron walkabouts undertaken with the Domestic Supervisors are undertaken monthly.

Cleanliness figures 2021/22:

Q1	Q2	Q3	Q4
97.96%	97.80%	96.88%	95.91%

Role of the IPC team (IPC QAT audit) – The IPC Team receive the ward IPC QAT audits and monitor compliance with the standard of cleanliness. If the score is below 95% the team request completion

of an action plan and monitor the plan for improvement. The Team actively undertake check audits to ensure scoring is a true reflection of the standard.

Deep Cleans

The Trust has an agreed list of circumstances / infections where a deep clean is required of a bed space or bay. When a patient has an infection identified on the list the requirement for a deep clean on discharge or transfer is discussed with the ward and site coordinator. On discharge or transfer the IPC Team, Ward or Site Coordinator arrange the deep clean with the Domestic Supervisor.

Number of deep cleans carried out 2021/22 was 9147 a decrease from the previous year which was 10,935.

4.0 Criterion 3

Ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events of antimicrobial resistance

Antimicrobial Prescribing Sub-Group (APSG)

This group includes representation from pharmacy, microbiology, nursing and medical staff in both primary and secondary care. Its remit is to oversee the use of antimicrobial agents within the trust and promote prudent, safe and cost-effective prescribing of these drugs.

The group undertakes the following actions:

1. Development and implementation of evidence based guidelines for antimicrobial use.

Key changes to guidelines this year:

- Removal of COVID-19 secondary bacterial pneumonia guidelines (HAP and CAP) - to reduce the use of third generation cephalosporins.
- Change to recommendations for patients with penicillin allergy in non-severe and severe cellulitis – to reduce recommendations for clindamycin in the elderly.
- Change to catheter-associated UTI guideline - to recommend catheter change/removal as soon as possible after CA-UTI is suspected.
- CDI management guideline in accordance with NICE guideline 199 (published July 2021).

The paediatric antimicrobial guidelines were reviewed and uploaded to MicroGuide™ in June 2021. The AMS Lead contributed to a new SDEC cellulitis pathway for use of once daily iv teicoplanin in patients who would otherwise require admission for iv antibiotics.

2. Monitoring antimicrobial use and compliance with guidelines within the Trust through a programme of audit.

Reflecting on all of the audits undertaken, the key successes were:

- HDFT performs better than other UK audits in prescribing antibiotics when clinically indicated
- HDFT perform better than average in rates of antibiotic reviews within 72 hours
- 50% of urological patients are switched from IV to oral antibiotics within 3 days

The key concerns were:

- Nearly 10% of antibiotic prescriptions in surgical inpatients are not indicated

- Disparity in clinical indication and documented indication on ePMA for antibiotic prescription
- High rates of unnecessarily broad-spectrum antibiotics initially prescribed for urological patients
- Low rates of microbiology samples collected from General Surgical patients
- Continued use of co-amoxiclav and third generation cephalosporins against local guidance

The recommendations of APSG:

- Adjustment of surgical handover sheet to include antibiotic and review column
- Improvement of ePMA user interface for antibiotic prescribing
- Junior doctor teaching session on sepsis criteria
- Introduction of a regular antimicrobial ward round in surgical patients
- Re-audit 2022-2023

3. Development of education and training resources for antimicrobial stewardship and the means to deliver them.

Alongside the antimicrobial stewardship training already provided for F1 doctors, enhanced training in prescribing and monitoring of gentamicin was provided. An interactive teaching session was given to final year medical students on the Post Finals Assistantship (PFA) programme in May 2021 and again at induction for F1s in July 2021.

4. Identification of antimicrobial agents for restricted use only and monitoring to ensure there is compliance with restriction policies.

HDFT continues to compare favourably to other Trusts in the region in terms of antibiotic use, particularly with regards to low use of broad spectrum agents (e.g. meropenem and piperacillin/tazobactam).

The AWaRe Classification of antibiotics was developed in 2017 by the WHO Expert Committee on Selection and Use of Essential Medicines as a tool to support antibiotic stewardship efforts at local, national and global levels. Antibiotics are classified into three groups, Access, Watch and Reserve, taking into account the impact of different antibiotics and antibiotic classes on antimicrobial resistance, to emphasize the importance of their appropriate use.

Access – first and second choice antibiotics for the empiric treatment of most common infectious syndromes;
Watch – antibiotics with higher resistance potential whose use as first and second choice treatment should be limited to a small number of syndromes or patient groups
Reserve – antibiotics to be used mainly as ‘last resort’ treatment options.

HDFT has the highest use of ‘access’ antimicrobials, and the lowest use of ‘reserve’ antimicrobials in the region.

5. Review of cases of C.difficile infection where inappropriate antimicrobial prescribing has been highlighted during post-infection review.

Since January 2022, antimicrobial prescribing lessons learnt from the CDI post-infection reviews have been formally fed back to the AMS team so they can be discussed at APSG.

6. Reviewing trends in local antimicrobial resistance patterns as well as data on prevalence of selected multi-resistant bacteria.

This is reported annually and uploaded to the HDFT intranet.

7. Encouraging and wherever possible, supporting good antimicrobial prescribing in primary care settings.

National antibiotic prescribing data shows that the local CCG is continuing to meet antimicrobial prescribing targets. The North Yorkshire Antibiotic Prescribing Guideline for Primary Care is overdue review (due Sept 2019). This has been delayed because of redeployment of key authors during the COVID pandemic. The HDFT AMS Lead continues to support with updates of this guideline and it is not foreseen any significant changes to the existing guidelines are required. The Outpatient Parenteral Antimicrobial Therapy (OPAT) MDT meets every week. In 2021 membership was extended to include representatives from Baxter, who hold the contract to provide the service in the community. This has vastly improved communication between the hospital and community and therefore positively impacted on patient care.

5.0 Criterion 4

Provide suitable accurate information on infections to service user, their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion

Communication

Advice leaflets have been produced for patients on a number of organisms / infections e.g. MRSA, CPE, *C. difficile* which are available to download from the website. This provides useful information to the patient and their family on the precautions required whilst they are hospital and when they are discharged home. Notification of a patient's infectious status is documented in the discharge letter. A patient's infectious status is documented as an IR Flag on their electronic notes.

The team have developed a system for COVID-19 patients documenting on a large visible green sticker in the medical notes the date of the positive result and date the isolation can end. This has provided a really useful quick highly visible reference guide which has been y well received by all staff.

IPC Guidance is kept up to date on the intranet and is easily accessible. COVID-19 guidance has been incorporated into guidance for Respiratory Virus Infections and is updated in line with any new national guidance.

6.0 Criterion 5

Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people

Alert organism system

The Infection Prevention and Control team are alerted on a daily basis by the laboratory when an alert organism is isolated on an inpatient. The notes are then electronically tagged with an IR Flag which alerts ward staff that the patient has an infection. The notes are labelled by the Team with a coloured sticker on the inside of the front cover with the type of infection e.g. MRSA.

Surgical Site Infection Surveillance (SSIS)

The Trust's mandatory Orthopaedic SSI was hip replacements in 2021. There were a total number of 77 operations, 3 SSI's were identified which is an infection rate of 3.9%.

Outbreak Management

The IPC team are involved in the identification and management of outbreaks and periods of increased incidence. The IPC team monitors (via the HCAI tracker) alert organisms to identify trends and potential links between cases based on their location. This is a manual task and is completed without the aid of an automated surveillance system. If links are identified then an investigation is undertaken to ascertain if the outbreak threshold has been reached. Outbreaks are managed in accordance with the IPC Outbreak policy.

In 2021/22 we had one C.difficile transmission event. This involved two patients with identical ribotypes and MVLA types on a medical ward at the same time.

COVID-19 outbreaks have continued to dominate throughout 2021/22 with 9 outbreaks affecting wards.

Including identification of patients with hospital acquired COVID (COVID database) / COVID contact tracing tool.

The IPC team have worked with colleagues in IT to develop a contact tracing tool. This is a database tool which allows the IPN's to robustly and efficiently find all patients in contact with an index case in order than measures can be put in place to reduce the risk of further transmission.

7.0 Criterion 6

Systems to ensure that all care workers including contractors and volunteers are aware of and discharge their responsibilities in the process of preventing and controlling infection

At the Trust, Infection Prevention responsibilities are included in all job descriptions.

In relation to contractors, documented IPC advice is provided to the person managing the contractors which covers current guidance on COVID-19 and other general IPC issues.

Staff Induction

All clinical staff receive IPC training on induction to the Trust. This is in the format of a national IPC e-learning package which provides information on Standard Precautions and hand hygiene including video clips and an assessment.

Staff Training and Education

All staff are required to complete a Mandatory Training session on Infection Prevention and Control which includes Hand Hygiene. Level 1 is for non-clinical staff and is required every 3 years. Level 2 is for clinical staff and is required annually.

Table 5.0

	Level 1	Level 2
Corporate	84.6%	81.2%
HiF	68.3%	50%
LTUC	82.2%	72.8%
PSC	82.6%	71.4%
CC	91.3%	84.7%
Total Compliance	85%	78%

The Team delivered on going education regarding COVID-19 whilst on the wards in response to the frequent changes in national guidance. We devised and delivered 'tool box' talks in wards and

departments covering the basics of IPC and highlighting lessons learnt from RCA's. Due to staff not being able to be released from the wards we were unable to deliver any study days which we had previously done pre-COVID.

8.0 Criterion 7

Provide or secure adequate isolation facilities

At HDFT all inpatient wards have single room (isolation) facilities. The proportion of single rooms available across our inpatient beds is 26% of these single rooms 60%are en-suite.

This can at times of high demand significantly impact the ability to isolate all patients who should be isolated according to national guidance. When demand exceeds single room occupancy a risk assessment is carried out to ensure the most appropriate patient is allocated a single room. The IPC team work closely with the Clinical Site Team to support the risk assessment and decision making. A priority isolation list is available to help the Clinical Site Team out of hours and ensure that practice is consistent.

Specialist isolation rooms are available in the emergency department and the Intensive Care unit. The Emergency Department has three single rooms in resus which can be put into negative pressure mode (*This is the mode you want when caring for a patient with a suspected/confirmed infection which spreads via the airborne route*). Intensive care has two single rooms which can be put into negative pressure mode.

9.0 Criterion 8

Secure adequate access to laboratory support as appropriate

Laboratory services for HDFT are located on-site. The Microbiology Laboratory has full UKAS ISO 15189 accreditation.

The IPC nurses work closely with the Consultant Microbiologists and the Senior Biomedical Scientists. One of the Consultant Microbiologists has the additional role (awarded 3PA's) of being the Infection Control Doctor and is the primary link between the IPC team and the laboratory service. The Microbiology Department has been carrying a WTE Consultant vacancy since December 2021 and the first attempt to recruit to this post was not successful. This has put an additional pressure on the Consultant Microbiologists and resulted in reduced capacity for non-clinical work.

The Laboratory department have continued to work flexibly with the Trust and have maintained an extended working hours rota to provide on-site COVID and respiratory virus testing until 9pm seven days per week. This is vital to maximising patient flow.

The Point of Care Team have worked with the IPC team and Microbiologists to expand the ID NOW testing platform within the Emergency Department. This allows COVID-19 testing to be performed at the patient bedside within the department. This reduces the turn around time for a result which has a positive impact on patient flow and placement throughout the organisation.

10.0 Criterion 9

Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections

The Trust has commissioned a large project this year to review in detail all of the policies, procedures and SOP's available via the intranet. This work has culminated in a standardised framework for policies, procedures and SOP's.

The IPC team have a total of 36 "policies". The majority of the information within these policies actually falls under the definition of a procedure. The IPCC have decided that the IPC team will have a single overarching policy describing the structure, role and governance of IPC service. Underneath this policy will sit a series of procedures which will be aligned to the National Manual for Infection Prevention and Control. Where appropriate a procedure will be accompanied by a quick reference guide "procedure on a page"

During the course of 2021/22 the following policies were reviewed and updated:

- Tuberculosis
- MRSA

Review of policies and converting them into procedure documents is a major work stream for 2022/23.

11.0 Criterion 10

Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection

The Trust has an Occupational Health Department who have responsibility for carrying out pre-employment health assessments and immunisation needs. Staff are able to self-refer to the Occupational Health service at any time for additional advice and support.

The Occupational Health department are an integral part of the multi-disciplinary team who have been responsible for the delivery of successful COVID-19 and Influenza staff vaccination campaigns. All HDFT employees were offered both vaccinations to protect themselves and the patients they look after.

The figures below show the uptake of both Influenza and COVID-19 vaccination by our Frontline staff. Our Trust had one of the highest staff COVID-19 vaccination uptakes in the country.

Total Frontline HCWs vaccinated with Influenza vaccine		
Total No. of frontline HCWs	Total No. of frontline HCWs vaccinated	% uptake in frontline HCWs
3789	2734	72.2

Total Frontine HCWs vaccinated with COVID-19 vaccine						
Total No. of frontline HCWs	No. of frontline HCWs vaccinated with dose 1	% uptake of dose 1 vaccine in frontline HCWs	No. of frontline HCWs vaccinated with dose 2	% uptake of dose 2 vaccine in frontline HCWs	No. of frontline HCWs vaccinated with dose 3	% uptake of dose 3 (booster) vaccine in frontline HCWs
3789	3675	97.0	3654	96.4	3419	90.2

12.0 IPC Work Plan for 2022/23

The Infection Prevention and Control Committee (IPCC) have responsibility for the HDFT IPC Board Assurance Framework. This framework provide the basis for the IPC annual work plan. The IPCC are responsible for overseeing progress against the work plan.

Work Plan Item Number	Task	Task Lead	Target Date	Progress
1	IPC Policy – Section 001 • Content reviewed and updated • Transferred to the new trust policy template • Approved at IPCC and then ratified at SMT	LH	Aug-22	
2	Review and update IPC Policies which are beyond their routine review date • Refer to detailed policy review plan (appendix 1)	SA	Mar-23	
3	Transfer the monthly IPC general inspection audit to Tendable	SA	Jun-22	
4	Hand back the responsibility for completion of the monthly IPC general inspection audit to ward managers with a peer-to-peer assessment model	SA	Sept-22	
5	Establish monthly IPC audits at Ripon and Selby MIU	SA	Aug-22	
6	Re-establish a programme of Matron “walk arounds”	SA	Jul-22	
7	IPCC to receive assurance report from Decontamination Committee at an agreed frequency	LH	Jul-22	
8	IPCC to receive assurance report from Water Safety Group at an agreed frequency	LH	Aug-22	
9	IPCC to receive quarterly cleaning assurance report from HiF	LH	Jun-22	
10	IPCC to receive bi-annual assurance report from APSG	LH	Sept-22	
11	Review of IPC information on Trust Website	SA	Oct-22	
12	Review of IPC information displayed within the trust	SA	Jun-22	
13	Review and update Patient information leaflets for alert organisms (CDI,CPE, MRSA and VRE)	SA	Nov-22	
14	Develop an annual audit programme of IPC information on discharge and transfer documentation	SA	Nov-22	
15	Produce an SOP for adding an iCS flag to a patient with an alert organism	AG	Jun-22	
16	Develop a quarterly audit programme for compliance with isolation policy	SA	Oct-22	
17	Develop a quarterly programme for the review of Datix incidents at IPCC	AG/IG	Jul-22	
18	Develop an assurance process for volunteers and compliance with IPC training	SA	Dec-22	
19	Produce a non-mandatory IPC training package and assurance framework	SA	Aug-22	
20	Proposal for asepsis training to be included in Mandatory training	LH	Jun-22	
21	Produce a document describing the number and status of single rooms within the inpatient setting for inclusion in IPC Policy-Section 002.	LH	Jul-22	
22	IPCC to receive assurance report from Occupational Health at an agreed frequency	LH	Sep-22	
23	Complete annual mandatory SSI surveillance audit	IG	Dec-22	
24	Re-establish the IPC Link person programme	JC	Mar-23	

Appendix 1: IPC Policy Review Plan

Policy number	Policy Title	Review date	Priority for review
001	Management and organisation of the prevention and control of HCAI	30/4/22	
002	Isolation of patients policy, principles and notification of infectious diseases	30/4/22	
003	Procedures for individual diseases	30/4/22	
004	Blood borne virus and inoculation incident	30/4/22	
005	Tuberculosis	29/2/24	
006	Meningococcal disease	30/04/22	
007	Haemophilus influenzae Type b (Hib) Disease	30/04/22	
008	Chickenpox and Shingles (VZV)	30/04/22	
009	Clostridium difficile	30/04/22	
010	Respiratory virus guidelines	30/04/22	
011	Scabies and other ectoparasites	30/04/22	
012	MRSA	31/01/26	
013	CJD	31/10/22	
014	Standard precautions including hand hygiene and PPE	30/4/22	
015	Infection Control in Intravenous Procedures	30/09/24	
017	Communicable diseases in staff and exclusion policy	30/04/22	
018	MRGNB	30/04/22	
019	Decontamination, antiseptic disinfectant and body fluid spillage	30/04/22	
020	Decontamination policy – procedures for items in general use	30/04/22	
021	Bed management and movement of patients	30/04/22	
022	Laundry	30/04/22	
023	Healthcare waste disposal	30/04/22	
024	CPE	30/04/22	
025	Pest Control	30/04/22	
026	Animals and pets in hospital and community settings	31/10/22	
027	Hospital outbreak	31/11/22	
029	Handling of bodies after death	31/10/21	
030	Infection control and Legionellosis	30/04/22	
031	Principles of asepsis	30/04/22	
032	Prevention of infection for Visitors, visiting staff, volunteers and work experience students	30/04/22	
037	Prevention of surgical site infections	30/11/22	
038	Prevention of CAUTI	30/04/22	
039	VHF	30/04/22	
042	RCA of hospital acquired infection	30/04/22	
043	HCAI Data Sheets for patient information	30/04/22	
044	Prevention of infection in the mortuary and post-mortem room	30/04/22	

13.0 Conclusion

The COVID-19 pandemic has continued to provide huge challenges for the NHS and our Trust throughout this year. Our staff have risen to that challenge incredibly well and by working together flexibly have been able to provide a safe environment for both patients and staff. This has required staff to work outside of “normal service” for prolonged periods. Restoration of the pre-pandemic service will be a challenge and we will need to retain resilience for any future waves of infection. Throughout this difficult year the IPCC has continued to evolve and develop. A clearer IPC strategy is emerging and is accompanied by a more robust assurance process. Continuing this good work and working collaboratively with each directorate to resume the pre-pandemic service will make up a large part of the workload for 2022/23. The IPC team are committed that we focus on the reduction of infections other than COVID so that we provide our patients with the best possible care.

14.0 Reference

Department of Health: The Health and Social Care Act 2008. Code of Practice on the prevention and control of infections and related guidance.

http://www.gov.uk/government/publications/the-health-and-social-care-act-2008-code-of-practice-on-the-prevention-and-control-of-infections-and-related-guidance

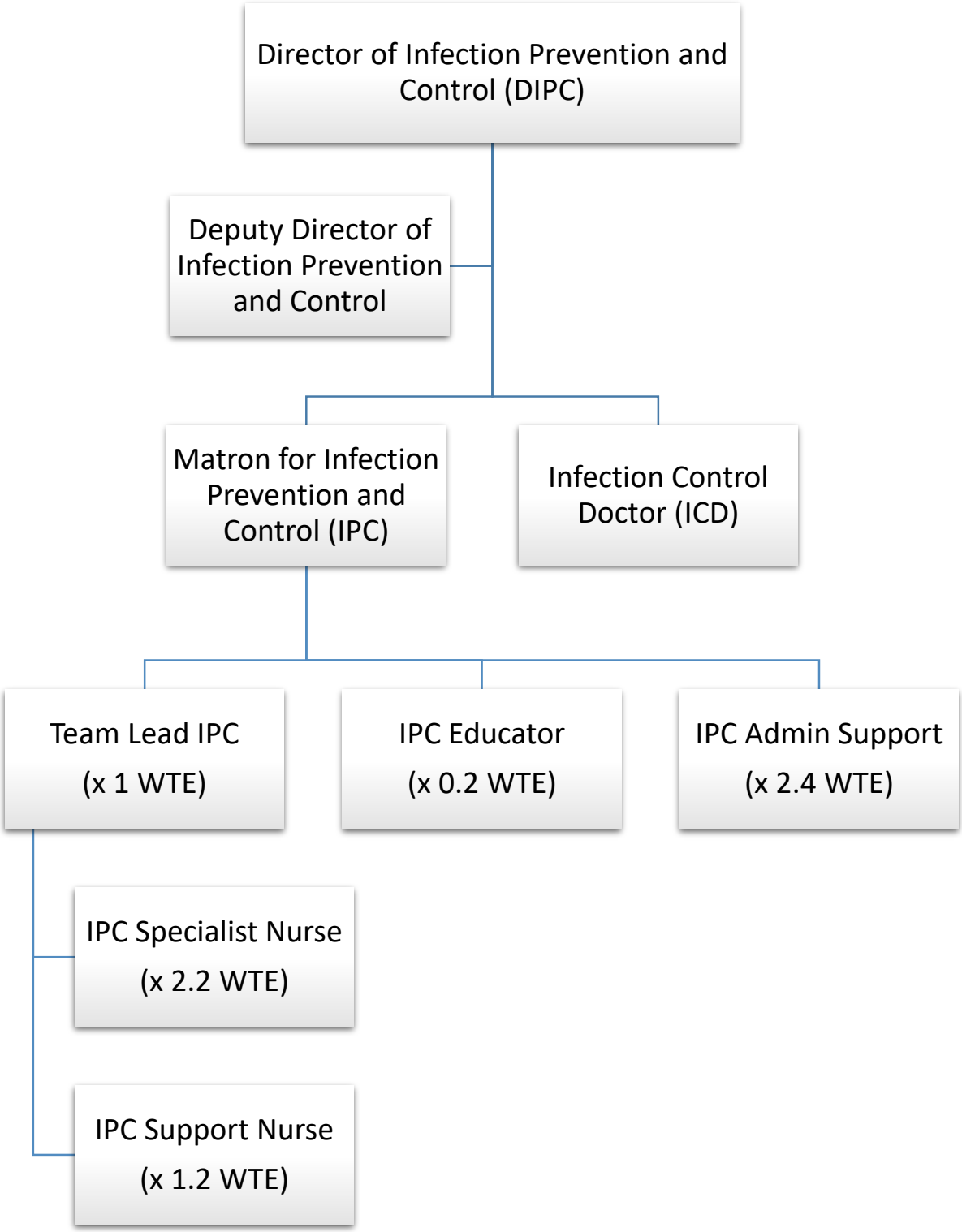
13.0 Appendices

1.0 Structure of IPCT

2.0 IPCC meeting record 2021/22

3.0 IPC Annual plan of work 2021/22

Appendix 1 –Structure of IPC Team



Appendix 2 – IPCC Meeting Record 2021/22

Date	DIPC	Deputy DIPC	Matron IPC	ICD	Deputy Director of Nursing	Lead Nurse LTUC	Lead Nurse PSC	Lead Nurse CC	Quality Matron	HiF
13.3.21	X	X	X	X	X					
May	No Meeting									
29.6.21	X	X	X	X	X	X			X	
27.7.21	X		X	X		X				
31.8.21	Rep	X		X	X					
28.9.21	X	X	X	X		X			X	
19.10.21	X	X	X	X		X				
30.11.21	X	X	X	X						X
Dec	No Meeting									
11.1.22	X	X	X	X	X					X
1.3.22	X	Rep	Rep	X						Rep
22.3.22	X	X	X	X			X			X

Rep – Representative sent

Appendix 3:

Infection Prevention and Control and TB Team's Annual Work Plan

April 2021 – March 2022

Monitored by: Infection Prevention and Control and TB Team meetings

Reports to: Infection Prevention and Control Committee

Report author: Sonya Ashworth, Matron Infection Prevention and Control

Operational Leads:

SA	Sonya Ashworth		LH	Lauren Heath
AG	Amanda Gooch		RH	Richard Hobson
SO	Sharon Oyston		AP	Anna Padget
IG	Iona Goodwin		CR	Christopher Richardson
LH	Lauren Heath		KC	Karina Coxhead
GM	Gillian Mitchell		JW	Jim Weightman

Responsible lead: Sonya Ashworth Matron Infection Prevention and Control

Plan produced by S Ashworth August 2021. Agreed by the IPC Committee September 2021

Infection Prevention and Control and TB Service Annual Work Plan April 2021 – March 2022

No	Issue	Actions	Op. Lead	Target Date	Progress 10/21
Criterion 1: Systems to manage and monitor the prevention and control of infection. These systems use risk assessment and consider the susceptibility of service users and any risks that their environment and other users may pose to them					
1a	Ensure all staff are aware of national and local guidance in relation to COVID-19	Ensure the Trust's IPC Covid Guidance document, posters and patient pathways are up to date reflecting local and national guidance.	SA	March 2022	Up to date with current guidance
		Posters are displayed in all patient areas so staff are aware of the correct PPE required	AG	Ongoing	Displayed
		Deliver tool box education sessions to staff at ward /dept. level	AG	March 2022	Delivered & ongoing
1b	Reduce the incidence of C. difficile	Deliver education at ward huddles on prompt sampling, isolation and decontamination including lessons learnt from RCA's	AG	March 2022	Delivered & ongoing
		Monitor cases to ensure there is no link with any other case or PII	LH /SA	March 2022	Ongoing
		Discuss all CDI cases with the CCG to determine lapses in care	AG/LH/SA	March 2022	All current cases reviewed
1c	Reduce the incidence of TB	The TB service to set up a system for delivering BCG vaccinations to at risk children	KC	Jan 2022	Delay due to Afghan refugee assessments
1d	Reduce the incidence of GNB bacteraemia	Continue to work with the CCG's on producing educational resources in relation to preventing dehydration and UTI's	SO/SA	March 2022	Work ongoing with York CCG
Criterion 2: Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections					
2	Improve cleanliness of equipment and the environment within in patient settings	Continue to work with the Head of Facilities with the implementation of the National Standards of Healthcare Cleanliness	SA	March 2022	Ongoing
		Undertake monthly IPCQAT verification audits to monitor the standard of cleanliness and review audit results at our team meeting and IPC Committee	AG	Ongoing	Ongoing
		Undertake monthly commode audits monitoring the standard of cleanliness. Results monitored at the IPC Team Meeting and IPC Committee	JW	March 2022	Ongoing

No	Issue	Actions	Op. Lead	Target Date	Progress 10/21
		Assist with annual PLACE inspections	AG	Nov 2021	Complete in October
		Undertake monthly audit of water filters in enhanced care areas. Results fed back to the Water Safety Group	JW	March 2022	Ongoing
		Undertake an annual audit of MIU in Ripon and Selby	SO	March 2022	MIU Ripon complete awaiting date for Selby
		Attend monthly Decontamination Committee meetings	JC	March 2022	Attend monthly
Criterion 3: Ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance					
3	Ensure appropriate antibiotic usage	Deliver education sessions on the Medicine's Management programme for hospital and community staff	AG	March 2022	Delivered and ongoing
		Undertake RCA for cases of CDI when antimicrobial issues are identified in the PIR and review cases with the CCG to determine lapses in care and lessons learnt	AG/LH	March 2022	Undertaken
		Continue Alert organism/condition surveillance	CR	March 2022	Ongoing
		Undertake orthopaedic surgical site infection surveillance	IG	Oct 2022	Due to be completed November 2021
		Submission of mandatory reports to PHE – MRSA, MSSA, Gram Negative bacteraemia	CR	March 2022	Ongoing monthly
Criterion 4: Provide suitable accurate information on infections to service users, visitors and any person concerned with providing further support or nursing / medical care in a timely fashion					
4	Produce and provide accurate information for patients, service users and providers.	Patient advice leaflets are up to date and provided to patients with Alert organisms e.g. CDI, CPE, MRSA and IPC advice discussed	AG	March 2022	Up to date
		IPC information for visitors is up to date, including posters inside and outside wards	SA	March 2022	Up to date Perch and Ponder posters
		Educational resources for health and social care providers are up to date and available on the Community IPC website	SO	March 2022	Up to date
		The TB resource page on the Internet is up to date	KC	March 2022	Up to date

No	Issue	Actions	Op. Lead	Target Date	Progress 10/21
Criterion 5: Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people					
5	Patients are isolated as per guidance and appropriate IPC precautions in place.	Continue with COVID-19 and Alert organism surveillance to ensure correct patient placement	SA	March 2022	Ongoing
		Ensure all patients who require isolation are isolated appropriately and correct signage placed on the door	AG	March 2022	Ongoing for each patient
		Annual audit of side room isolation trolleys to be undertaken by the Ward Hygienist	JW	March 2022	Completed
		Provide advice and support during outbreaks	AG	March 2022	Ongoing
		Provide support to Care Homes to ensure residents are isolated where possible during an outbreak	SO	March 2022	Ongoing
		Undertake monthly cannula and line audits, results discussed at monthly Team meeting and IPC Committee	GM	March 2022	Monthly audits completed and discussed
Criterion 6:Systems to ensure all care workers including contractors and volunteers are aware of and discharge their responsibilities in the process of preventing and controlling infection:					
6	Increase awareness of IPC precautions, policies and resources	Review all Trust IPC Policies to ensure they are up to date. Produce 'Policy on a page' for all reviewed policies	SA	March 2022	Ongoing
		Deliver training to the volunteers as per schedule	AG	March 2022	Delivered and ongoing
		Deliver training on the fundamentals of care to Care Support Workers quarterly	AG	March 2022	Delivered and ongoing
		Deliver virtual training to Care Homes as requested by the LA's	SO	March 2022	Delivered as required
		Participate in Global initiatives e.g. WHO Hand Hygiene Awareness	AG	March 2022	Video produced by IPC Team in May
		Produce monthly newsletters for Health and Social Care providers	AP	March 2022	Produced monthly

No	Issue	Actions	Op. Lead	Target Date	Progress 10/21
Criterion 7:Provide or secure adequate isolation facilities					
7	Prevent the spread of infection to patients, staff and visitors.	Ensure all patients who require isolation are isolated appropriately and correct signage placed on the door	AG	March 2022	Ongoing
		Annual audit of side room isolation trolleys to be undertaken by the Ward Hygienist	JW	March 2022	Completed
		Provide support to Care Homes to ensure residents are isolated where possible during an outbreak	SO	March 2022	Ongoing
		Assist Clinical Site Co-ordinators with side room allocation when there are bed capacity issues	SA	March 2022	Ongoing
Criterion 8:Secure adequate access to the laboratory support as appropriate					
8	Prompt notification of positive results	Notify wards promptly of all positive cases and advise appropriate IPC precautions as per guidance and policies. Check daily COVID-19 and respiratory virus results on SQL and ensure wards are notified accordingly	AG	March 2022	Ongoing for each case
Criterion 9: Have and adhere to policies, designed for the individuals care and provider organisations that will help to prevent and control infections					
9	Ensure IPC Policies are up to date for the Trust and H&SC providers	Review all Trust IPC Policies in line with the review dates. Produce 'Policy on a page' to accompany the policies	SA	March 2022	In progress
		Review and amend Community IPC Policies in line with National Guidance	SA	March 2022	In progress
		Marketing of Community IPC Resources to income generate for CIP target of £92,000	AP	March 2022	Ongoing – orders in place for £110,000
Criterion 10: Have a system in place to manage occupational health needs and obligations of staff in relation to infection					
10	Ensure OCH receive information on staff exposure	Liaise with Occupational Health regarding staff who have been in contact with an infection and their vaccination status is required	AG	March 2022	Ongoing

Integrated Board Report - June 2022

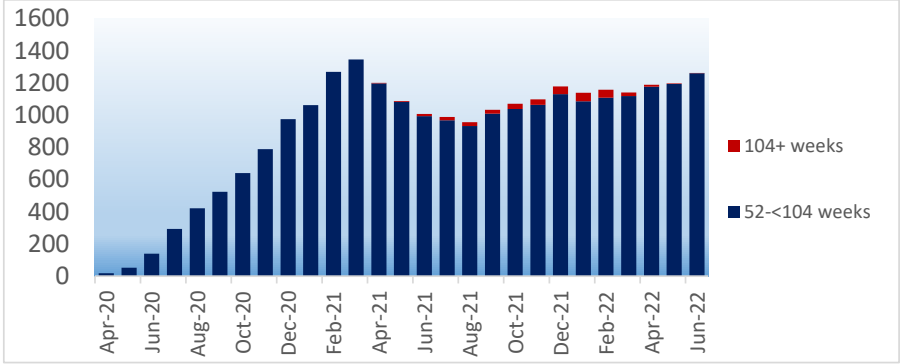
Domain 5 - Responsive

Indicator	**5.1 - RTT Incomplete pathways - 52+ weeks**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Jun-22
Value / RAG rating	1261

Indicator description

The number of incomplete pathways waiting over 52 weeks.

Trend chart



Narrative

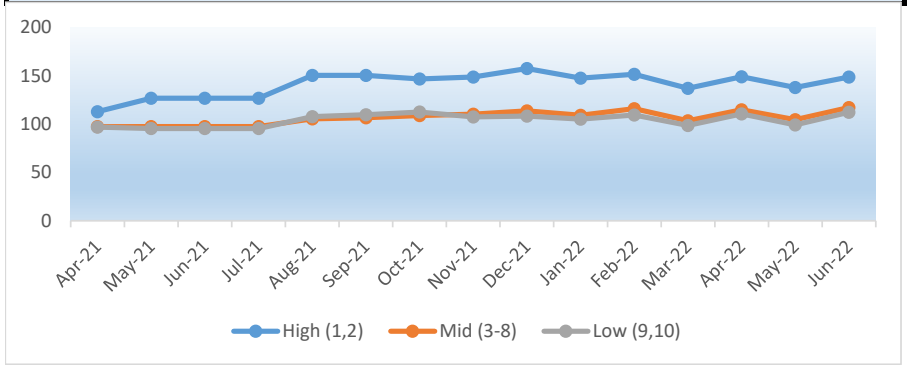
Due to the Covid-19 pandemic and the ceasing of elective work, waiting times have risen significantly. The over 52 weeks waiters peaked in March 2021. Risks remain in two main specialties of T&O and Community Dental (which together account for 78% of the over 52 week waiters). Plans in place to reduce this number to 750 by March 2023. There has been a significant reduction in over 104 week waiters since November 2021. The Trust reported 1 patient waiting over 104 weeks at the end of June - this is due to patient choice.

Indicator	**5.2 - RTT waiting times - by level of deprivation**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Jun-22
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.

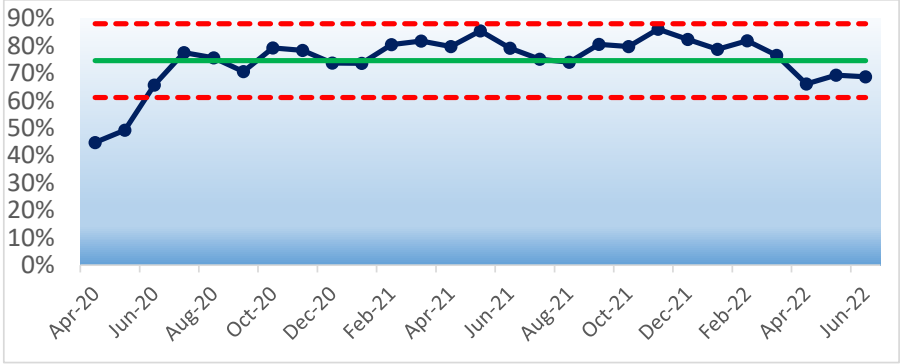
Work also continues in improving the recording of ethnicity and use of the learning disabilities flag across our clinical systems.

Indicator	**5.3 - Diagnostic waiting times - 6-week standard**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Jun-22
Value / RAG rating	68.7%

Indicator description

Percentage of patients waiting 6 weeks or less for a diagnostic test. The operational standard is 99%.

SPC chart



Narrative

Performance has remained statis this month with 1,863 waiting over 6 weeks (1,811 last month) – including 578 Dexa, 456 ultrasound, 366 MRI and 299 audiology.

The new DEXA scanner went live on the 11th July so an extra 100% capacity to increase patient throuput. Ultrasound and audiology activity has reduced due to COVID sickness and vacancies where replacement staff have not been found. Extra support from central recrtuiment team to help aid the directorate to source quality candidates.

Modelling indicates a return for 6 week diagnostic target by November 2022.

Indicator	**5.4 - Outpatient follow-up waiting list - 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.

SPC chart

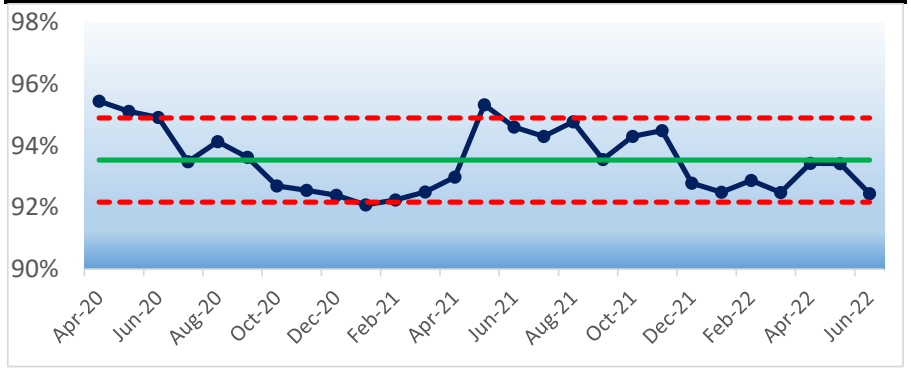
Narrative

Indicator	**5.5 - Data quality on ethnic group - inpatients**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Jun-22
Value / RAG rating	92.5%

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.

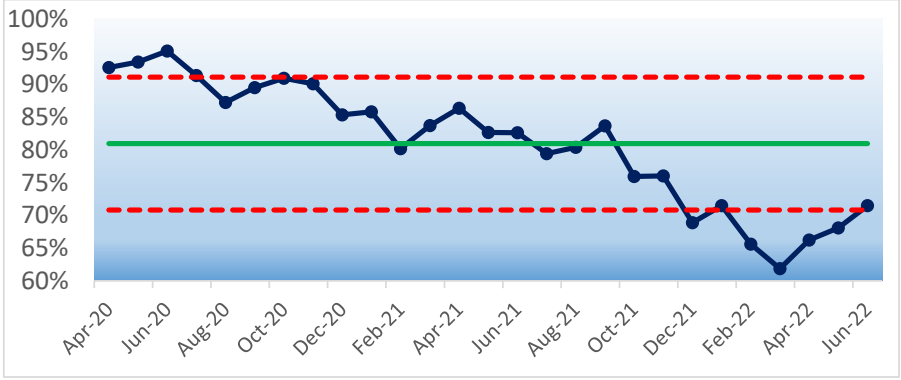
- Made contact with the lead at Central London Community NHS Trust (CLCH) who have improved their ethnicity recording rates on their patient records – they are organising a webinar to talk through their actions
- Reminded staff of the process regarding the collection of this data including reception 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	Jun-22
Value / RAG rating	71.5%

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 is improving but remains below the 95% standard. Performance reflects the continuing significant pressures with high bed occupancy relating to discharge challenges and staff absenses. The Trust continue to support the HNY system which is significantly pressured (OPEL 4) with regular diverts of ambulance patients to Harrogate - this negatively impacts on HDFT's 4 hour performance and length of stay. It should be noted that this is the 4th month of improvement on this metric.

Current work underway to improve this position includes:

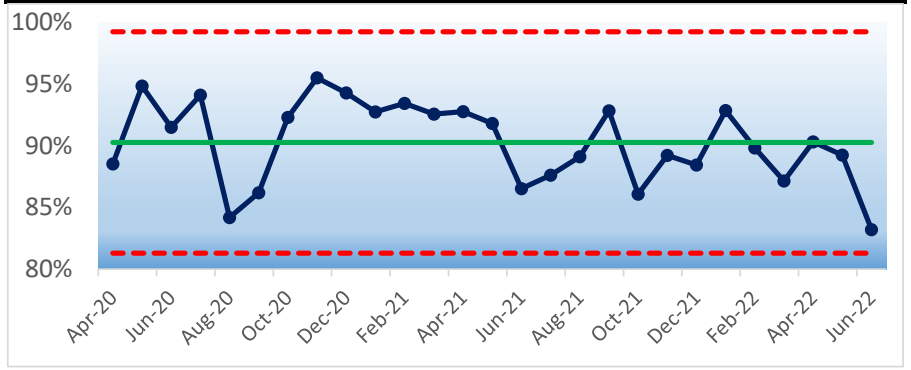
- delivering 7 day SDEC service and a direct to SDEC pathway with YAS;
- streaming of minors at the front door;
- utilising Criteria to Reside flow software to identify patients no longer requiring hospital care;
- developing a 2 hour crisis response service, expanding ARCH in-reach to ED and maximising SDEC opportunities;
- educating other specialties to avoid using ED as their triage and assessment service;
- increased GP Out of Hours provision to avoid Primary Care attendance;
- revision of infection control procedures as soon as national guidance changes to allow more rapid flow;
- implementing a 'fit to sit' area to improve flow

Indicator	**5.7 - Ambulance handovers - % within 15 mins**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Jun-22
Value / RAG rating	83.2%

Indicator description

The percentage of ambulance patients who were handed over to Emergency Department staff within 15 mins.

SPC chart



Narrative

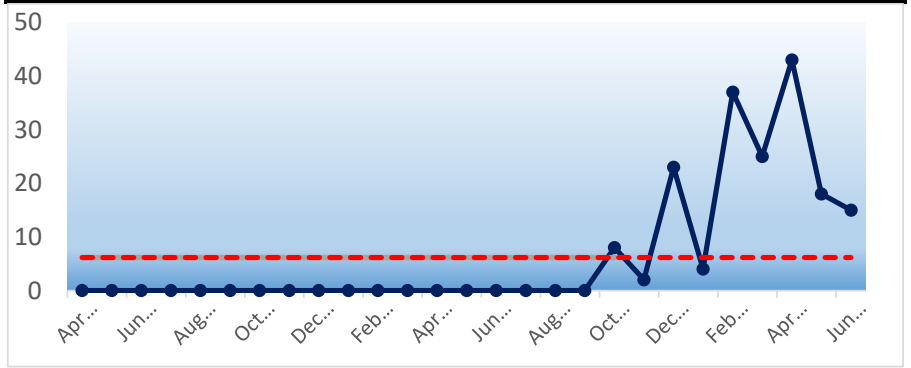
83% of ambulance handovers took place within 15 minutes in June. There were 32 over 30-minute handover breaches with 2 over 60-minutes in June. Prevention of ambulance handover delays continues to be a focus with the Trust operational processes being shared across the region by NHSE/I. Despite the high bed occupancy, acuity and activity, the lost hours to handover in Harrogate remains very low and in the top quartile nationally.

Indicator	**5.8 A&E - number of 12 hour trolley waits**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Jun-22
Value / RAG rating	15

Indicator description

The number of patients spending more than 12 hours in the Emergency Department between a decision to admit and being admitted.

SPC chart



Narrative

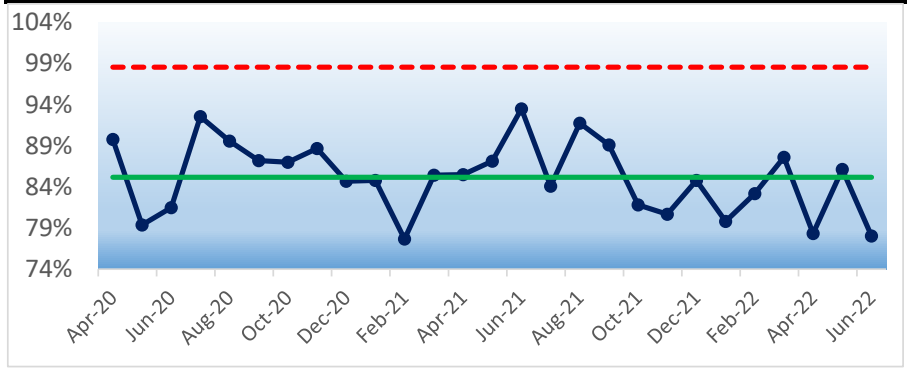
15 over 12 hour trolley waits were reported in June, a second month of improvement. As it stands, RCAs have been completed and reviewed at internal quality and performance meetings for 14 of the 15 reported cases. None of the 14 patients reviewed so far were harmed as a result of their wait in the Emergency Department. The long waiting patients are linked to times when there are no available beds in the hospital.

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	Jun-22
Value / RAG rating	78.0%

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 June (78.0%). There were 66.0 accountable treatments (76 patients) in June with 14.5 treated outside 62 days. Of the 11 tumour sites treated in June, performance was below 85% for 7 (Colorectal, Gynaecology, Lung, Other, Sarcoma, Upper GI,Urology). All pathway delays will be reviewed by the breach panel at the end of July.

Provisional data indicates that 45% (9/20) of patients treated at Tertiary centres in June were transferred for treatment by day 38, compared to 53.3% (8/15) last month.

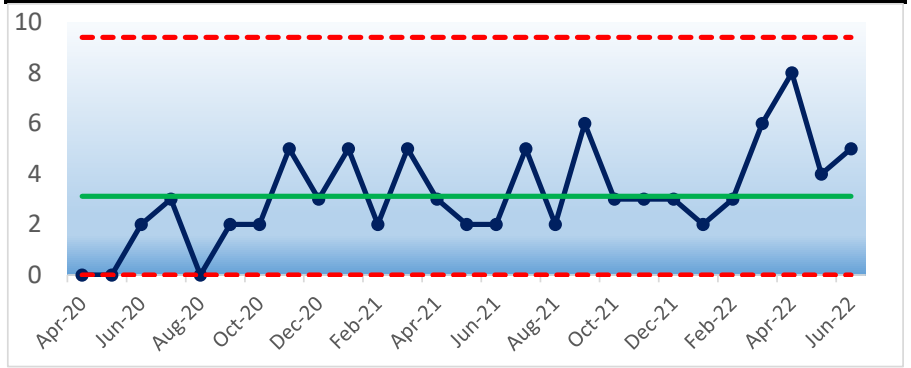
There are currently challenges with Colorectal elective capacity, and also Colorectal oncology capacity is severely limited. There are also continuing challenges in Urology outpatients for both new and follow-up appointments.

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	Jun-22
Value / RAG rating	5

Indicator description

The number of cancer patients waiting 104 days or more since urgent GP referral.

SPC chart



Narrative

5 patients waited 104+ days for treatment in June (2 x Harrogate Colorectal; 2 x Leeds Renal; 1 x Leeds Gynae/Sarcoma).

All 3 tertiary treatments were transferred after day 38. The five 104+ day delays were predominately due to diagnostic/medical complexity and patient choice, but there were further delays due to consultant leave.

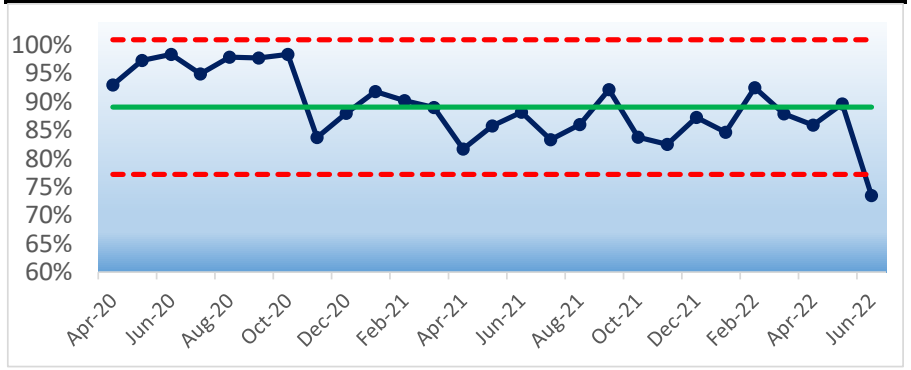
All patients have now received treatment and their pathways will be reviewed by the breach panel at the end of July.

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	Jun-22
Value / RAG rating	73.5%

Indicator description

Percentage of urgent GP referrals for suspected cancer seen within 14 days. The operational standard is 93%.

SPC chart



Narrative

905 patients attended their first appointment for suspected cancer in June which is a 6.2% decrease on last month (965). Overall attendances in Q1 2022/23 were 2.9% higher than in Q4 2021/22.

Outpatient capacity for 2ww GI Face-to-Face first appointments continues to be challenging for patients not going straight to test. This will begin to impact on the Trust long waiter position for pathways that remain open. There are also continuing challenges for outpatient appointments in Urology.

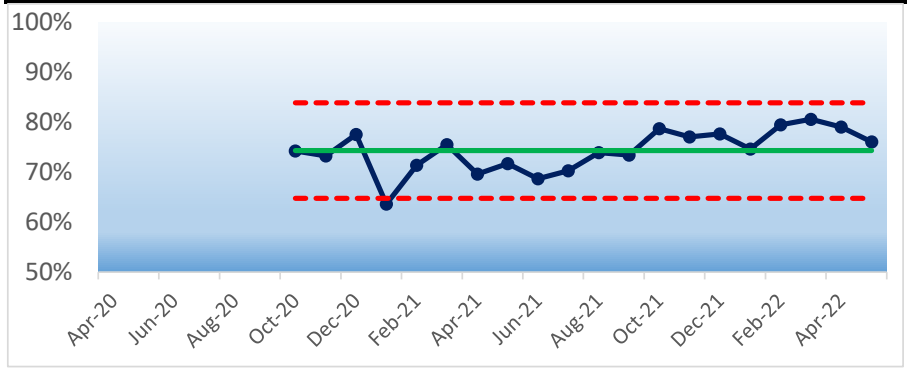
Performance for the breast 2WW standard was at 73.3% in June which is below the operational standard and a deterioration on the previous month. Performance for all 2WW breast attendances in June was at 74.5% compared to 96% in May.

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	Jun-22
Value / RAG rating	80.4%

Indicator description

From October 2021, 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

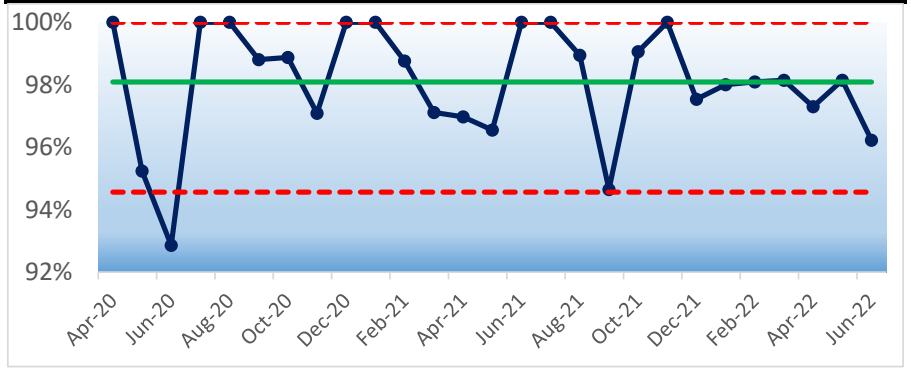
Provisional data indicates that in June combined performance for the three 28 days standards (2WW suspected cancer, 2WW non-cancer breast symptoms, Screening) has remained above the proposed operational standard of 75% (2WW cancer - 84.1%; 2WW Breast Symptoms - 100%; Screening - 43%).

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	Jun-22
Value / RAG rating	96.2%

Indicator description

Percentage of cancer patients starting first treatment within 31 days of diagnosis. The operational standard is 96%.

SPC chart



Narrative

Provisional data indicate that 106 patients received First Definitive Treatment for cancer at HDFT in June, with 4 Colorectal surgical patients treated outside 31 days (96.2%).

The 4 colorectal surgical delays were predominately due to a lack of elective capacity in General Surgery.

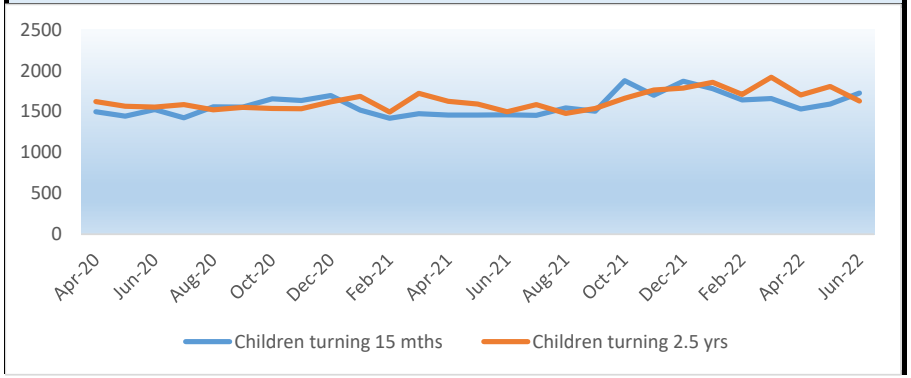
Overall peformance was above the expected standard of 96%.

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

The chart shows the number of children turning 15 mths and 2.5 yrs across the full footprint of HDFT's 0-19 Services.

SPC chart



Narrative

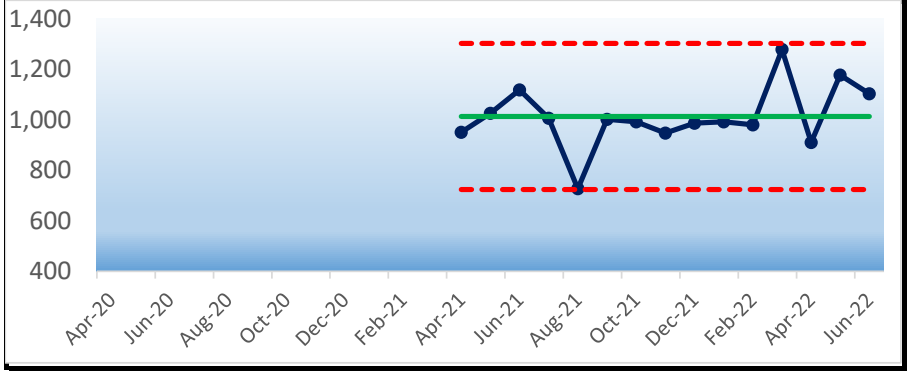
The 15 month old caseload increased in June, whilst the 2.5 year old caseload decreased.

Indicator	**5.14 - Children's Services - Safeguarding caseload**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Jun-22
Value / RAG rating	1103

Indicator description

The chart shows the number of Child Protection strategies as an estimate for Safeguarding caseload.

SPC chart



Narrative

The chart shows the number of Child Protection strategies as an estimate for Safeguarding caseload.

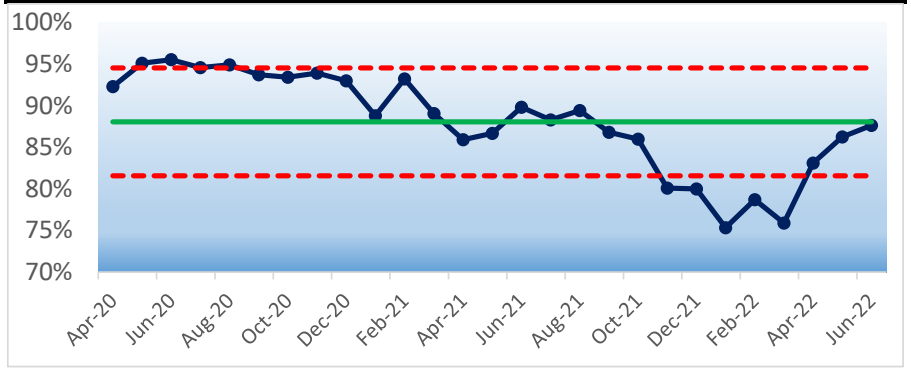
We continue to see very high levels of Safeguarding across our 0-19 Contact Areas which is in excess of the levels seen over the last three years. Additional resource has been added to the Safeguarding team to support these levels of activity.

Indicator	**5.15 - Children's Services - Ante-natal visits**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Jun-22
Value / RAG rating	87.6%

Indicator description

The number of mothers receiving a first face to face antenatal contact at 28 weeks or above before birth.

SPC chart



Narrative

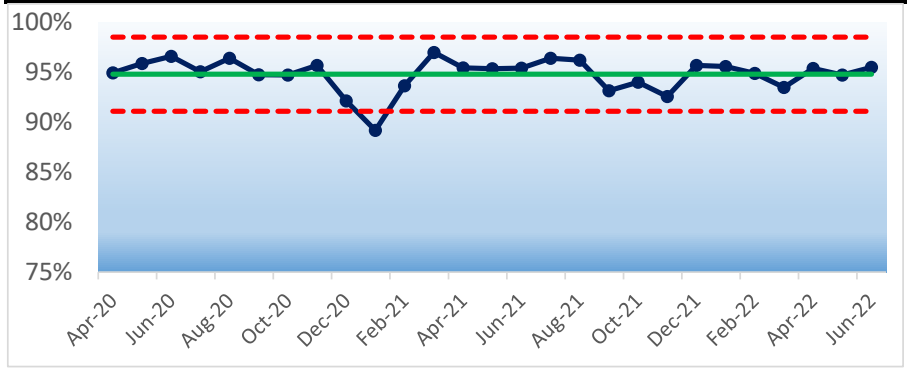
88% of eligible pregnant women received an initial antenatal visit in June, a further improvement on recent months. Middlesbrough performance (which was the main reason for the deterioration seen in recent months) improved to 83%, a significant improvement.

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	Jun-22
Value / RAG rating	95.5%

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

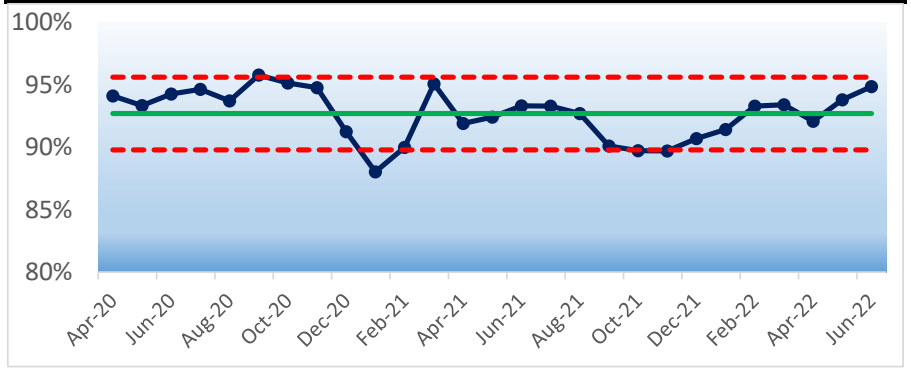
96% of infants received a new birth visit within 10-14 days of birth during June.

Indicator	**5.17 - Children's Services - 6-8 week visit**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Jun-22
Value / RAG rating	94.9%

Indicator description

The number eligible infants who received 6-8 week review by 8 weeks of age.

SPC chart



Narrative

95% of infants received a 6-8 week visit by 8 weeks of age during June.

Indicator	**5.18 - Children's Services - 12 month review**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Jun-22
Value / RAG rating	93.1%

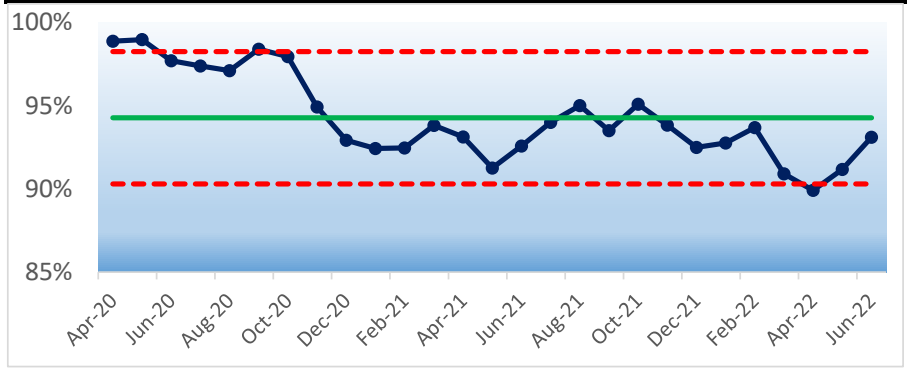
Indicator description

The number of children that received a 12 month review by 15 months of age.

Narrative

93% of eligible children received a 12 month review by 15 months of age during June.

SPC chart

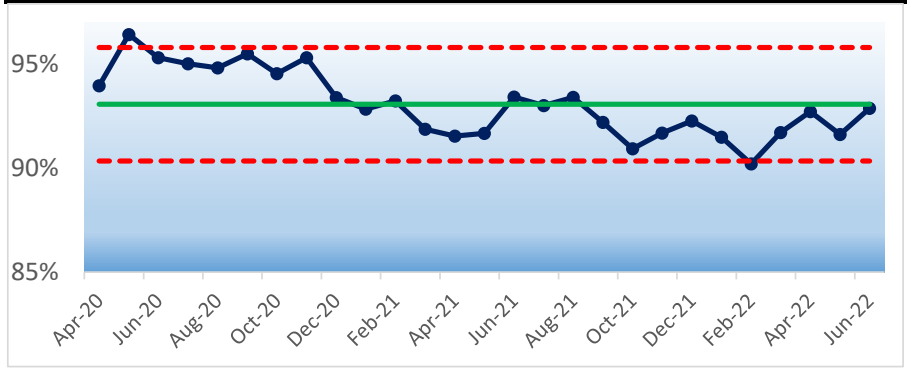


Indicator	**5.19 - Children's Services - 2.5 year review**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Jun-22
Value / RAG rating	92.9%

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

93% of eligible children received a 2 - 2.5 year review by 2.5 years of age during June.

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

A one-off audit was carried out on North Yorkshire data in 2021 which looked at children born in 2017/18 and how many mandated contacts they had received. This showed that 62% of children had received all mandated contacts. 0.4% of children were recording as not having had any mandated contacts. A list of these children was shared with service managers to follow up.

The intention is to repeat this audit annually and extend to include all localities covered by HDFT's Children's Services.

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

CC Directorate have started to discuss and record OPEL levels for 0-19 Services at their Safety and Governance huddles. The position for May was:
Acute Paediatrics 1
Darlington 2
Durham 3
Gateshead 3
Immunisation 1
Middlesbrough 3
North Yorkshire 2
Northumberland 3
Safeguarding 3
Stockton 1
Sunderland 3

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

The NHS Operational Planning and Contracting Guidance 2021/22 set out the first stage for implementing the community two-hour crisis response standard in England by March 2022. All integrated care systems (ICSs) in England must ensure that crisis response care is available to all people within their homes or usual place of residence, including care homes, within two hours.

From March, the Trust has started to submit data related to this standard as part of the monthly Community Services Data Set submissions to NHS England. We are awaiting confirmation from NHS England as to how organisations wil be assessed against the standard. Provisional data suggests that the Trust achieved the 2 hour standard for 89% of eligible cases in April, 93% in May and 92% in June. However it is likely that our true perofrmance is on or near 100% and the small number of breaches reported reflect data quality issues, rather than true breaches. The service are working to address this.

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.

Narrative

SPC chart

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

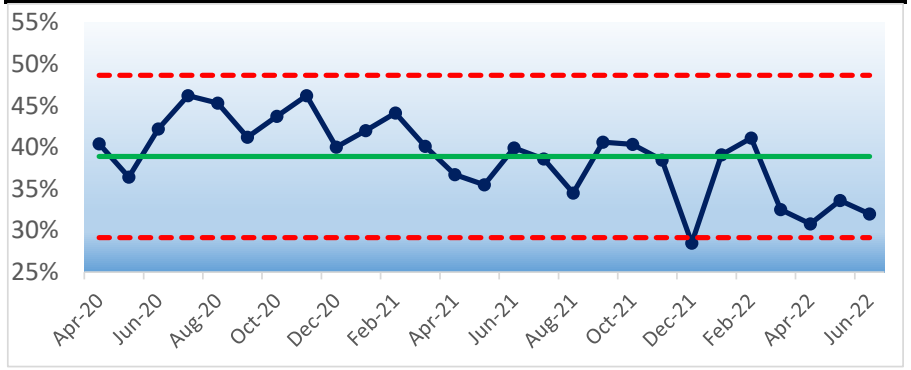
Narrative
CC Directorate have started to discuss and record OPEL levels for Adult Community Services at their Safety and Governance huddles. The overall position for June remained at level 3.

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	Jun-22
Value / RAG rating	32.0%

Indicator description

The percentage of telephone clinical assessment for URGENT cases carried out within 20 minutes of call prioritisation.

SPC chart



Narrative

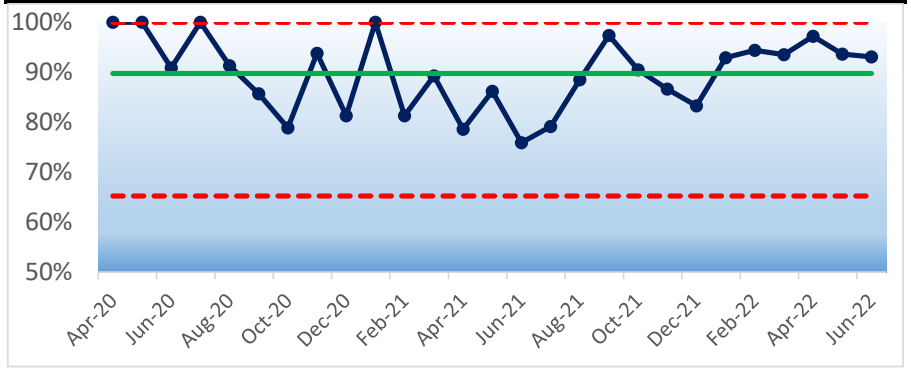
In June, 32% of urgent GPOOH cases received a telephone clinical assessment within 20 minutes of call prioritisation, remaining below the 95% target. The COO has requested an immediate deep dive into the GPOOH service to understand the demand and capacity gap that is being ancedotally mentioned at operational meetings.

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	Jun-22
Value / RAG rating	93.1%

Indicator description

The percentage of home visit face to face consultations started for URGENT cases within 2 hrs.

SPC chart



Narrative

In June, 93% of urgent GPOOH cases received a home visit face to face consultation within 2 hours.

Integrated Board Report - June 2022

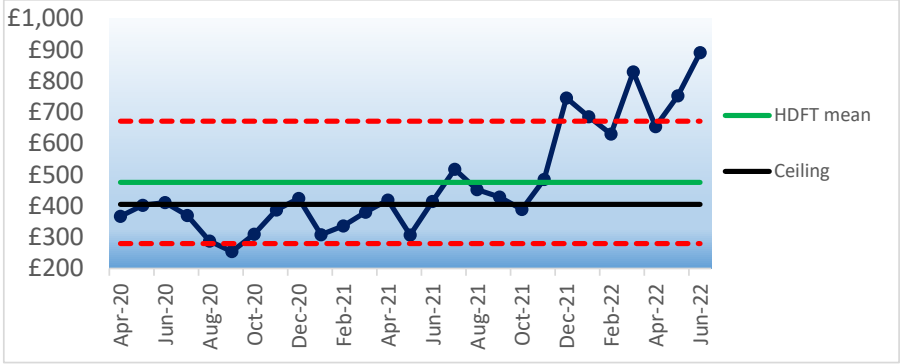
Domain 6 - Efficiency and Finance

Indicator	**6.1 - Agency spend**
Executive lead	Jordan McKie, Finance Director
Board Committee	Resources Committee
Reporting month	Jun-22
Value / RAG rating	£890

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 expenditure remains a significant concern for the Trust. Whilst the usage is mitigating risks regarding quality, safety and recovery, the level of expenditure clearly exceeds historic trends and planned expectations.

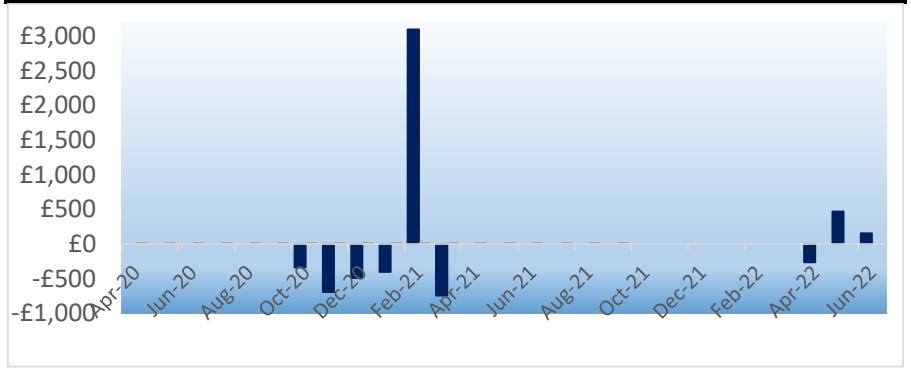
Further information is included within the Committee reports on this.

Indicator	**6.2 - Surplus / deficit and variance to plan**
Executive lead	Jordan McKie, Finance Director
Board Committee	Resources Committee
Reporting month	Jun-22
Value / RAG rating	£157

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 Trust has reported a small surplus, however, this includes the recognition of income associated with the Capital Programme. Removing this would result in a deficit position of £314k. Clearly this is a concern, with recovery actions being put in place to address this and the recurrent impact of the pressures emerging.

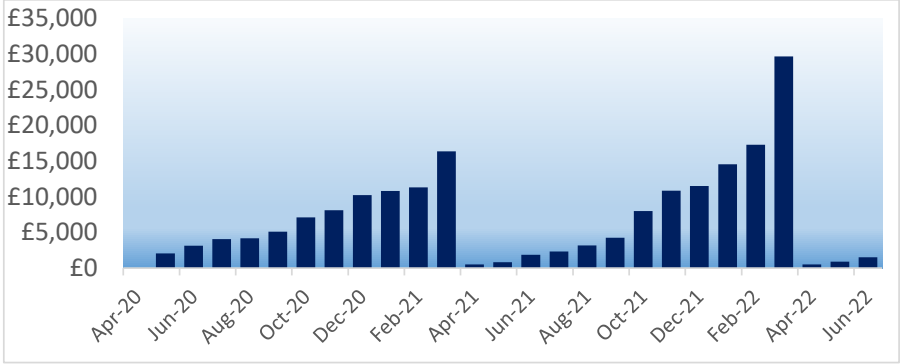
Key drivers include the impact of Covid-19 being above the levels outlined in the planning guidance, delivering of Savings Programme, Escalation and a number of drivers for agency expenditure.

Indicator	**6.3 - Capital spend**
Executive lead	Jordan McKie, Finance Director
Board Committee	Resources Committee
Reporting month	Jun-22
Value / RAG rating	£1,506

Indicator description

Cumulative Capital Expenditure by month (£'000s)

Trend chart



Narrative

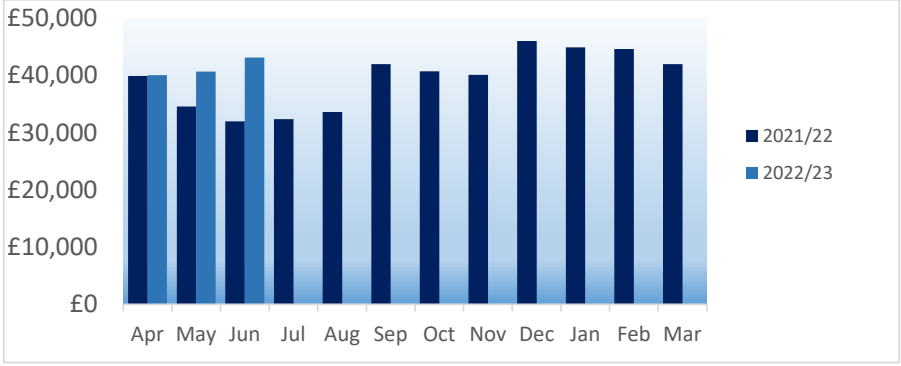
The Trust continues to implement this year's programme.

Indicator	**6.4 Cash balance**
Executive lead	Jordan McKie, Finance Director
Board Committee	Resources Committee
Reporting month	Jun-22
Value / RAG rating	£43,156

Indicator description

The Trust's cash balance by month (£'000s)

Trend chart



Narrative

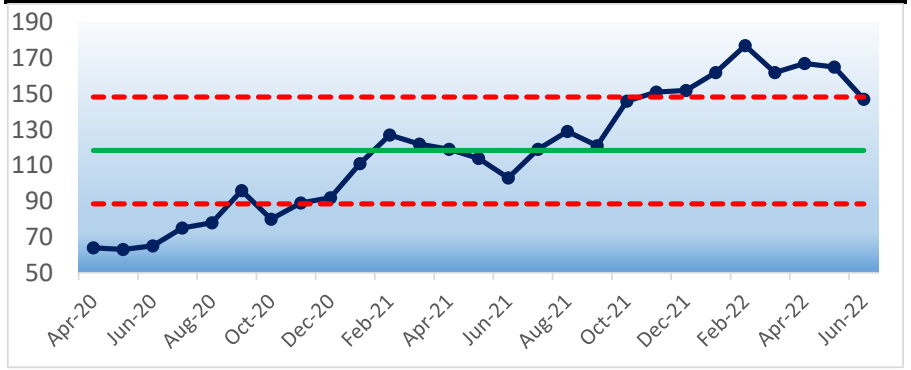
The Trust cash balance remains positive.

Indicator	**6.5.1 - Long stay patients - stranded (>7 days LOS)**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Jun-22
Value / RAG rating	147

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

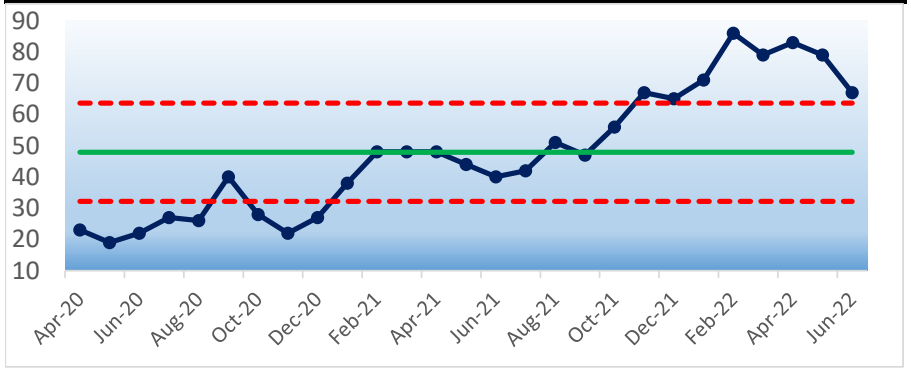
The number of long stay patients (> 7 days) was 147 in June, a reduction on recent months but remaining high. This is being driven by the increase in COVID patients, COVID 'pop ups' at day 7 and patients requiring observation as COVID contacts alongside the impact of COVID on POC, residential and nursing home providers.

Indicator	**6.5.2 - Long stay patients - superstranded (>21 days LOS)**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Jun-22
Value / RAG rating	67

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

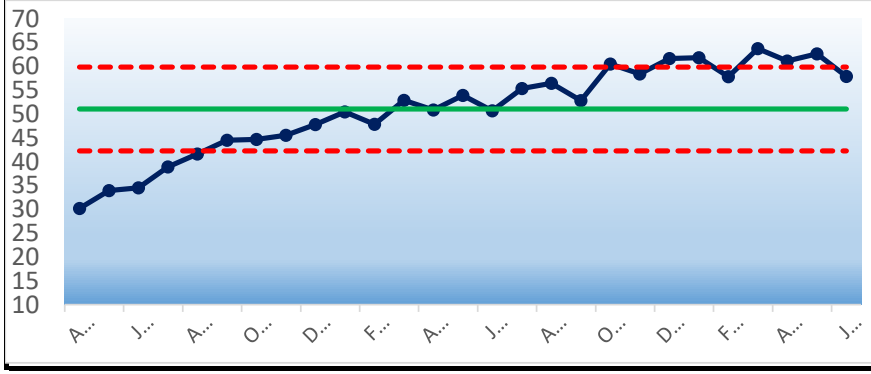
The number of long stay patients (> 21 days) was 67 in June, a reduction on recent months but remaining high. This is being driven by the increase in COVID patients, COVID 'pop ups' at day 7 and patients requiring observation as COVID contacts alongside the impact of COVID on POC, residential and nursing home providers.

Indicator	**6.6 - Occupied bed days per 1,000 population**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Jun-22
Value / RAG rating	57.9

Indicator description

The number of occupied bed days expressed per 1,000 population, using the mid-2020 population estimate for Harrogate.

SPC chart



Narrative

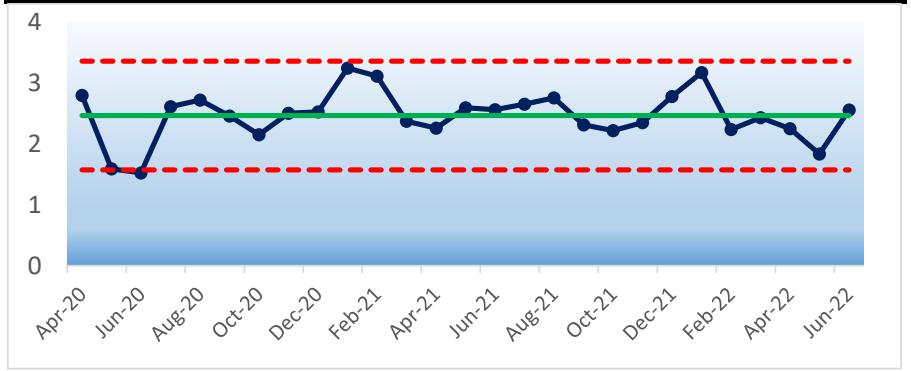
Occupied bed days decreased to 57.9 in June. In the 2 years prior to the pandemic, occupied bed days per 1,000 population averaged 57.8, below the current level.

Indicator	**6.7.1 Length of stay - elective**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Jun-22
Value / RAG rating	2.6

Indicator description

Average length of stay in days for elective (waiting list) patients. The data excludes day case patients.

SPC chart



Narrative

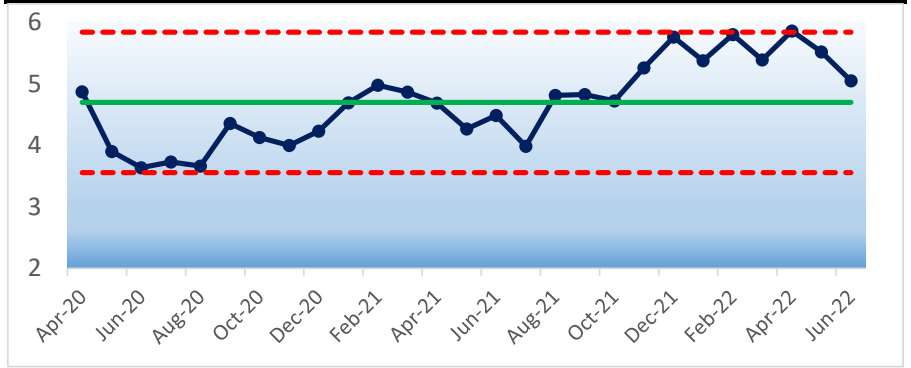
Elective length of stay increased in June and is now above our local stretch target of 2.5 days.

Indicator	**6.7.2 Length of stay - non-elective**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Jun-22
Value / RAG rating	5.1

Indicator description

Average length of stay in days for non-elective (emergency) patients.

SPC chart



Narrative

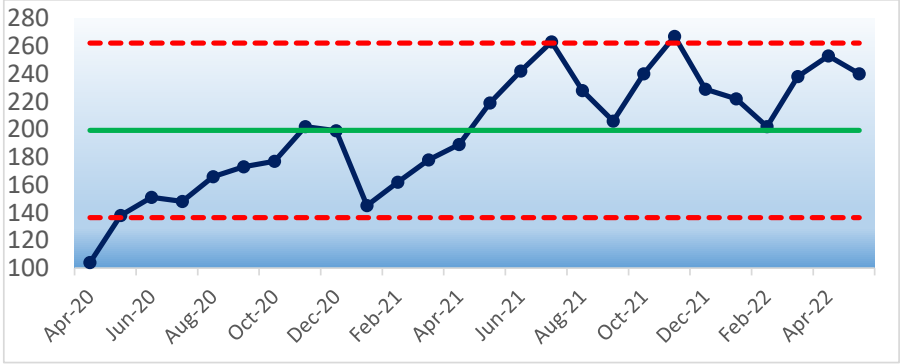
Non-Elective length of stay decreased in June but remains above our local stretch target. There is a combination of factors affecting patient flow, as described in indicators 6.5.1 - 6.7.1.

Indicator	**6.8 - Avoidable admissions**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	May-22
Value / RAG rating	240

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 240 avoidable admissions in May, an increase on the previous month but remaining within the expected range. The most common diagnoses this month were urinary tract infections and pneumonia. Excluding children and admissions via CAT/SDEC, the May figure was 109.

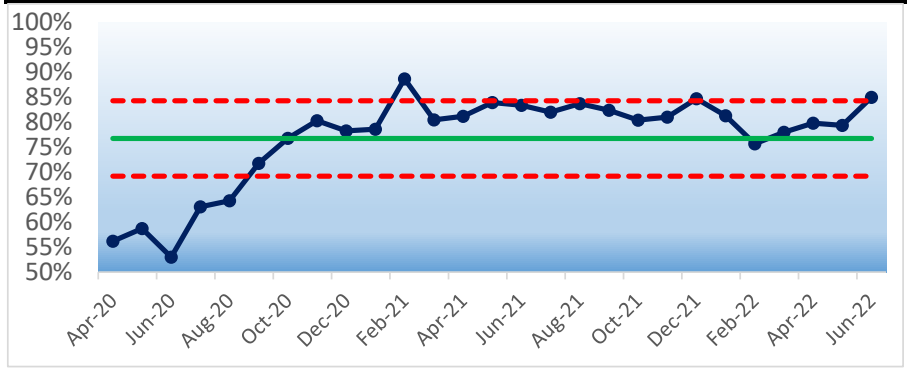
This is below pre-Covid levels - the average per month in 2018/19 was 270.

Indicator	**6.9 - Theatre utilisation (elective sessions)**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Jun-22
Value / RAG rating	85.0%

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 increased in June but remains below the local intermediate target of 90%.

Indicator	**6.10 - Day case conversion rate**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Jun-22
Value / RAG rating	2.4%

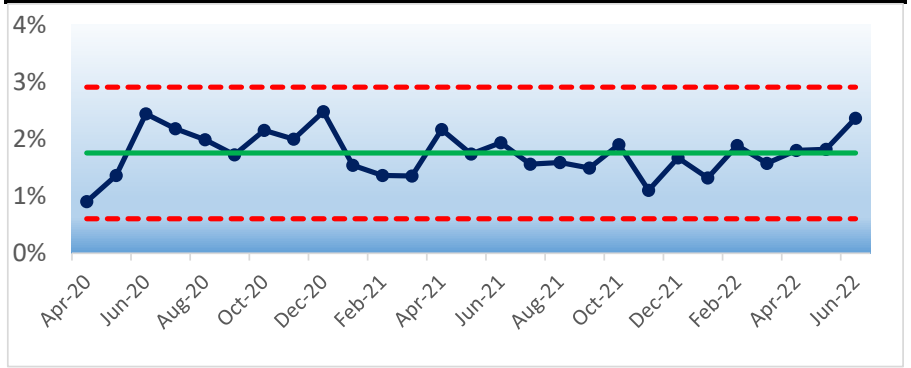
Indicator description

The percentage of intended elective day case admissions that ended up staying overnight or longer.

Narrative

2.4% (52 patients) of intended day cases stayed overnight or longer in June.

SPC chart



Integrated Board Report - June 2022

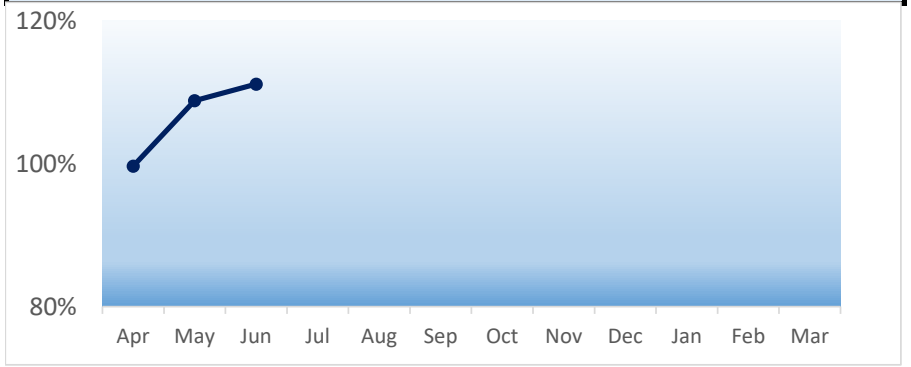
Domain 7 - Activity

Indicator	**7.1 - GP referrals against 2019/20 baseline**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Jun-22
Value / RAG rating	111.1%

Indicator description

GP referrals against 2019/20 baseline.

SPC chart



Narrative

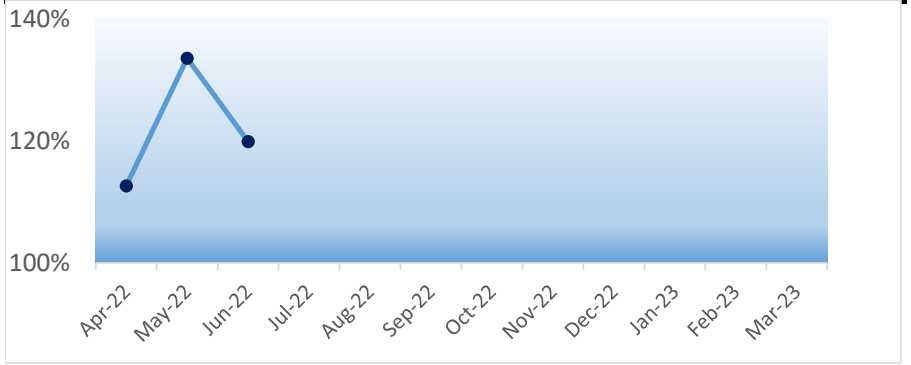
In June, GP referrals were 11% above the equivalent month in 2019/20.

Indicator	**7.2 - Outpatient activity (consultant led) against plan**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Jun-22
Value / RAG rating	119.9%

Indicator description

Outpatient activity (consultant led) against plan. The data includes new and follow up attendances.

Trend chart



Narrative

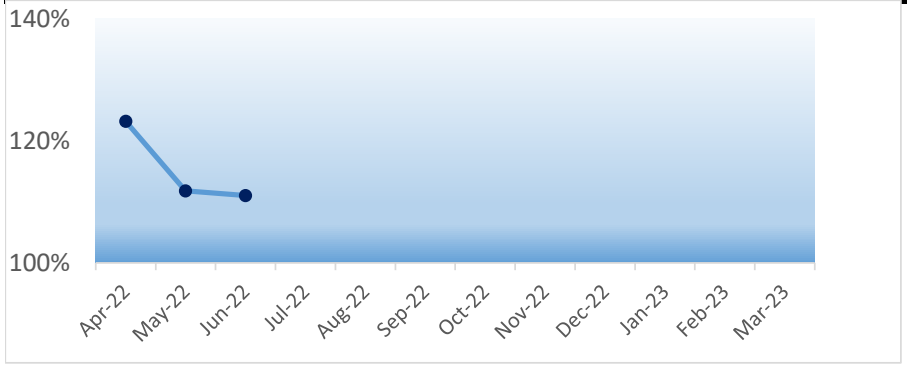
Outpatient activity was 20% above plan in June. New outpatient attendances were 7% below plan, whilst follow up attendances were significantly over plan (38%).

Indicator	**7.3 - Elective activity against plan**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Jun-22
Value / RAG rating	111.0%

Indicator description

Elective activity against plan. The data includes both elective inpatient and elective day case admissions.

Trend chart



Narrative

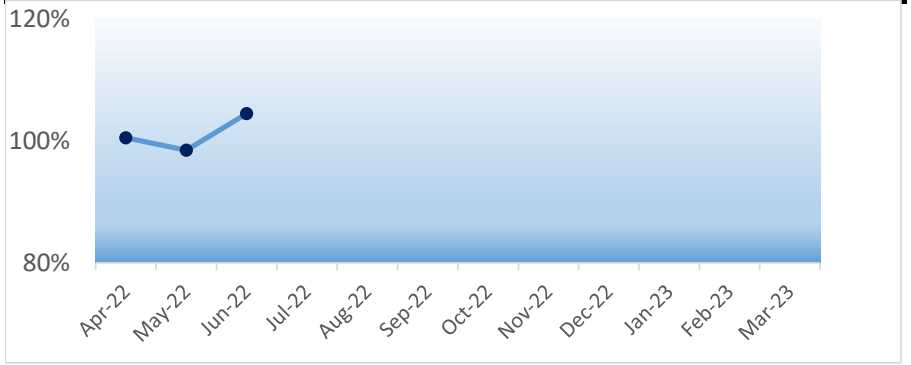
Elective admissions were 11% above plan in June. Elective day cases were 13% above plan and elective inpatients were 2% below plan.

Indicator	**7.4 - Non-elective activity against plan**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Jun-22
Value / RAG rating	104.4%

Indicator description

Non-elective activity against plan.

Trend chart



Narrative

Non-elective activity was 4% above plan in June.

Indicator	7.5 - Emergency Department attendances against plan
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Jun-22
Value / RAG rating	91.3%

Indicator description

Emergency Department attendances against plan.

Narrative

Emergency Department attendances were 9% below plan in June.

Trend chart

Integrated Board Report - June 2022

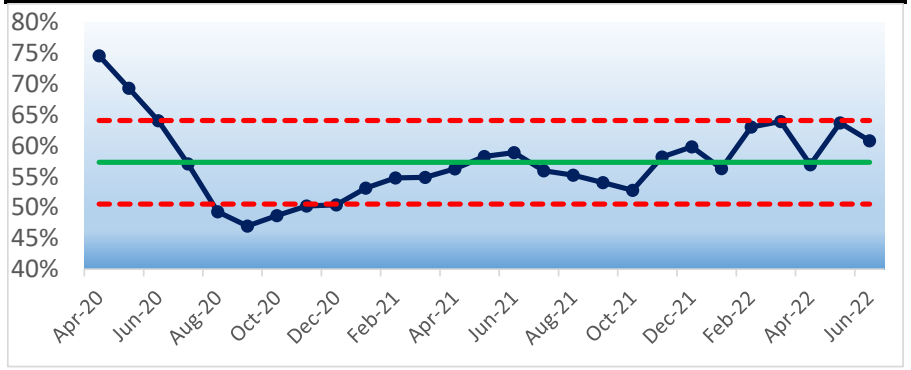
Domain 4 - Workforce

Indicator	**4.1 - Staff appraisal rate**
Executive lead	Angela Wilkinson
Board Committee	People and Culture Committee
Reporting month	Jun-22
Value / RAG rating	60.8%

Indicator description

The number of staff who had an appraisal within the last 12 months. The Trust aims to have 90% of staff appraised.

SPC chart



Narrative

The appraisal rate in June decreased to 60.8% from 63.7% the previous month. Sickness and annual leave are contributing factors. Corporate Services Directorate has seen the greatest decrease in appraisal rates this month, from 48.7% in May to 38.1% in June.

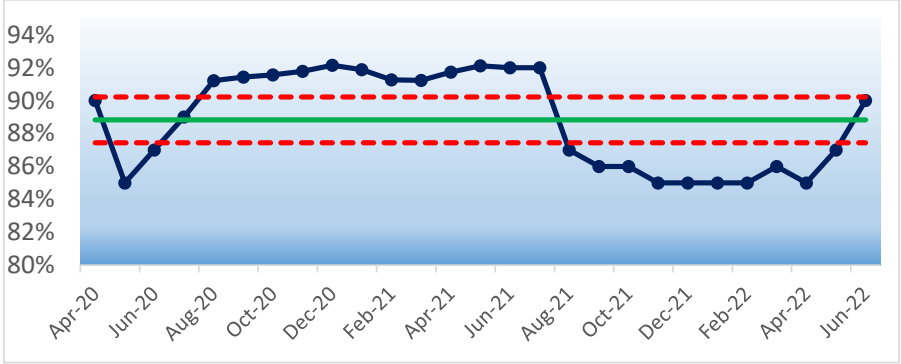
- Non-Medical appraisal % = 59.8% (previous month 63.2%)
- Medical appraisal % has increased to 73.3% (previous month 69.1%)

Indicator	**4.2 - Mandatory training rate**
Executive lead	Angela Wilkinson
Board Committee	People and Culture Committee
Reporting month	Jun-22
Value / RAG rating	90.0%

Indicator description

Latest position on the % of substantive staff trained for each mandatory training requirement

SPC chart



Narrative

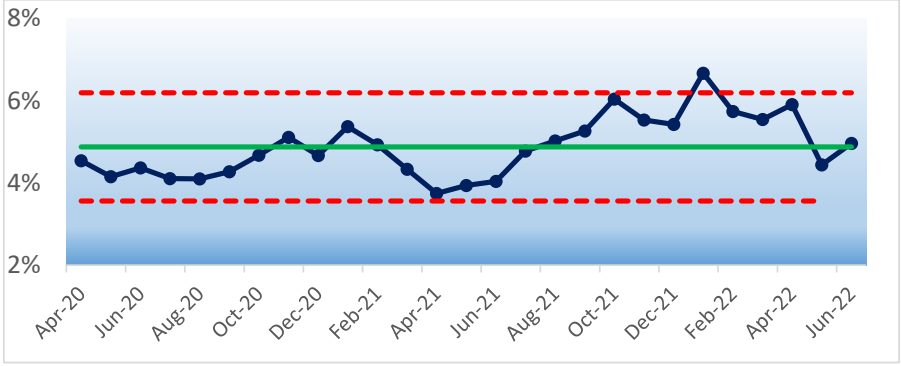
The data shown is for the end of June for the Mandatory Core elements of training. The overall compliance rate for substantive Trust staff is 90% and has increased by 3% since the previous month. The overall compliance for Mandatory core and role based training for Trust substantive staff is currently 81% and has increased by 1% since the previous month.

Indicator	**4.3 - Staff sickness rate**
Executive lead	Angela Wilkinson
Board Committee	People and Culture Committee
Reporting month	Jun-22
Value / RAG rating	5.0%

Indicator description

Staff sickness rate - includes short and long term sickness. The Trust has set a threshold of 3.9%.

SPC chart



Narrative

Sickness had seen a general decreasing trend since the start of the year, however June has seen an increase to 5.0% from 4.4% in May. An increase in Covid related sickness is a factor to the overall rise in sickness rates, as Covid sickness rates have increased from 0.8% last month to 1.0% this month. Excluding Covid related sickness, the Trust's sickness rate is 3.9%, in line with the Trust's threshold.

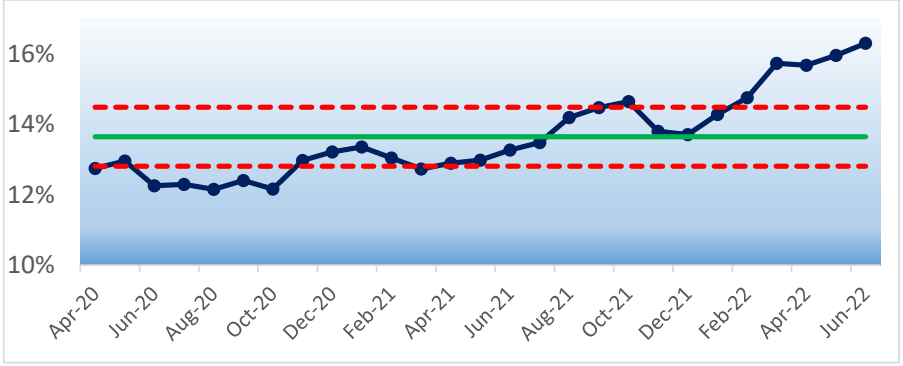
Long term sickness has remained at a similar level this month (2.5%), however short term sickness has increased from 2.0% to 2.5%. "S15 Chest & respiratory problems", which is the sickness reason used for recording Covid related sickness, is the top reason for sickness this month and contributes to 25.4% of the overall sickness.

Indicator	**4.4 Staff turnover rate**
Executive lead	Angela Wilkinson
Board Committee	People and Culture Committee
Reporting month	Jun-22
Value / RAG rating	16.3%

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

The Trust has seen an increasing trend in turnover rates, with a further increase this month to 16.3%. Involuntary termination turnover has increased in June to 3.8% from 3.7% last month. Voluntary termination turnover has also increased to 12.5% in June from 12.4% in May. Compared to the previous month, the number of leavers has increased by 12.61wte and the average staff in post has decreased by 1.85wte, which is the reason for the increase in the turnover rate.

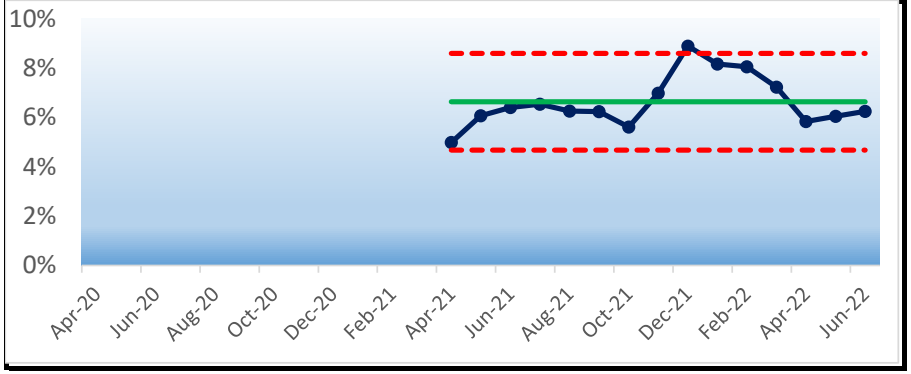
PSC and CC Directorates have seen increases to turnover this month and have turnover rates of 18.5% and 15.5% respectively. In PSC Directorate, there has been high turnover in June within Critical Care and also within the surgical wards. The turnover rates within these areas are now at 25.8% and 29.1%. Turnover within the 0-19 Children's Services is the reason for the increased turnover rates in the CC Directorate. The Northumberland and North Yorkshire localities are the greatest contributors to the increase.

Indicator	**4.5 - Vacancies**
Executive lead	Angela Wilkinson
Board Committee	People and Culture Committee
Reporting month	Jun-22
Value / RAG rating	6.25%

Indicator description

The chart shows the total number of vacancies across the Trust. This data is provided a month in arrears.

SPC chart



Narrative

The Trust's vacancy rate in June is 6.25%, which is an increase from 6.04% from the previous month. This equates to 255.95wte vacancies.

PSC and LTUC Directorates have the greatest vacancy rates of 12.19% (124.39wte vacancies) and 7.88% (85.79wte vacancies) respectively.

Board of Directors (Public)
September 2022

Title:	**Board Assurance Framework**
Responsible Director:	Chief Executive
Author:	Associate Director of Quality and Corporate Affairs

Purpose of the report and summary of key issues:	The report provides the Trust Board with key updates and actions since the previous meeting in July 2022. Each Board Assurance Framework risk has been reviewed and assessed with the designated responsible Executive Director. A revised BAF in line with the new Trust strategy will be presented to Board in November 2022.	
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.	
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.	

Board Assurance Framework **APPENDIX 1**

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	July 2022 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 Reciprocal mentoring programme EDI work programme Inpulse Survey and Analysis Exit Interviews Mental Health Nurse – recruited Colleague Wellbeing Programme Lead – recruited Quiet room developed in the Education Centre Refreshed wellbeing intranet Mental Health Champions in place Thrive Wellbeing Conversations	Board of Directors Senior Management Team People and Culture Committee Sarah Armstrong – Non-Executive Director for Wellbeing Guardian	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	Assurance controls and gaps in assurance have been updated as has the related corporate risk register. This scope of this risk will be reviewed for potential inclusion onto the revised BAF
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 Reciprocal mentoring programme EDI work programme Inpulse Survey and Analysis Exit Interviews Becoming and Anti-Racist Work programme EDS2 Programme commissioned	Board of Directors SMT People and Culture Committee Wallace Sampson – Non-Executive Director for Inequality and Diversity	Staff Survey	EDI programme governance paused, a need to re-establish	People and Culture Committee	A Wilkinson, Director of Workforce and OD	Assurance controls and gaps in assurance have been updated. This scope of this risk will be reviewed for potential inclusion onto the revised BAF

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	July 2022 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 has increased capacity to work with strategic partners	Medical Director Board Report Director of Strategy Board Report SMT	HARA Yorkshire Health Network LMC	This risk could be exasperated due to the potential local government and NHS (integrating care) reorganisation. Currently no strategic Harrogate Place Forum – discussions are ongoing to develop forum. Further work required on Harrogate as an anchor institution.	SMT	M Graham, Director of Strategy J Andrews, Executive Medical Director	This scope of this risk will be reviewed for potential inclusion onto the revised BAF
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 Executive Team are key members of strategic groups across the two ICSs.	ICS Groups eg the Provider Collaborative	The required input across the two local ICS may lead to a lack of clarity of funding arrangements. Requirement for HDFT to be members of two ICS means that Executive capacity needs to spread across two structures rather than one.	SMT	M Graham, Director of Strategy	assurance controls and gaps have been updated to reflect the current position. This scope of this risk will be reviewed for potential inclusion onto the revised BAF

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	July 2022 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	2	4	8	2 x 4 = 8	Apr-22	None	A number of key quality governance changes have taken place 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. Safe Staffing Review completed. Procured Perfect Ward with planned roll out in January and February 2022.	CQC Action Plan Quality Account Caring at Our Best programme Appointment of Quality Matron to support rollout of ward/team accreditation Weekly Quality Summit and Learning Summit in place Complaints back log cleared	CQC Inspections Bi-monthly Assurance meetings with CCG Internal Audit Report – Board to Board reporting – significant assurance	Do not have consistent quality control in place Workforce challenges impacting	Quality Committee	Emma Nunez, Director of Nursing	Current Risk rating reduced from 12 to 8 with the Target Risk met. Assurance controls and gaps in assurance have been updated. This scope of this risk will be reviewed for potential inclusion onto the revised BAF
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	The appointment of the Director of Strategy has given renewed focus and increased resource on the development of the Clinical Strategy and a strategic governance programme is under development	SMT Directorate Oversight on Annual Clinical Plans Quality Committee Board of Directors	WYATT Committee in Common Carnell Farrer report Ongoing Clinical Services review to develop Clinical Strategy Ongoing conversations with WYATT	Trust and Clinical Strategy under development however they are not yet in place.	Quality Committee	J Andrews, Executive Medical Director	Assurance controls and gaps in assurance have been updated. This scope of this risk will be reviewed for potential inclusion onto the revised BAF
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 visibility of the child in adult pathways which will impact on the individualised care for patients.	4	4	16	2	4	8	2 x 4 = 8	Apr-22	None	'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 Trust Wide Action Plan – now closed.	CQC Outstanding Report OFSTED Reports JTAI Reports	Metrics required to monitor the embedding of CQC Actions. Paediatric Emergency Department – workforce and environment	Quality Committee	Emma Nunez, Director of Nursing	Current Risk rating reduced from 12 to 8 with the Target Risk met. Assurance controls and gaps in assurance have been updated. Risk to be closed.
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 23	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, day case 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 Operational Management Group	NHSE/I Reporting		Quality Committee	Russell Nightingale, Chief Operating Officer	This scope of this risk will be reviewed for potential inclusion onto the revised BAF

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 Increased safeguarding activity referrals have continued into 2022 with an increase in workforce pressures. See CRR57 for activity information.		Emma Nunez, Director of Nursing	Current mitigation and gaps in control updated.

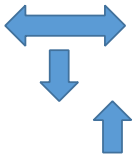
4. STRATEGIC OBJECTIVE: TO ENSURE CLINICAL AND FINANCIAL SUSTAINABILITY

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	May 2022 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 WYATT – creating financial framework to look at opportunities. The piece of work is being mirrored internally.	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 and the requirement to move to pre Covid levels of activity No new long-term productivity programme currently in place **External:** no governance structure or programme of work with Leeds regarding transformation	Resource Committee	Finance Director	Assurance controls and gaps in control update. Noted that the financial position for 2021-22 will be achieved. However, future funding nationally has not yet been confirmed. Risk is now closed
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 Ongoing discussions with the ICS future allocation Site development group developing plan	Capital Oversight Group H2 efficiency programme	Ongoing discussions based on winter planning and national and regional allocations. H2 planning now in place with efficiency programme.	**Internal:** No efficiency programme	Resource Committee	Finance Director	Assurance controls and gaps in control update. Noted that the capital is available but potential risks as no long term site development plan currently in place. Risk is now closed
BAF#4.3	To provide high quality care and to be a financially sustainable organisation in relatin to digital maturity	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	Digital Strategy Digital Board Training provided by NHS Digital/NHS Providers NHSI Digital Maturity Programme Working with digital aspirant programme to create strategic outline case for digital funding.	Capital Oversight Group Digital Strategy Group		Ongoing refresh of the Clinical Strategy and the Digital Strategy	Resource Committee	J Andrews, Executive Medical Director	Assurance controls and gaps in control update. This scope of this risk will be reviewed for potential inclusion onto the revised BAF
#4.4	To be financially stable to provide outstanding quality of care	Due to the allocation formula not providing sufficient resources to meet the needs of the unique demography of the local area, there is a risk that standards of care are compromised which will impact on the Trust's ambition to provide outstanding care and its reputation for quality	4	4	16	2	4	8	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	Lack of system wide financial plan New financial allocations need to be agreed. Chief Executive/Finance Director has with ICS's and regulators Carnell Farrer Review	Resource Committee	J Coulter, Deputy Chief Executive/ Finance Director	Current risk rating updated to 8. Target risk met. Assurance controls and gaps in control update. Noted that the financial position for 2021-22 will be achieved. However, future funding nationally has not yet been confirmed. This scope of this risk will be reviewed for potential inclusion onto the revised BAF

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

HIF HARROGATE INTEGRATED FACILITIES
Taking Pride in our Services

NHS
Harrogate and District
NHS Foundation Trust

10

Harrogate and District NHS Foundation Trust

Trust Strategy

teamHDFT
At our best

Contents

WELCOME FROM OUR

Chief Executive and Chair

Joint message and images to be supplied for this page

Introduction

The aim of our Strategy is to establish shared understanding and clarity for our workforce, Board of Directors and partners about Harrogate and District NHS Foundation Trust's (HDFT) purpose, ambitions and priorities.

Our Strategy provides a framework to align our endeavours and mobilise our resources and workforce. It is for everyone in the Trust, in every role and every function. It will drive what we do as a Trust, as Directorates, Services and individually.

The Trust does not operate in isolation. We are part of a large and complex health and care system and we will only be successful if we work in collaboration and partnership. Our strategy must align with and support delivery of the national and system strategies, and complement those of our partners.

The Trust exists to serve two groups: the patients who we care for in our hospitals and community services in Harrogate and District, and wider North Yorkshire; and the children and young people who we support through our Children's Public Health Services across large parts of the North East and Yorkshire. Our Strategy makes it clear that our patients and children always come first.

Our purpose is to improve the health and wellbeing of our patients, children and communities.

As well as caring for patients when they are unwell, we can also help improve people's health and contribute to the wellbeing of our communities through our services and how we use our resources.

To do this our ambitions are to:

These are supported by three enabling ambitions:

Our Strategy guides our decision making about today's priorities, ensuring they support our purpose and long term ambitions. Annually, we will set clear, specific priorities and objectives for each ambition and goal, and track their delivery.

About HDFT
Our Services

Acute & Community Services for Harrogate and District, and wider North Yorkshire:

- Harrogate District Hospital
- Ripon Community Hospital
- Harrogate & Rural Alliance
- North Yorkshire Specialist Community Services

Children's Public Health (0-19) Services

- 9 local authorities in North East and Yorkshire
- Looking after over 500,000 children
- The largest provider of 0–19 services in England

About HDFT
In Numbers

3 INTEGRATED CARE SYSTEMS

OVER **5,000** COLLEAGUES

80,000 VIRTUAL OUTPATIENT ATTENDANCES

118,000 HOME VISITS

HOSPITAL CATCHMENT POPULATION **c200,000**

£300m TURNOVER

LOOKING AFTER OVER **500,000** CHILDREN

COMMUNITY SERVICES POPULATION **c620,000**

LARGEST **EMPLOYER** IN HARROGATE & DISTRICT

55,000 EMERGENCY DEPARTMENT ATTENDANCES

OVER **2,000** CANCER TREATMENTS

National and System Strategies

The Trust does not operate in isolation – we are part of a large and complex health and care system and we will only be successful if we work in collaboration and partnership. Our strategy aligns with and supports delivery of the national and system strategies, and complements those of our partners.

HDFT is part of three Integrated Care Systems:

Humber and North Yorkshire Health and Care Partnership

West Yorkshire Health and Care Partnership

ICS

Humber & North Yorkshire

To provide person centred, integrated care we need to work with local partners, including primary care, North Yorkshire County Council, the voluntary and community sector, and other NHS trusts – in Harrogate, in North Yorkshire and more widely.

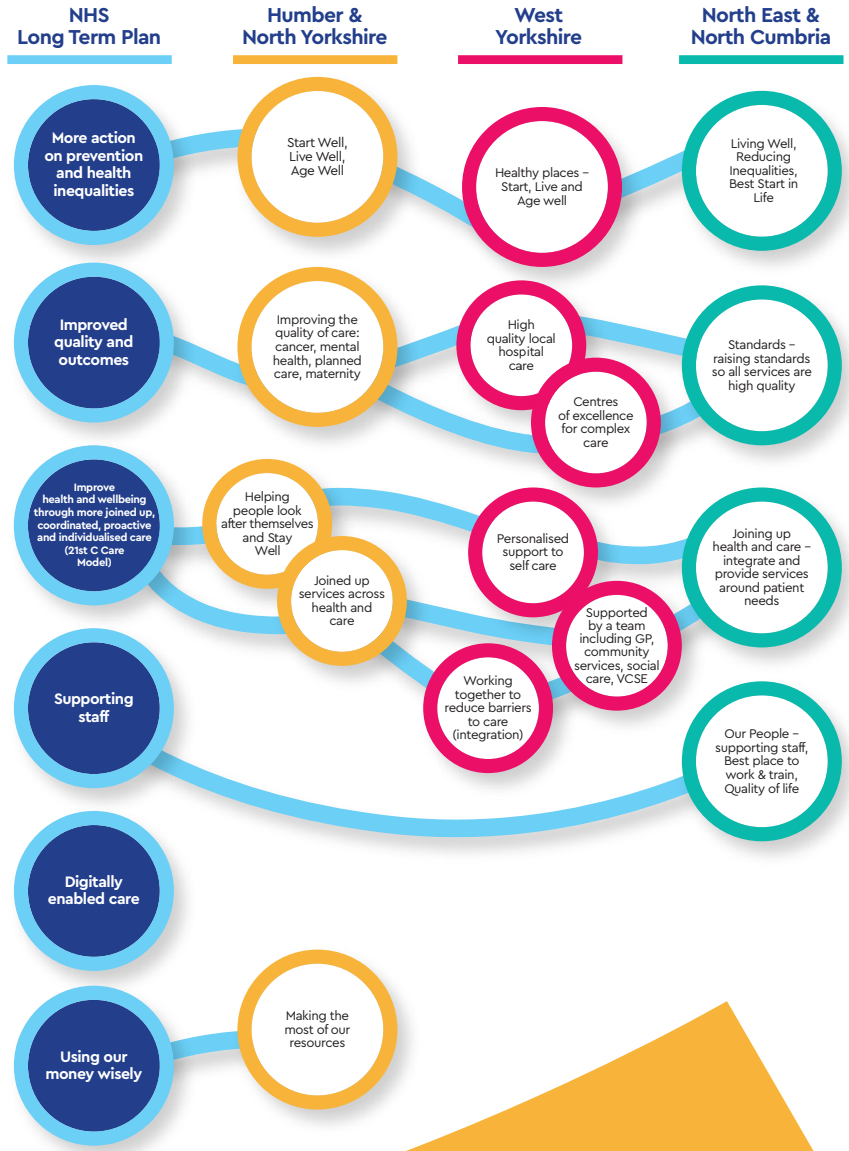
West Yorkshire

HDFT is a member of the West Yorkshire Association of Acute Trusts (WYAAT) and many of our patient pathways for more specialised hospital services are with West Yorkshire and WYAAT.

North East & North Cumbria

HDFT provides Children and Young People's Public Health Services for most of the North East. We are a member of the Child Health and Wellbeing Network and committed to delivering the "Working Together" strategy.

Our Strategy has been developed to align with and support delivery of the ICS strategies, which are summarised and compared below:



Who we Engaged to Develop our Strategy

To develop the Trust's Strategy, we engaged with the public, staff and key stakeholders:

A PUBLIC SURVEY
shared with our Members and Governors, and with 80 organisations through Healthwatch, which
RECEIVED OVER
150
RESPONSES

A STAFF SURVEY
WITH OVER
500
RESPONSES;
SIX CLINICAL STRATEGY WORKSHOPS WITH
50–100
STAFF AT EACH

OVER
40
INTERVIEWS
with internal and external stakeholders, including Non-Executive Directors, local authorities, primary care, integrated care system leaders and other trusts

The key themes highlighted through our engagement, have been reflected in our Strategy's ambitions and goals:

Recognising our role in
IMPROVING HEALTH AND WELLBEING,
reducing health inequalities

The importance of focusing on
DELIVERING HIGH QUALITY CARE
and listening to what is important to our patients, children and young people

WORKING IN COLLABORATION
and partnership to integrate care

Building on our position as the
LARGEST PROVIDER OF CHILDREN'S PUBLIC HEALTH SERVICES IN ENGLAND

THE ABSOLUTE IMPORTANCE OF SUPPORTING OUR WORKFORCE
having sufficient, skilled colleagues; training and developing people; creating a compassionate, diverse culture with great leaders – being a great place to work

PROVIDING EXCELLENT SUPPORTING INFRASTRUCTURE
– estates, equipment, digital – to enable the best care

OUR PURPOSE, AMBITIONS & ENABLING AMBITIONS

Trust Strategy

Purpose

THE PATIENT AND CHILD FIRST
Improving the health and wellbeing of our patients, children and communities

Ambitions

- BEST QUALITY, SAFEST CARE
- PERSON CENTRED, INTEGRATED CARE; STRONG PARTNERSHIPS
- GREAT START IN LIFE

AT OUR BEST: MAKING HDFT THE BEST PLACE TO WORK
Our KITE Behaviours

KINDNESS | INTEGRITY | TEAMWORK | EQUALITY

Enabling Ambitions

- AN ENVIRONMENT THAT PROMOTES WELLBEING
- DIGITAL TRANSFORMATION to integrate care and improve patient, child and staff experience
- HEALTHCARE INNOVATION TO IMPROVE QUALITY

AMBITION

Best Quality, Safest Care

EVER SAFER CARE
through continuous learning and improvement

EXCELLENT OUTCOMES
through effective, best practice care

A POSITIVE EXPERIENCE
for every patient by listening and acting on their feedback

Our ambition is to provide the best quality, safest care, where quality is defined by safety, effectiveness and patient experience.

Through continuous learning and improvement we will make our processes and systems ever safer – we will never stop seeking improvement.

We want excellent outcomes for our patients and the children and young people we support which improve their health, wellbeing and quality of life – we will do this by providing effective care based on best practice standards.

We want every patient, child and young person to have a positive experience of our care – we will do this by listening and acting on their feedback to continuously improve.

Caring at Our Best (Quality Programme)
Priorities and objectives agreed each year to improve towards our goals

AMBITION

Person Centred, Integrated Care; Strong Partnerships

THE BEST PLACE FOR PERSON CENTRED, INTEGRATED CARE

AN EXEMPLAR SYSTEM FOR THE CARE OF THE ELDERLY and people living with frailty

EQUITABLE, TIMELY ACCESS TO BEST QUALITY PLANNED CARE

For Harrogate and District, our ambition is to support person centred, integrated care through strong local partnerships.

Our goal is for Harrogate and District to be recognised as an exemplar for person centred, integrated care to ensure that patients get the right care, from the right staff, in the right place.

With an increasingly elderly and frail population we will prioritise providing the highest quality care and best outcomes for this group, while ensuring that all our patients also benefit from the services and approaches for the elderly and those living with frailty.

By increasing our capacity and productivity, we will reduce waiting times for planned care and ensure that there is equitable access for all.

Planned Care Programme
Urgent & Emergency Care Programme
Priorities and objectives agreed each year to improve towards our goals

AMBITION

Great Start in Life

THE NATIONAL LEADER FOR CHILDREN AND YOUNG PEOPLE'S PUBLIC HEALTH SERVICES

HOPES FOR HEALTHCARE:
services which meet the needs of children and young people

HIGH QUALITY MATERNITY SERVICES
with the confidence of women and families

HDFT is the largest provider of public health services for children and young people in England supporting over 500,000 children and young people to have a great start in life.

We have the opportunity to lead the development of children and young people's public health services, sharing our expertise to benefit children nationally.

As a district general hospital we often care for children and young people in our adult services so we will ensure that every service meets the needs of children and young people by implementing the 'Hopes for Healthcare' principles co-designed with our Youth Forum.

Providing high quality, safe care and a great patient experience for mothers and their babies, and ensuring they and their families have confidence in that care, is the beginning of a great start in life.

Children & Young People's Programme
Priorities and objectives agreed each year to improve towards our goals

AMBITION

At Our Best – Making HDFT the Best Place to Work

LOOKING AFTER OUR PEOPLE: physical and emotional support to be 'At Our Best'

BELONGING: teams with excellent leadership, where everyone is valued and recognised; where we are proud to work

NEW WAYS OF WORKING: education, training and career development for everyone

GROWING FOR THE FUTURE: the right people with the right skills in the right roles

Our People & Culture Strategy, 'At Our Best', follows the NHS People Plan themes and our teamHDFT 'KITE' values and culture.

Our ambition is to make HDFT the best place to work. We will provide physical and emotional support to enable us all to be 'At Our Best'.

We will build strong teams with excellent leadership and promote equality and diversity so everyone is valued and recognised and we are all proud to work for HDFT.

We will offer everyone opportunities to develop their career at HDFT through training and education.

We will design our workforce, develop our people, recruit and retain, so we have the right people, with the right skills in the right roles to provide care to our patients and to support our children and young people.

At Our Best (People & Culture Programme)
Priorities and objectives agreed each year to improve towards our goals

ENABLING AMBITION

An Environment that Promotes Wellbeing

A PATIENT AND STAFF ENVIRONMENT THAT PROMOTES WELLBEING

AN ENVIRONMENT AND EQUIPMENT THAT PROMOTES BEST QUALITY, SAFEST CARE

MINIMISE OUR IMPACT ON THE ENVIRONMENT

The environment in which we work or are cared for has a huge impact on our physical and emotional wellbeing.

At HDFT we will continuously improve our estate and our equipment to promote wellbeing and enable us to deliver the best quality, safest care. We will prioritise investments and design new facilities to promote wellbeing and best quality.

As the largest employer in Harrogate and District, and covering a huge footprint across the North East and Yorkshire, we have an important leadership role in reducing our impact on the planet through our buildings, energy use, transport and food. We will build on our strong track record to continuously reduce our impact on the environment and achieve net zero carbon by 2040.

Environment & Sustainability Programme
Priorities and objectives agreed each year to improve towards our goals

ENABLING AMBITION

Digital Transformation

To Integrate Care and Improve Patient, Child and Staff Experience

SYSTEMS WHICH ENABLE STAFF TO IMPROVE THE QUALITY AND SAFETY OF CARE

TIMELY, ACCURATE INFORMATION
to enable continuous learning and improvement

AN ELECTRONIC HEALTH RECORD
to enable effective collaboration across all care pathways

Our ambition at HDFT is provide digital tools and services which make it easier for us to provide the best quality, safest care and which help us provide person centred, integrated care that improves patient experience.

Digital technology is an essential part of delivering high quality healthcare, but it is also important to remember that it is a tool, not an end in itself. Through digitisation we can collect huge amounts of data about our services – we will increase our ability to create useful information which enables us to learn and continuously improve our services.

Over the next few years, we intend to implement a new electronic health record which will revolutionise how we provide care.

Digital Programme
Priorities and objectives agreed each year to improve towards our goals

ENABLING AMBITION

Healthcare Innovation to Improve Quality and Safety

To be a leading trust for the **TESTING, ADOPTION AND SPREAD OF HEALTHCARE INNOVATION**

To be a leading trust for the **CHILDREN'S PUBLIC HEALTH SERVICES RESEARCH**

To increase **ACCESS FOR PATIENTS TO CLINICAL TRIALS** through growth and partnerships

As a district general hospital and the largest provider of children's public health services in England, HDFT has two key opportunities.

First, to use our agility to become the first choice for testing healthcare innovations to improve care for patients. We will develop partnerships with industry, academia, government, the voluntary sector and our local system to offer a real world testbed for healthtech and digital innovations.

Second, to use our size and expertise to be the leading NHS trust partner for research in children's public health services.

In addition access to research and clinical trials improves quality and outcomes for patients so we will increase access for our patients through more clinical trials at HDFT and through partnerships with our Clinical Research Network.

Innovation and Research Programme
Priorities and objectives agreed each year to improve towards our goals

Conclusion

Everything we do at HDFT is focussed on the patients and children we serve.

We exist to improve the health and wellbeing of our patients, children and communities by:

- providing the best quality, safest care;
- offering person centred, integrated care through strong partnerships; and
- supporting children to have a great start in life.

Because healthcare is provided by people for people, we want to be the best place to work:

- where we are supported physically and emotionally;
- where everyone belongs to a well-led team and is valued and recognised;
- where everyone can develop themselves and their career; and
- with the right people, with the right skills, in the right roles.

To support our people we will:

- provide an environment that promotes patient and staff wellbeing;
- digital transformation will enable integrated care and improve patient and staff experience; and
- we will encourage innovation and research to improve quality.

We will be an organisation where everyone demonstrates our values of KITE (Kindness, Integrity, Teamwork and Equality), to care for the patients and children, who are the focus of everything we do.

www.hdft.nhs.uk
www.harrogateintegratedfacilities.co.uk

teamHDFT At our best

HIF HARROGATE INTEGRATED FACILITIES Taking Pride in our Services

NHS Harrogate and District NHS Foundation Trust

Published September 2022

22/23 Strategic Objectives

Ambitions, Programmes & 22/23 Strategic Objectives

Best Quality, Safest Care	Person Centred, Integrated Care; Strong Partnerships		Great Start in Life	At Our Best: making HDFT the best place to work	An environment that promotes wellbeing	Digital transformation to integrate care and improve experience	Healthcare innovation to improve quality
Caring at Our Best (Quality)	Elective	UEC	Children & Young People	At Our Best (People & Culture)	Environment	Digital	Innovation & Research
Theatres Safety	Wharfedale (TIF1) Theatres	ED Streaming	Children's PH Services Strategy	Looking after our People	Green Plan (incl SALIX)	Digital Maturity	Harrogate Innovation Hub
Pressure Ulcers	HDH (TIF2) Theatres	ED Reconfig (Fit2Sit; RIAT)	Children's PH Services Op Model	Belonging	Deliver 22/23 ED Reconfig Plant Rooms Wellbeing	EHR	NIHR portfolio research delivery (clinic space)
Falls Prevention	Outpatient Transform-ation	ED/Ac Med Flow (incl Acute Care AOB)	Hopes for Healthcare	New ways of working		Priority Digital Projects	Children's PH Services Research
Results of Clinical Investigations	Theatres Productivity	Virtual Ward Expansion (incl 2 Hr Response)	Maternity (Ockenden etc)	Growing for the Future	Plan 23/24 Wensleydale Aseptics CT ED2 TIF2	Data & Information	
Medication Errors							
Patient Communi-cations							

Programme Leadership & Governance

Programme	SRO (Accountable)	2nd Exec	Board Committee	Management Group
At Our Best (People & Culture)	Angela Wilkinson	Emma Nunez	People & Culture	Workforce Board (New)
Caring at Our Best (Quality)	Emma Nunez	Jackie Andrews	Quality	QGMG
Elective Recovery	Russell Nightingale	Kat Johnson Matt Shepherd	Resources	Elective Board
Children & Young People	Matt Graham	Natalie Lyth	Children's PH Services Board Working Group	C&YP Board
UEC	Russell Nightingale	Emma Edgar Matt Graham	Resources	UEC Board
Environment	Matt Graham	Jordan McKie	Resources	Environment Board (1st meeting 27 Sep)
Digital	Jackie Andrews	Matt Shepherd	Innovation Committee	Digital Board (New) EPR Prog Board (New)
Innovation & Research	Jackie Andrews	Matt Graham	Innovation Committee	R&I Board

WEST YORKSHIRE ASSOCIATION OF ACUTE TRUSTS

PROGRAMME EXECUTIVE MEETING NOTES AND ACTIONS

Tuesday 5th July 09:30-12:30
Microsoft Teams

Item	Notes and Actions
1.	**Apologies and Attendees** Julian Hartley, Chair (LTHT) Brendan Brown (CHFT) Jonathan Coulter (HDFT) Trudie Davies (MYHT) John Holden (BTHFT) Foluke Ajayi (ANHST) Lucy Cole (WYAAT)
2.	**Actions and Minutes** The minutes from the previous meeting were accepted as a true record. The action log was reviewed, and the following updates were given: Action 57 – *LC to arrange attendance at each Trust's Executive Team Meeting* – Lucy Cole (LC) confirmed that she is still awaiting a date for ANHST. Action 58 – LC to bring recommendation on clinical leadership within WYAAT to a future Programme Executive. – LC informed the members that this will be held in the Programme Executive meeting slot for September. Action 61 – *MP to discuss the maternity issues with the WY Place Leads and Rob Webster and feedback to the group.* – It was confirmed that Bev Geary is to hold a meeting on this subject and Mel Pickup has been invited to the discussion.
3.	**WYAAT Collaborative Programme Report** LC gave the following updates in regard to the WYAAT Collaborative Programme Report: • Pharmacy asepetics: Allocation of £24m will support aseptics programme as well as Bradford Teaching Hospitals with an aseptic site. LC informed the group that the aseptic board is meeting and discussions to move forward to identify the full solution (including the site of the second hub) is being held. • Outpatients – Programme is thinking about how to get to position by end of March and these actions have been taken to the ECG. LC informed the group that the citizens panel restarted a year on from when first met still work to do about communications with patients that are on the waiting list. • Diagnostics – shared reporting solution - technical issue on reporting multi body part issues and the way the PACS been set up and reporting information on the multiple body part – looking at these issues and testing these issues. LIMS – potential in delay for deployment -12 July deadline date for the information to then see what delay we might possibly have.

Item	Notes and Actions
	• NSO – COOs had discussion about managing the transition – about seeing patients and sustainable service. Agreed to do longer timeout session for operational colleagues to work through this. • CDC – business case writing stage – on track to have cases submitted by the end of this month. Trudie Davies said that within planned care update there is a line about financial value and funding – this might not illustrate the level of risk.
4.	**WY HCP Report** *The WY HCP Report was noted by the members.* LC raised that there is a lot of working ongoing around the virtual wards at place level. LC informed the members that they have been approach by Ashley Moore to gain interest as to WYAAT leading this work at a West Yorkshire level. LC noted that she felt this work should be focused at Place rather than at ICS level, other than facilitating sharing of best practice across clinical teams. Programme Executive agreed that the approach should be focused at Place and there little value in creating a WYAAT-level programme.
5.	**Update on National Improvement work** Following Amanda Pritchard's speech JH outlined his role nationally on developing an improvement approach. Julian Hartley (JH) asked the members to share their thoughts on the improvement work. Brendan Brown (BB) wondered where GIRFT was involved in this and how do we bring what we have already on working together. BB added that there is an opportunity to pave the way as a collaborative. TD said that the big success in this area has been where we have had clinical leaders, but there isn't any bespoke support or training which could be beneficial to help drive this work. TD also added that the measurement of outcomes and outputs is missing. Jonathan Coulter added that there is a struggle with capacity of the facilitators and prep work to support improvement approaches. There was agreement that a single national methodology would not be appropriate and all existing improvement methodologies had comparable content and merit. JH if Chief Execs would be willing to showcase the work across the trusts and discuss with NHSE. There was support for this approach.

Item	Notes and Actions
6.	**Digital Pathology Business Case** • **Confirm support for progression to WYAAT CIC** *Bash Hussain, Darren Treanor, Ian Mason joined the meeting.* *The presentation which was circulated with the papers was shared.* Len Richards (LR) confirmed that the Diagnostics Board had supported the case and this was an area in which WYAAT was at the forefront and this offered future opportunity for the use of assistive AI. *The members supported the business case and are happy for the business case to progress to Committee in Common.*
7.	**Evolving the WYAAT approach to risk management** *Rob Kurau joined the meeting.* The presentation which was circulated to the members were shared and the following points were discussed: • Maturing our Risk Management Capabilities, a collaboration with the private sector • Our Risk Management Framework • Our Common Risk Language • Evolving our Risk Appetite approach • Next steps and future developments • How may we collaborate further across WYAAT? The following support to individual trusts were outlined: • Risk management maturity reviews for each Trust CEO • Risk networking events between Trust risk professionals to share expertise • A common risk language to add greater structure to Trust risk management frameworks • Risk & control guidance to help Trusts improve how they describe their risks • A consistent Board-level approach to risk appetite for each Trust The following support to WYAAT was discussed as below: • Risk escalation procedure to provide guidelines as to when Trust risks should be escalated • Quarterly risk profile reporting between Trusts to show similarities and differences between Trusts • WYAAT risk & control self-assessment to evidence that its risks are being managed effectively JC noted that it would be useful to share each Trust's risk appetite profiles to support with collaboration.

Item	Notes and Actions
	There was interest in further exploring the work from a number of members of the group. **Action: LC to share RK's contact details with CEOs.** *The members support the update on WYAAT & Risk Management.*
8.	**Finance Update** • **Current position / risks** • **Efficiency Strategy** *Gary Boothy (GB) joined the meeting.* GB highlighted the current financial position at Month 2. The Programme Executive specifically discussed the pressures related to delivery of elective activity and achieving the 104% value weighted level of activity. TD highlighted that Trusts were focused on reducing long-waiting patients which didn't necessarily map to those specialties / procedures attracting a higher financial weighting. GB described the work that the WYAAT DoFs group had commenced in developing an efficiency strategy. The focus of this work was to utilise benchmarking information to identify opportunities for waste reduction initiatives at an organisational, Place and WYAAT level. GB noted the intention to complete this work in September to share with WYAAT executive teams and gain support for the approach. *The members supported the efficiency strategy work.*
9.	**Fragile Services** • **Findings from Haematology and Neurology reviews** *Asfia Ali & Sal Uka joined the meeting.* *The presentation which was circulated to members was shared & discussed.* The following conclusions were made for Neurology: • **Propose WYAAT programme for Neurology services** Including: – *Service planning for acute in-patient and out-patient pathways* – *Workforce recruitment and transformation* – *GIRFT – NHSEI Neuro Transformation Programme* – *Health inequalities* • Pre-referral and Pathway Optimisation across Places and partner organisations • Neurophysiology adequate service – align opportunities with neurology transformation • **Propose more immediate actions:** – Establish Clinical Reference Group – Co-ordinated procurement of the independent sector (new patients) – Clinical validation of FU patients – Mutual Aid for ASI and RTT backlog

Item	Notes and Actions
	The following conclusions were made for Haematology: • Evidence of some fragility in WY but insufficient to warrant whole system change • Explore and enable options to support service fragility in Harrogate • Support ongoing collaboration between Airedale and Bradford • Consider review of sub-speciality services • Continuous review of NSO impact *The members support the work and this will now be shared at the Committee in Common meeting.*
10.	**Draft Annual Report** • **Confirm support for progression to WYAAT CIC** The members supported the Annual Report for progression to the WYAAT Committee in Common.
11.	**Letters of Support (Drafts for Approval)** • **LTHT (OBC Hospitals of the Future)** • **MYHT (Teaching Hospital status)** *The members approved the letters.*
12.	**Committee in Common Draft Agenda** *The members agreed the CIC draft agenda.*
13.	**AOB** No AOB was raised.
Meeting Close	
Date and time of next meeting: 2 August 2022, 0930-1230 MS Teams	

Humber and North Yorkshire
Health and Care Partnership

Collaborative of Acute Providers (CAP) Board Meeting
25th April 2022 9.30 – 11.30
Via Teams

Those Present: Chris Long (CL), CEO HUTH (Chair)
Simon Morritt, CEO Y&STFT
Jacqueline Myers (JM), Director, HCV CAP
Wendy Scott (WS), COO, Y&STFT
Peter Reading (PR), CEO, NLaG
Shaun Stacey (SS), COO (NLaG)
Jonathan Coulter (JC), CEO HDFT
Michelle Cady (MC), Director of Strategy & Planning (HUTH)

Attendance: Sallie Shields, Elective Recovery Programme Manager (SS) (Note Taker)

1 **Apologies:** Ivan McConnell (IMc), Director of Strategic Development, NLaG

2 **Minutes of the meeting held on the 24th January 2022**
All pages agrees as a true record.

3 **Anchor update:**
A paper has been distributed and MG gave an update on this, a meeting of the 4 Trusts was held on 8/4 and after more detailed discussions it was agreed that all trusts are in a similar position. The main areas for opportunities are procurement and Estates contracts. Procurement – MG is to look for regional and national examples of good practice that can be used, Estates contracts-local employment is to be encouraged and reflected in the updated strategies including equality and inclusion. There is no ICS network set up as yet as work is being done with individual Trusts, the plan is then to draw them together under a network group.MG is to connect with Corinna Ellis. Next steps more understanding of the good work in the wider systems is required. MC told the group that HUTH are reflecting employment in the strategic delivery framework and measuring how progress is being made at place. Matt to update the group in 4 months (September meeting).

4 **Work Plan:** draft plans have not been discussed with Coo's as yet. JM will discuss with COO's and sign off for the next meeting. Comments from this group to JM please.

5 **CAP Director Report:** JM gave the highlights – the green light for development has been agreed. JM is leaving her post at the end of May. Briefing papers have been sent to the 4 Trusts, with a view to setting up governance – Chief Execs to let JM know their leads please.

Humber and North Yorkshire
Health and Care Partnership

ICS transition – no update
More place locality directors have been appointed. The Director for Elective Recovery interviews are being held this Thursday (28/4) with 4 external candidates being interviewed. There have been no applicant for the deputy post to JM.

Out Patient planning –SE assurance meeting attended by JM, progress since 1st draft has been noted 103% of 104% activity accepted. 104 week target discussed, trajectory for 0 by the end of June, risks were noted, specifically in Orthodontics who may not have a clock stop until 4-5 appointments have been held.
The financial gap £60 million, hope sof additional funding for exceptional activity/work. The final submission is 28/4

Newton Europe the report was delivered on the last day of the contract, leaving no opportunity to discuss the findings, which in essence are what the ICS has been working on. The BI and Information teams are working on 3 year forecasting and this work will be carried on. Feedback on Newton Europe performance was requested to be given to the regional team.

Community Diagnostic Hubs – Chris O'Neill is to provide a report on progress to JM.

4 Action tracker
The action tracker was updated following the meeting and will be circulated with the minutes.

5 Any other Business
A meeting will be held around the replacement for JM and what the Trusts will be looking for in the person appointed.

SS reported that a 2nd follow on meeting has been held as part of the Newton Europe work on Clinical Alliances. A report will be ready for the June CAP meeting. To be added to the June agenda.

Board of Directors (Public)
28th September 2022

Title:	Review of Treasury Management Policy
Responsible Director:	Jordan Mckie
Author:	Neil Outhwaite

Purpose of the report and summary of key issues:	The Trust's Treasury Management Policy has been reviewed by the Audit Committee (September 2022). The Audit Committee approved the policy and recommended onward approval by the 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	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.	
Report History:		
Recommendation:	To approve the attached Treasury Management Policy.	

14

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
18	Aug 2022	12 month review of Policy	August 2023

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 Board of Directors Board of Directors	May 05 – Jan 15 Oct 2015 Sep 2016 Aug 2017 Sep 2018 Oct 2019 Nov 2020 Nov 2021

CONTENTS

1 INTRODUCTION

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

Treasury Management includes the management of:

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

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

2 AIMS AND OBJECTIVES

The Treasury Management Policy aims and objectives are:

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

3 KEY RESPONSIBILITIES AND CONTROLS

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

The Finance Director is responsible for the following:

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

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

4 INVESTMENTS

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

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

- UK Government Departments and Agencies (excluding those contracted out to the private sector).
- Local Authorities.
- Banks, Building Societies and any similar institutions granted permission to trade by the Prudential Regulatory Authority (PRA) 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 1.75%, 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