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, the Health & Safety Risk has been updated to include new high level risks, with a combined High Level risk of 16. Nursing Shortages (CRR5) remains a High Level risk, however mitigation is in place. A new risk has been included around insufficient staffing for the special care baby unit; this is scored at a High Level risk of 12.					
Initial Date of Assessment	1st July 2022						
Last Reviewed	22nd December 2022						

Strategic Ambition	Corporate Risk ID	Principle Risk	Key Targets	Current Position (December 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 NHSE/I bid for increased international recruitment - 60 in total at the higher tariff to commence January'23 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 between June '22 and January '23. There has been a development of 'bootcamp' style courses in preparation for OSCES Refreshed recruitment and retention operational group recommenced in June with two focused task and finish groups established – one for recruitment and one for retention. Working with Directorates re bed bases / establishments and staffing models including principles for changing WFM's to provide additional support to the ward/ departments	Focus on recruitment and retention and effective roster practice As specialty areas fill their vacancies and risk reduces, this will be reflected in local risk registers Likely to continue with risk for some time until newly qualified staff begin to emerge from undergraduate programmes.	**(4x2) - 8**	**(4X4) - 16**

				Focused work on HealthRoster KPIs and performance of effective rostering practice Focused work on additional roles to support nursing, business case being produced Preceptorship programmes to retain newly qualified and new starters refreshed Successful Bid for 2 x 0.5 wte Legacy Mentors to support retention from NNHSE Working with Directorates re: bed bases / establishments and staffing models including principles for changing WFM's to provide additional support to the ward/ departments Focused work on HealthRoster KPIs and performance of effective rostering practice Focused work on additional roles to support nursing, business case being produced. Workforce governance approved at Review group for all of above			
An Environment that promotes wellbeing	CRR75: Health and Safety (CHS1, CHS2 CHS3, CHS4 & CHS8)	Organisational Risk to compliance with legislative requirements due to a failure to make a suitable and sufficient assessment of the risks to the health and safety of employees, patients and others.		Trust / HIF currently use SALUS H&S folders. These are used sporadically across both the Trust and HIF. Suitability of the assessments that exist means few are meeting legislative requirements or relevant guidance. Majority of the assessments are out of date and do not reflect current practices or relevant guidance. Auditing of the folders by SALUS, has not taken place since October 2019 (contract now expired). Previous reports were primarily a tick box exercise rather than a detailed review of content. Audit Yorkshire Report (July 2021) found that RA's were in some cases 10 years out of date, and that oversight and governance of SALUS was not operating effectively. All hazards not being identified and subsequently assessed, and therefore the Trust / HIF is failing to ensure suitable measure are being taken to protect the health and safety of its employees, patients and others who come in to contact with our activities. Meeting held with Finance manager to confirm next steps – potential to use existing budget that had been created for admin support in H&S Team Procurement to provide analysis to support business case Digital project support to be identified. Discussions held with other NHS Trusts currently using EVOTIX to assist with rollout. H&S Team receiving more frequent contact regarding SALUS, additional TRUST wide communications to be done H&S team will respond on a case by case basis to immediate concerns.	H&S team is reviewing current risk assessment provision. Temporary control measures are being created where possible. Meetings held with provider (EVOTIQ) to purchase a new digital risk management system to replace SALUS. This is a system used by multiple NHS Trusts and will provide a user friendly system, accessible to all Trust / HIF employees that will facilitate the achievement of the above conditions. Business case being developed for the purchase of EVOTIQ (approx. cost is 23k annually). ***Action:*** ***To ensure that new alternative to SALUS will be able to link into Datix, if possible.*** ***Action:*** ***Risk score to be amended to 16 given mitigations which are in place.***	**(2x4) - 8**	**(4x4) - 16**
		Organisational risk to compliance with legislative requirements, with the risk of major injuries, fatality, or permanent disability to employees, patients and others, and the unauthorised access of persons to restricted areas		Risk assessment completed for the goods yard. Temporary measures have been implemented: Security guard (Mon-Fri 8am – 6pm) Temporary heras fenced walkway to access Pharmacy lift and stairwell. Instruction to all Trust staff made via email and Team talk. Use of his-vis clothing for those that need to routinely access the yard as part of their duties. Instruction to contractors that the yard area is not to be used as a car park, delivery drop off / collection only. Loading bay entrance remains unsecure 24/7 as doors do not close. Particular security issue on an evening / during the night when staff presence is limited and access remains open to patients and others.	Capital investment will be required to implement all control measures identified within the risk assessment. Including: Security barrier. Permanently marked / protected walkways for pedestrians. Resurfacing of the yard area. Replacement of the loading bay doors. Swipe card access to estates area from within HDH Matter to be raised at Environment Board 24/1/23 as to whether the work can be included in the 23/24 Estates programme.	**(2x4) - 8**	**(3x4) - 12**

		of the hospital through the loading bay entrance.			Risk assessment to be reviewed every 3 months ***Action:*** ***The likelihood of this risk can be reduced (3x4). Change risk to a 12.***		
		Organisational risk to compliance with legislative requirements, with the risk of major injuries, fatality, or permanent disability to employees, patients and others, and the unauthorised access of persons to restricted areas of the hospital through the loading bay entrance.		Fire risk assessments are not currently available for all areas of HDH, content and quality is sporadic. Ward changes made over the last 2 months are yet to be reflected in an updated fire risk assessment or evacuation procedure. Communication of information to all relevant persons is not currently happening. Use of Fire Wardens is again sporadic. The assessment of contractors and construction work is not being reflected consistently in Trust fire assessments or evacuation procedures. Corridors, escape routes and exits continue to be blocked. Fire doors regularly found wedged open on Wards. Identification of fire compartmentation and fire doors at HDH is not in place. Testing of fire procedures is inadequate. No clear picture of the Fire safety standards in properties leased by the Trust.	Review of all current fire provisions by HIF and the H&S team External provision being sourced to provide, competent advice, Fire Manager and Authorising Engineer. Review of HDH fire compartmentation being carried out, to result in action plan for required remedial work. New fire safety policy and management protocols have been drafted. Fire risk assessments being completed for all HDH areas by external consultant. Corridor management protocol is being established to ensure beds etc. are removed in a timely manner. New Stores delivery process is in operation, stores being delivered and decanted on to the wards at the same time. SLA now in place with Leeds Teaching Hospitals NHS Trust (LTHT) to provide fire safety advice / management (including review of all fire risk assessments, dedicated weekly time from the Fire Manager, full access to Leeds Fire team, 24hr access to AD / Fire engineer) External provider has produced 20 fire assessments (approx. 100 to be carried out), these are being reviewed by LTHT Review meeting of progress by external provider 25/1/23 **Action:** **The risk score needs to be reduced to a 16 down from 20. (4x4).**	**(2x5) - 8**	**(4x4) - 16**
		Organisational risk to compliance with legislative requirements, with the risk of major injuries, fatalities, or permanent disability to employees, patients and others, due to the failure to manage the impact of contractors, and construction work at Trust premises.		Control of contractors on site is not consistent, examples of failings include corridors being blocked by contractors working in roof voids. Uncontrolled access to restricted areas (plant rooms, HDH roof), subsequently being left unsecured and accessible by any other person. (near miss of patient accessing roof above Wensleydale - summer 2022) Trust has failed to appoint a competent Principal Designer for any of the current construction projects at HDH, and has therefore accepted the legal duties of the Principal Designer by default. Salix / Plant rooms scheme has in effect been operating without a Principal Designer, and subsequent programme delays related to design issues have resulted. Trust hasn't established agreed fire protocols with the various contractors currently on site.	Review of all current contractor procedures required by HIF / H&S team / Planning Temporary overview of Salix / Plant rooms work by Heads of Estates, Health and Safety, including attendance at site meetings, progress meetings. New fire protocols for raising the alarm agreed for Salix / Plant room work, new fire routes agreed and implemented for Imaging Services and Chapel. Work being done jointly HIF, H&S and Capital Design Team to agree the process, through Environment Board, for the management of all future construction projects. External consultant has been identified, costs being provided, to carry out part of the Principal Designer role, and produce the	**(2x4) – 8**	**(4x4) – 16**

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<td>Organisational requirements, with the risk of major injuries, fatalities, or permanent disability to employees, patients and others, due to the failure to manage the risk associated with RAAC roofing.</td>
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<td>WSP contracted to conduct survey of RAAC roof at HDH site, including unique identification, deflection survey (ongoing).
Temporary supports were installed to RAAC roof on corridor outside Nidderdale as part of Breathe work. (costs to replace this roof to be provided by Breathe (January 2023)
RAAC roof to kitchen plant room – costs to replace this roof as part of Salix scheme (quote January 2023 – remove March 2023)
Currently x3 areas with panels requiring immediate action (x5 panels in Estates/Stores area, x6 panels in Therapy Services, Emergency corridor at the bottom of Swaledale)
DECISION REQUIRED REGARDING OCCUPANCY OF THESE AREAS UNITIL REMEDIAL TAKEN. Decision taken 23/12/22 – access prohibited to all areas apart from x2 areas in DSU, ongoing risk accepted against operational loss

Additional at risk panel identified in corridor between ITU and Farndale
All remedial work to be completed on a weekend to limit impact on operational activities
Remedial work by Whitaker & Leach commenced 7/8 January and will continue each weekend until complete.
x2 panels now protected in Therapy Services and Silverdale.
Work will continue 14/15 January with work to utility/dirty room in DSU, and ITU/Farndale corridor.
Work on x2 panels in Opthalmic area of DSU was started on 7/8 January, however complications with the services meant original design could not be implemented – structural engineer (WSP) to identify new solution, engineer attending site on 13/1/23.
Deflection survey by WSP to commence on 15 January and will continue each Sunday until complete, Whitaker & Leach to assist surveyor removing / replacing ceiling.
Funding of £490k secured from NHSE for 22/23, which will cover costs already incurred, surveying and remedial work being carried out.</td>
<td>Health & Safety file at the conclusion of the Salix / Plant rooms project.
Heads of H&S and Estates continue to attend regular site meetings to mitigate immediate concerns re PD role.
Trust / HIF decision regarding the role of Principal Designer to be raised / discussed at Environment Board 24/1/23

Action:
It was confirmed that the overarching risk score for Health and Safety would be a score of 16

Damian Quinn has joined the regional NHS RAAC group to access support (including access to central funding)

Contracted WSP to carry out the identification and surveying of the RAAC roofing at HDH Funding request of £700k has been requested from the central (NHSE) fund to cover the costs of immediate actions.

WSP to design temporary engineering solutions for panels / areas at risk of collapse. Cost requested from Whittaker & Leach to install temporary supports. (Estates / Stores area)

Task group to be established, via Environment Board. Head of Estates and Head of H&S to lead.</td>
<td>(2x4) - 8</td>
<td>(4x4) - 16</td>
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<td>Best Quality, Safest Care</td>
<td>CRR73 – Insufficient staffing for special care baby unit</td>
<td>Insufficient capacity to meet the key national safety standard of a Qualified in Specialty (QIS) staff member on every shift and 70% of the establishment (8.3wte) qualified on Special Care Baby Unit (SCBU).</td>
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<table>
<tr><td colspan="2">Establishment</td><td></td><td>January Plan</td><td>February Plan</td><td>March Plan</td><td>April Plan</td><td>May Plan</td><td></td></tr>
<tr><td></td><td>Budget</td><td>Amended budget plan</td><td>QIS</td><td>QIS</td><td>QIS</td><td>QIS</td><td>QIS</td><td>Minimum QIS Standard 70%</td></tr>
<tr><td>B5</td><td>8.81</td><td>6.20</td><td>3.22</td><td>4.14</td><td>4.14</td><td>4.14</td><td>4.14</td><td>2.75</td></tr>
<tr><td>B6</td><td>3.01</td><td>5.62</td><td>3.52</td><td>3.52</td><td>4.30</td><td>4.30</td><td>5.52</td><td>5.52</td></tr>
<tr><td>Total</td><td>11.82</td><td>11.82</td><td>6.74</td><td>7.66</td><td>8.44</td><td>8.44</td><td>9.66</td><td>8.27</td></tr>
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There is planned ward QIS cover on each shift but very limited ability to react to short-notice sickness/absence, even with the shift incentive. Colleagues with QIS across wider HDFT team are being proactively contacted to identify if they would be willing to support and their training/familiarisation needs to enable increase in bank availability, including offer to cover travel expenses and travel time where contracted bases are not in Harrogate e.g. for Safeguarding nurse with QIS from Middlesbrough.
</td>
<td>Increase in % of substantive establishment with QIS or on development pathway to obtain QIS

Increase of available bank/agency QIS nurses to support SCBU

B6 recruitment

Action:
The wording relating to the current position needs to be reviewed.</td>
<td>(2x4) – 8</td>
<td>(3x4) - 12</td>
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				3 newly appointed B5 postholders are being supported to achieve their QIS, two are newly qualified so will commence their training when in post – they will need to complete foundation level first so development will take approx. 2years. The third has completed their foundation level. We are exploring whether a derogation of duties could apply to this third colleague whilst they complete their training to gain their QIS. Recent retiree with QIS has returned on zero hours contract for 12months to support – is currently working 0.61wte. SOP for QIS gap ratified at OMG 14/10/22 following input by Maternity services and clinical input from Paediatrics & CC Directorate clinical leadership and available to on call managers/directors Fostered solid relationships with current staff therefore staff have willingly regularly worked NHSP shifts as well as being flexible with their substantive shifts to maintain the QIS cover. Workforce & Education strategy for SCBU has been drafted in line with ODN strategy to support embedding of regional objectives to support colleague retention. Reviewed the opportunity to operate a shadow rota – unfortunately only 2 substantive staff members have confirmed they would be willing with a significant incentive. Not feasible to put into place. Business case being worked up to make permanent the agreed B5 to B6 changes already implemented and for creation of a B7 clinical educator/safeguarding lead post to support the retention strategy.			

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 are no Corporate Risks that link to this domain.					
Initial Date of Assessment	1st July 2022						

Last Reviewed	22nd December 2022						
Strategic Ambition	**Corporate Risk ID**	**Principle Risk**	**Key Targets**	**Current Position (2022)**	**Plans to Improve Control and Risks to Delivery**	**Risk Rating Target (CvL)**	**Risk Rating Current (CvL)**

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 Risk within this Domain. The impact of COVID and Operational Pressures on workforce wellbeing (previously wellbeing of staff) (CRR6) remains a High Level risk at 16. 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	22nd December 2022						

Strategic Ambition	**Corporate Risk ID**	**Principle Risk**	**Key Targets**	**Current Position (December 2022)**	**Plans to Improve Control and Risks to Delivery**	**Risk Rating Target (CvL)**	**Risk Rating Current (CvL)**
At Our Best – Making HDFT the Best Place to Work	CRR6: The impact of Covid and Operational Pressures on Workforce Wellbeing	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	Inpulse engagement scores National Staff survey scores: Engagement, morale, Sickness absence levels Turnover Vacancy rate	• **Staff Engagement** Awaiting results of national staff survey, Inpulse not run in September due to this. • **Turnover** Turnover is high for HDFT, at 15.76% against a target of 12%. There has been a slight decreased this month from 15.83% to 15.62% as of 31st December against the target of 12% but relative to private sector organisations low – work on retention to stem the flow of colleagues leaving the organisation is a priority. Work on retention of Health Care Support workers is underway, enabled by external funding from NHSE for a temporary Band 4 post.	A number of Financial supports are in place to assist colleagues with escalating cost of living. These include some of the following welfare fund, additional 10p per mile (fuel costs), free car parking. A wide range of Financial Wellbeing resources available on Living at Our Best pages of the Internet. Flu and Covid Vaccines available for all colleagues since September 2022 until January 2023. Current vaccination levels have increased from last month to 62.7% for Covid and 58% Flu.	**(3x4) - 12**	**(4x4) - 16**

				• **Sickness Absence** At 5.65% Sickness absence is has increased from the previous month's figure of 4.88%. Overall, Covid related sickness has reduced however cold/flu sickness has increased across all directorates, in particular LTUC • **Vacancy Rate** There has been an increase in vacancy rate from 6.66% last month to 8.36%	Recruitment and Retention groups underway. Wellbeing fund of 0.5 million provided to upgrade working environment. New clinical leadership model in place from December 2022. OD programme to be delivered to support new structure and enable compassionate and inclusive leadership teams who have a strong focus on the delivery of clinical excellence. Inpulse survey feedback to be handled locally by line managers to support increased engagement and morale Health & Safety Team and Occupational Health Team to work in collaboration over conducting an organisational work related stress audit to enable the development of a wider programme of work to be rolled out to directorate and team level around this issue.		

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, this has increased to 16 from 12 and working is ongoing to determine future needs of the service. Numbers on the waiting list has increased from 676, last month to 713. Longest wait has also increased from 53 to 58. 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	22nd December 2022						

Strategic Ambition	Corporate Risk ID	Principle Risk	Key Targets	Current Position (December 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)	It was agreed with commissioners that HDFT would have an autism pathway review day (3/11/22) to agree a proposal which improves pathway and access but also includes waiting list stabilisation/reduction options. This followed a meeting in July where senior commissioners requested joint working to support a new referral pathway and to address waiting lists. It was envisaged this would incorporate learning from two pilots that commissioners had agreed in Scarborough & Selby. Unfortunately this evaluation data was delayed and did not give the benefits for the cost originally envisaged. In addition, NYCC raised concern around any referral pathway proposal which would give SENCOs in schools a higher workload (as per Selby pilot). A further meeting with commissioners to discuss HDFT proposal took place on 8/12/22 with Kirsty Kitching (Mental Health commissioner), Suzanne Bennett (Children's commissioner) and Jacob Gilson (CYP Neurodevelopmental Project Manager with the commissioners). Commissioners were clear at this meeting that they would like to explore the difference in our triage of referrals (HDFT do not accept 7% of referrals in comparison to 35% at The Retreat) and our diagnosis rates. They will be setting up a meeting to undertake a focused piece of work in collaboration with their provider for Scarborough & Ryedale (The Retreat) that looks at drivers for the variation. Commissioners acknowledged that the different referral pathways may account for the differing %'s (The Retreat have GP only referrals, HDFT have referrals from other health professionals). Commissioners acknowledged that given the scale of increase in referrals this work would not address the continued deteriorating waiting list position. However that also stated they do not have funding to support increase in staffing or our updated service model. Commissioners also presented data where they raised concerns at our cost in comparison to their other provider 'The Retreat' – they indicated we were approx. twice the cost. We were able to feedback in the meeting the childhood population figures for all districts (included below for	Executive input & strategic decision around next steps for Autism Assessment service.	**(3X2) - 6**	**(4X4) - 16**

reference) to show that our districts are roughly twice the size of the other provider and our cost per assessment approximately the same.

In summary, the risk is escalating in line with referral demand and waiting list deterioration and with no indication that joint working with the commissioners will deliver additional funding to support the growing demand and waiting list stabilisation.

It was agreed at SMT that the issue would be escalated up the ICB by our Executive team to agree an approach between the Trust and ICB.

HDFT - £528,495 (*ICB felt £74,365 non recurrent WLI was also in the Trust income position for 22/23 but this needs to be followed up with our finance and contracting leads)
Retreat - £250,000

NYCC District	Childhood population (0-19)	Total service population	Provider %	Provider
Hambleton	18600			HDFT
Harrogate & Rural	36000			HDFT
Richmondshire	11700	66300	68%	HDFT
Ryedale	10350			The Retreat
Scarborough	20632	30982	32%	The Retreat
Total	*97282*			

- Numbers on the waiting list: (has increased from last month to 802) last month's figure was 760
- Longest wait: (has increased to 55 weeks) Last month's figure was 53 weeks (excluding exceptions)
- Financial year to date delivery 418 completed assessments against a plan of 420

	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sept-22	Oct-22	Nov-22	*Dec-22 (provisional)*	*Jan-23 (provisional)*
Total incomplete RTT pathways	24,714	25,384	25,134	25,629	25,564	25,490	25,437	25,388	*24,961*	*25,912*
> 52 weeks	1,187	1,196	1,261	1,297	1,297	1,350	1,285	1,201	*1,299*	*1,231*
> 78 weeks	205	184	169	155	144	133	112	100	*120*	*121*
> 104 weeks	11	3	1	0	0	0	0	0	*0*	*0*
RTT new clock starts	6,403	7,219	6,382	6,817	6,917	6,669	6,727	6,869	*5,226*	*2,281*
RTT clock stops	4,290	5,136	5,119	5,244	5,515	5,291	5,655	5,998	*4,563*	*1,231*

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 the impact of Covid 19 (added 13/03/2020)	92% 18 week incomplete performance standard 52+ Waits 78+ Waits (zero by March 23) 104+ Waits (zero by July 22)	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. 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) 34 patients have had their care delivered through this mechanism. The 5th room to support capsule endoscopy remains operational and Endoscopy lists are available seven days per week	**Additional theatre lists at a weekend** Clinicians continue to undertake additional work on a weekend, with lists now being booked for Community Dentistry Paediatric sessions, General Surgery , Ophthalmology and Urology. 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. 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 Limited access to an interim solution through a vanguard theatre at Wharfedale is being progressed to impact quarter 3 2022/3. The independent sector support is being increased with circa 500 cases being delivered in this way.	**(3x2) -6**	**(3x4) - 12**

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<td>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
Ongoing mutual aid across WYATT and more latterly HNY is used to support system clearance of long waiting patients. HDFT have supported both systems.
104 week waiting patients were cleared in advance of the July 2022 deadline. The community dental over 104 weeks is also now zero.
All patients over 88 weeks have a date for surgery. Some of these treatment dates deliver surgery at 99-102 weeks.

78 week waiters (clearance target March 2023)
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. Trajectories by speciality are produced on a weekly basis for achievement of over 78 week waiters.

There are 89 patients still requiring a date for surgery before end of March to reach the zero position. Gen Surgery-19, Urology29, Breast 2, T&O 6, Gynaecology 32</td>
<td>None treatment RTT waiting over 52 weeks is minimal currently with only Gastroenterology, Neurology and specialist gender endocrinology-having patients waiting this long. Recovery plans in gastroenterology and neurology are currently in development.

Validation and real-time updating of RTT waiting lists

The following actions are underway/ completed to improve accuracy of waiting list, which will further reduce the numbers allowing closer scrutiny of genuine waiting patients.

• Standardised Reporting Dashboard : piloted & in place
• Elective recovery meeting: weekly in place, using new data/ format. Directorates implementing equivalent at service level.
• 6:4:2 – booking levels and utilisation improving (confounded by covid absence to some degree)
• RTT out coming: business case and funding are approved and moving forward procurement.
• RTT team – move to embedding in directorates. Final model agreed, consultation with affected staff to commence in next 4 weeks.
• Validation of full waiting list: AI supported validation tool is in place with training being rolled out. This alongside a review of current processes to close the ‘gap’ between clock starts, clock stops and growth in RTT waiting list. RTT team gaining some agency support for a validation exercise in January</td>
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<td>Best Quality, Safest Care</td>
<td>CRR61: ED 4-hour Standard</td>
<td>Risk of increased morbidity/ mortality for patients due to failure to meet the 4 hour standard.</td>
<td>A&E 4 hour standard (below 95% in August 2022)

12 hour DTA breaches (82 in August 2022)

Ambulance Handovers (15 over 30 minute handover breaches and 2 over</td>
<td>A&E 4 hour standard remains below the 95% target.

4 hour performance
<table>
<tr><th></th><th>May 22</th><th>June 22</th><th>July 22</th><th>Aug 22</th><th>Sept 22</th><th>Oct 22</th><th>Nov 22</th><th>Dec 22</th><th>Jan 23 (so far)</th></tr>
<tr><td>Type 1</td><td>62.7%</td><td>66.5%</td><td>65.8%</td><td>60.1%</td><td>57.5%</td><td>62.6%</td><td>60.5%</td><td>57.7%</td><td>67.4%</td></tr>
<tr><td>Type 1 + 3 combined</td><td>68.1%</td><td>71.6%</td><td>71.2%</td><td>66.6%</td><td>63.9%</td><td>68.0%</td><td>66.2%</td><td>63.4%</td><td>72.2%</td></tr>
<tr><td>York ambulance diverts*</td><td>66</td><td>83</td><td>72</td><td>65</td><td>68</td><td>59</td><td>70</td><td>86</td><td>23</td></tr>
</table>
*Excluding YO51 postcodes as Boroughbridge patients come under HDFT</td>
<td>Streaming launch 4 January 2023.

Capital works ongoing to centralise acute services at front door and provide enhanced access to diagnostics.

Fit2sit now open, but three cubicles out of action due to current phase of building works

1 Nov pilot of SDEC opened for additional 2 hours every weekday evening to support flow out of the ED. To run until end March 23 or earlier if pilot determines unsuccessful. Analysis of first 2 weeks underway.</td>
<td>(3x2) - 6</td>
<td>(3x5) – 15</td>
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<td>60 minute in August 2022)</td>
<td>Number of attendances in December in line with average for 2022
Performance against the 4hr standard was significantly below the 95% target
Average of total time in department for non-admitted patients was below 4hrs in December
Significant waits for admitted patients reflecting significantly high capacity of hospital and difficulties with flow.
Frequent ‘bedding down’ of patients in ED overnight and ambulance patients cohorted while waiting to offload and handover
Significant increase in Covid/ Flu/ RSV patients (putting extreme pressure on admission beds and hence flow.)
<table>
<tr><th></th><th>12 Hour DTA</th><th>12 Hour total wait</th><th>30 Min HO</th><th>60 Min HO</th></tr>
<tr><td>June 22</td><td>15</td><td></td><td>30</td><td>1</td></tr>
<tr><td>July 22</td><td>37</td><td>219</td><td>14</td><td>2</td></tr>
<tr><td>August 22</td><td>82</td><td>346</td><td>16</td><td>2</td></tr>
<tr><td>September 22</td><td>60</td><td>286</td><td>77</td><td>25</td></tr>
<tr><td>October 22</td><td>72</td><td>247</td><td>42</td><td>41</td></tr>
<tr><td>November 22</td><td>67</td><td>224</td><td>79</td><td>28</td></tr>
<tr><td>December 22</td><td>165</td><td>431</td><td>183 (including 60+ mins)</td><td>97</td></tr>
</table>
</td>
<td>AFU now relocated to Swaledale with the net increase of 8 patient spaces including frailty SDEC further enhancing flow out of the ED

Community 2 hour response to reduce admissions/attendances over next 6 months.

The plans for improvement in performance are likely to take 3-6 months to address the different elements contributing to poor performance.

Action: Risk rating to remain the same, but the target date is to change to June 2023.</td>
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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 is no Corporate Risk within this Domain.					
Initial Date of Assessment	1st July 2022						
Last Reviewed	22nd December 2022						

Strategic Goal	Corporate Risk ID	Principle Risk	Key Targets	Current Position (November 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 3 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. Underlying Financial risk is a new risk added to the corporate risk register, this is a High Level risk scoring 15.					
Initial Date of Assessment	1st July 2022						
Last Reviewed	22nd December 2022						

Strategic Ambition	Corporate Risk ID	Principle Risk	Key Targets	Current Position (December 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. Agency Review meetings in place with Directorates to bring great focus on the issue. Specific review of problem medical areas.	Substantive recruitment and retention schemes Clear escalation on cascades where appropriate and available	**(3X3) - 9**	**(3X5) - 15**
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)- 4**	**(4x3) - 12**

				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.		
Overarching	CRR 76: Underlying Financial Position	Risk to financial sustainability and regulatory impacts as a result of not achieving breakeven. Risk to providing value for money to taxpayer. Risk to service sustainability as a result of resources available to provide services.	Improved understanding of the underlying run rate, and the balancing of this risk against other service risks. Improved planning and implementation of Savings Programme schemes Mitigations for inflationary pressures as a result of wider economic position	The Trust is currently at risk of managing within resources available in future years. Current high level position – Underlying Run Rate £12m adverse System Support in 2019/20 £3.5m favourable National Savings requirement (3%) £9m adverse Reduction in Covid Income £5m adverse ERSF Risk £6.5m adverse Recurrent Impact of LA pay award £1.8m adverse In planning terms this would suggest a £30m issue entering 2023/24, pre any mitigation and/or developments. Currently setting waste reduction targets for directorates at 3% plus any historic issues. Performance against this will contribute to the Yellow figures. Awaiting guidance on elective recovery funding to understand the risk in Blue, how this may be mitigated by improved performance and what this may provide to mitigate waste reduction.	2023/24 planning process Productivity review Various financial controls Output from HFMA financial sustainability checklist Waste reduction programme Elective recovery workstreams Outpatient Transformation work	**(5x1) - 1**	**(5x3) - 15**

Harrogate and District NHS Foundation Trust

2

Board of Directors held in Public
25 January 2023

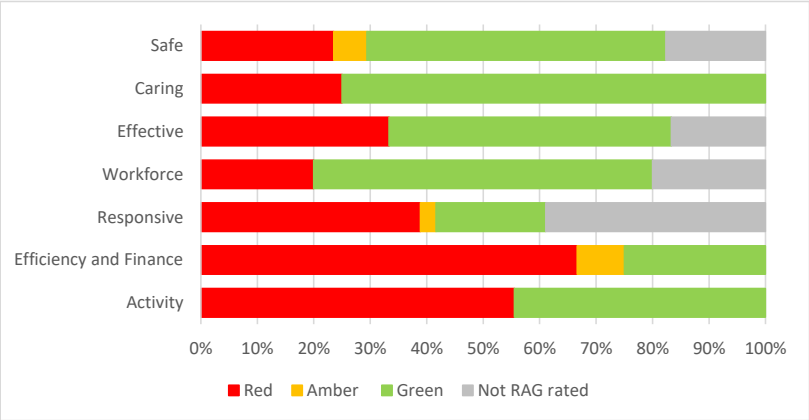
Title:	***Integrated Board Report***
Responsible Director:	Executive Directors
Author:	Head of Performance & Analysis

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

Integrated Board Report - Summary of indicators - December 2022

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

		RAG ratings			
Domain	**Total indicators**	**Red**	**Amber**	**Green**	**Not RAG rated**
Safe	17	4	1	9	3
Caring	4	1	0	3	0
Effective	6	2	0	3	1
Workforce	5	1	0	3	1
Responsive	36	14	1	7	14
Efficiency and Finance	12	8	1	3	0
Activity	9	5	0	4	0
Total	**89**	**35**	**3**	**32**	**19**



Integrated Board Report - Summary of December 22 performance

Domain	Indicator number	Indicator name	Latest position
Safe	1.1	Pressure ulcers - hospital acquired - cat 3 or above - per 1,000 bed days	0.68
Safe	1.2	Pressure ulcers - community acquired - cat 3 or above - per 1,000 patient contacts	0.56
Safe	1.3	Inpatient falls per 1,000 bed days	7.1
Safe	1.4	Infection control - C.diff hospital acquired cases due to a lapse in care	0
Safe	1.5	Infection control - MRSA hospital acquired cases due to a lapse in care	0
Safe	1.6	Incidents - ratio of low harm incidents	50.00
Safe	1.7.1	Incidents - comprehensive serious incidents (SI)	0
Safe	1.7.2	Incidents - Never events	0
Safe	1.8.1	Safer staffing levels - fill rate	89.8%
Safe	1.8.2	Safer staffing levels - CHPPD	7.3
Safe	1.9	Maternity - % women seen by a midwife (or healthcare professional) by 12w 6d	96.1%
Safe	1.10	Maternity - % women with Continuity of Care pathway	
Safe	1.11	Infant health - % women smoking at time of delivery	5.2%
Safe	1.12	Infant health - % women initiating breastfeeding	82.6%
Safe	1.13	VTE risk assessment - inpatients	94.8%
Safe	1.14.1	Sepsis screening - inpatient wards	93.5%
Safe	1.14.2	Sepsis screening - Emergency department	94.1%

Domain	Indicator number	Indicator name	Latest position
Caring	2.1.1	Friends & Family Test (FFT) - Patients	93.1%
Caring	2.1.2	Friends & Family Test (FFT) - Adult Community Services	81.8%
Caring	2.2.1	Complaints - numbers received	14
Caring	2.2.2	Complaints - % responded to within time	100%
Effective	3.1	Mortality - HSMR	113.67
Effective	3.2	Mortality - SHMI	1.052
Effective	3.3.1	Readmissions to the same specialty within 30 days - following elective admission	1.8%
Effective	3.3.2	Readmissions to the same specialty within 30 days - following non-elective admission	7.6%
	3.4	Returns to theatre	
Effective	3.5	Delayed Transfer of Care	27.5%
Workforce	4.1	Staff appraisal rate	68.0%
Workforce	4.2	Mandatory training rate	91.0%
Workforce	4.3	Staff sickness rate	5.65%
Workforce	4.4	Staff turnover rate	15.6%
Workforce	4.5	Vacancies	8.36%

Domain	Indicator number	Indicator name	Latest position
Responsive	5.1.1	RTT Incomplete pathways performance - median	13
Responsive	5.1.2	RTT Incomplete pathways performance - 92nd centile	44
Responsive	5.1.3	RTT Incomplete pathways - total	24951
Responsive	5.1.4	RTT Incomplete pathways - 52-<104 weeks	1228
Responsive	5.1.5	RTT Incomplete pathways - 104+ weeks	0
Responsive	5.2.1	RTT waiting times - by ethnicity	
Responsive	5.2.2	RTT waiting times - by level of deprivation	
Responsive	5.2.3	RTT waiting times - learning disabilities	
Responsive	5.3	Diagnostic waiting times - 6-week standard	62.7%
Responsive	5.4	Outpatient follow-up waiting list - number of follow up patients past due date	
Responsive	5.5	Data quality on ethnic group - inpatients	91.5%
Responsive	5.6	A&E 4 hour standard	63.4%
Responsive	5.7	Ambulance handovers - % within 15 mins	71.5%
Responsive	5.8	A&E - number of 12 hour trolley waits	153
Responsive	5.9.1	Cancer - 62 day wait for first treatment from urgent GP referral to treatment	80.8%
Responsive	5.9.2	Cancer - 62 day wait for first treatment from urgent GP referral to treatment - number of 104 days waiters	2
Responsive	5.10	Cancer - 14 days maximum wait from urgent GP referral for all urgent suspect cancer referrals	74.9%
Responsive	5.11	Cancer - 28 days faster diagnosis standard (suspected cancer referrals)	74.4%
Responsive	5.12	Cancer - 31 days maximum wait from diagnosis to treatment for all cancers	100.0%

Domain	Indicator number	Indicator name	Latest position
Responsive	5.13.1	Children's Services - 0-12 months caseload	1842
Responsive	5.13.2	Children's Services - 2-3 years caseload	1731
Responsive	5.14	Children's Services - Safeguarding caseload	745
Responsive	5.15	Children's Services - Ante-natal visits	94.9%
Responsive	5.16	Children's Services - 10-14 day new birth visit	97.1%
Responsive	5.17	Children's Services - 6-8 week visit	92.6%
Responsive	5.18	Children's Services - 12 month review	95.5%
Responsive	5.19	Children's Services - 2.5 year review	95.7%
Responsive	5.20	Children's Services - % children with all 5 mandated contacts	
Responsive	5.21	Children's Services - Delivery of Immunisation trajectory	
Responsive	5.22	Children's Services - OPEL level	1/2/3
Responsive	5.23	Community Care Adult Teams - performance against new timeliness standards	
Responsive	5.24	Community Care Adult Teams - Number of virtual beds delivered in Supported Discharge Service	
Responsive	5.25	Community Care Adult Teams - Number of cancelled routine visits	
Responsive	5.26	Community Care Adult Teams - OPEL level	3
Responsive	5.27	Out of hours - telephone clinical assessment for URGENT cases within 20 minutes of call prioritisation	19.4%
Responsive	5.28	Home visit: Face to face consultations started for URGENT cases within 2 hrs	80.8%

Domain	Indicator number	Indicator name	Latest position
Efficiency and Finance	6.1	Agency spend	£ 938
Efficiency and Finance	6.2	Surplus / deficit and variance to plan	-£ 1,758
Efficiency and Finance	6.3	Capital spend	£ 4,728
Efficiency and Finance	6.4	Cash balance	£ 28,449
Efficiency and Finance	6.5.1	Long stay patients - stranded (>7 days LOS)	155
Efficiency and Finance	6.5.2	Long stay patients - superstranded (>21 days LOS)	71
Efficiency and Finance	6.6	Occupied bed days per 1,000 population	62.5
Efficiency and Finance	6.7.1	Length of stay - elective	2.72
Efficiency and Finance	6.7.2	Length of stay - non-elective	5.21
Efficiency and Finance	6.8	Avoidable admissions	233
Efficiency and Finance	6.9	Theatre utilisation (elective sessions)	81.2%
Efficiency and Finance	6.10	Day case conversion rate	1.4%

Domain	Indicator number	Indicator name	Latest position
Activity	7.1	GP Referrals against 2019/20 baseline	99.9%
Activity	7.2.1	Outpatient activity (consultant led) against plan (new and follow up)	82.7%
Activity	7.2.2	Outpatient activity (consultant led) against 2019/20 baseline (new and follow up)	87.5%
Activity	7.3.1	Elective activity against plan	80.2%
Activity	7.3.2	Elective activity against 2019/20 baseline	85.9%
Activity	7.4.1	Non-elective activity against plan	97.6%
Activity	7.4.2	Non-elective activity against 2019/20 baseline	93.6%
Activity	7.5.1	Emergency Department attendances against plan	99.3%
Activity	7.5.2	Emergency Department attendances against plan, 2019/20 baseline	100.2%

Integrated Board Report - List of indicators

Domain	Indicator number	Indicator name	Clinical Directorate(s) metric is applicable to	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Exec Lead	Committee reported to:	Monthly RAG thresholds: Red	Amber	Green
Safe	1.1	Pressure ulcers - hospital acquired - cat 3 or above - per 1,000 bed days	PSC, LTUC	0.37	0.00	0.61	0.34	0.55	1.06	0.61	0.74	0.80	0.50	0.75	0.58	1.11	1.08	0.32	0.90	0.82	0.93	0.20	1.02	0.68	EN	Quality	>0		0
Safe	1.2	Pressure ulcers - community acquired - cat 3 or above - per 1,000 patient contacts	LTUC	1.38	1.36	0.61	1.01	1.25	0.66	0.56	0.89	1.51	0.88	1.24	0.74	1.11	0.56	1.24	1.38	1.20	1.08	0.99	0.43	0.56	EN	Quality	>0		0
Safe	1.3	Inpatient falls per 1,000 bed days	PSC, LTUC	5.1	6.1	4.9	5.9	7.4	8.6	6.0	7.6	8.0	8.0	6.7	9.1	6.9	6.1	6.5	6.1	8.7	7.1	7.0	6.5	7.1	EN	Quality	above HDFT average for 2021/22 (7.0)	0-20% below HDFT average for 2021/22	>20% below HDFT average for 2020/21 (5.6)
Safe	1.4	Infection control - Hospital acquired C.difficile cases, lapse in care identified	All	0	0	1	0	0	1	1	1	1	0	0	0	0	0	0	0	0	0	0	0	0	EN	Quality	>40 YTD (total cases)		<=40 YTD (total cases)
Safe	1.5	Infection control - Hospital acquired MRSA cases, lapse in care identified	All	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	EN	Quality	>0 YTD		0 YTD
Safe	1.6	Incidents - ratio of low harm incidents	All	16.49	21.29	19.98	27.63	19.58	25.29	50.76	66.71	43.38	37.50	56.65	39.91	48.71	51.63	74.38	43.52	44.91	42.77	50.62	50.11	50.00	EN	Quality	HDFT in bottom 25% of Acute Trusts	HDFT in middle 50% of Acute Trusts	HDFT in top 25% of Acute Trusts
Safe	1.7.1	Incidents - comprehensive serious incidents (SI)	All	3	1	4	1	3	0	0	1	2	6	1	1	5	5	3	3	1	4	1	1	0	EN	Quality	>0		0
Safe	1.7.2	Incidents - Never events	All	0	1	0	0	0	0	0	0	0	1	1	1	0	1	1	0	0	1	0	0	0	EN	Quality			
Safe	1.8.1	Safer staffing levels - fill rate	All	93.8%	93.1%	92.5%	92.6%	90.1%	85.9%	86.2%	89.6%	88.0%	81.2%	80.8%	81.5%	81.1%	87.0%	89.2%	85.8%	89.1%	88.4%	88.0%	93.3%	89.8%	EN	Quality	<80%	80% - 95%	>=95%
Safe	1.8.2	Safer staffing levels - CHPPD	All	8.6	8.4	8.6	8.0	7.9	7.8	7.2	7.5	7.4	7.1	6.8	6.8	6.9	7.4	7.6	7.1	7.2	6.3	7.3	7.5	7.3	EN	Quality	tbc		
Safe	1.9	Maternity - % women seen by a midwife (or healthcare professional) by 12w 6d	PSC	99.4%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	96.6%	99.3%	95.7%	99.2%	100.0%	98.6%	97.6%	96.6%	95.4%	96.2%	96.0%	93.1%	98.7%	96.1%	EN	Quality	<90%		>=90%
Safe	1.10	Maternity - % women with Continuity of Care pathway	PSC																						EN	Quality			
Safe	1.11	Infant health - % women smoking at time of delivery	PSC	6.6%	2.9%	7.4%	5.2%	3.0%	4.3%	3.0%	7.2%	4.6%	6.6%	5.6%	4.2%	5.8%	6.4%	3.7%	3.5%	2.3%	3.9%	7.4%	3.5%	5.2%	EN	Quality	>15%		<=15%
Safe	1.12	Infant health - % women initiating breastfeeding	PSC	83.6%	82.6%	84.8%	83.8%	79.2%	87.4%	81.1%	88.2%	85.9%	83.5%	81.7%	86.2%	82.9%	84.6%	81.8%	75.2%	81.8%	84.0%	82.5%	90.8%	82.6%	EN	Quality	<75%		>=75%
Safe	1.13	VTE risk assessment - inpatients	PSC, LTUC	96.7%	97.1%	96.9%	96.3%	96.6%	95.7%	97.1%	96.8%	96.3%	95.9%	95.7%	95.5%	96.1%	96.3%	95.6%	95.1%	96.2%	96.0%	95.9%	95.7%	94.8%	EN	Quality	<95%		>=95%
Safe	1.14.1	Sepsis screening - inpatient wards	All	91.8%	96.1%	93.2%	93.5%	92.5%	90.8%	91.5%	89.8%	92.3%	89.3%	90.6%	87.7%	88.6%	93.0%	93.8%	89.8%	88.2%	95.4%	94.0%	92.7%	93.5%	EN	Quality	<90%		>=90%
Safe	1.14.2	Sepsis screening - Emergency department	LTUC	85.9%	89.2%	88.9%	86.6%	88.0%	88.8%	89.3%	92.5%	92.9%	91.9%	94.6%	94.8%	94.0%	92.2%	92.6%	95.6%	92.3%	93.4%	90.6%	91.6%	94.1%	EN	Quality	<90%		>=90%
Caring	2.1.1	Friends & Family Test (FFT) - All Patients	All	94.2%	92.7%	93.7%	93.7%	92.8%	93.3%	93.4%	92.7%	93.9%	94.7%	92.0%	91.8%	94.1%	92.7%	92.2%	92.3%	79.5%	80.9%	92.2%	92.3%	93.1%	EN	Quality	<90%		>=90%
Caring	2.1.2	Friends & Family Test (FFT) - Adult Community Services	CC	94.7%	95.5%	96.5%	96.1%	95.3%	96.0%	90.5%	90.5%	95.4%	96.6%	98.7%	97.3%	94.4%	91.9%	90.6%	93.9%	95.9%	90.9%	95.7%	93.5%	81.8%	EN	Quality	<90%		>=90%
Caring	2.2.1	Complaints - numbers received	All	14	24	18	20	31	19	13	9	18	11	14	22	17	10	9	12	10	13	9	7	14	EN	Quality	above HDFT average for 2021/22 (18)		On or below HDFT average for 2021/22 (18)
Caring	2.2.2	Complaints - % responded to within time	All		50%	35%	56%	56%	48%	50%	53%	53%	53%	55%	58%	72%	79%	70%	50%	45%	58%	80%	75%	100%	EN	Quality	<95%		>=95%
Effective	3.1	Mortality - HSMR	All	94.45	95.61	91.58	95.56	98.45	99.68	102.34	105.86	108.72	113.26	113.15	114.09	118.15	117.26	117.4	113.81	114.71	115.9	113.67			JA	Quality	Higher than expected		Within expected range or below expected
Effective	3.2	Mortality - SHMI	All	0.964	0.978	0.988	1.008	1.021	1.047	1.066	1.062	1.073	1.077	1.074	1.093	1.097	1.103	1.085	1.085	1.066	1.063	1.052			JA	Quality	Higher than expected		Within expected range or below expected
Effective	3.3.1	Readmissions to the same specialty within 30 days - following elective admission - as % of all elective admissions	All	1.8%	1.6%	1.6%	1.8%	2.1%	1.6%	2.0%	1.5%	1.5%	1.5%	1.9%	1.5%	1.8%	2.1%	2.0%	1.5%	1.6%	2.0%	2.2%	1.8%		RN	Resources	> 3%	2% - 3%	<= 2%
Effective	3.3.2	Readmissions to the same specialty within 30 days - following non-elective admission - as % of all non-elective admissions	All	9.5%	8.2%	7.3%	8.2%	8.4%	7.9%	8.0%	7.4%	7.4%	8.9%	7.2%	8.5%	8.6%	6.8%	7.9%	7.1%	6.7%	7.4%	7.8%	7.6%		RN	Resources	> 10%	8% - 10%	<= 8%
Effective	3.4	Returns to theatre	PSC																						RN	Resources	tbc		
Effective	3.5	Delayed Transfer of Care - % inpatients not meeting the criteria to reside	LTUC	22.0%	14.5%	20.6%	24.0%	10.6%	21.9%	24.7%	7.4%	20.4%	20.8%	25.0%	12.0%	30.9%	24.5%	28.1%	38.3%	36.9%	37.5%	29.4%	29.8%	27.5%	RN	Resources	> 17.5%	15% - 17.5%	<= 15%
Workforce	4.1	Staff appraisal rate	All	56.3%	58.3%	58.9%	55.9%	55.2%	54.0%	52.8%	58.2%	59.8%	56.3%	63.0%	63.9%	56.9%	63.7%	60.8%	61.6%	61.7%	61.6%	63.3%	65.2%	68.0%	AW	People and Culture	<70%	70% - 90%	>=90%
Workforce	4.2	Mandatory training rate	All	91.7%	92.1%	92.0%	92.0%	87.0%	86.0%	86.0%	85.0%	85.0%	85.0%	85.0%	86.0%	85.0%	87.0%	90.0%	90.0%	89.0%	89.0%	90.0%	91.0%	91.0%	AW	People and Culture	<50%	50% - 75%	>=75%
Workforce	4.3	Staff sickness rate	All	3.74%	3.94%	4.04%	4.77%	5.02%	5.26%	6.04%	5.53%	5.42%	6.67%	5.74%	5.54%	5.90%	4.44%	4.96%	5.32%	4.59%	4.84%	4.88%	4.88%	5.65%	AW	People and Culture	>3.9%		<=3.9%
Workforce	4.4	Staff turnover rate	All	12.9%	13.0%	13.3%	13.5%	14.2%	14.5%	14.6%	13.8%	13.7%	14.3%	14.8%	15.7%	15.7%	16.0%	16.3%	16.4%	15.9%	15.8%	15.9%	15.8%	15.6%	AW	People and Culture	>15%		<=15%
Workforce	4.5	Vacancies	CC	4.98%	6.06%	6.40%	6.53%	6.25%	6.23%	5.61%	6.98%	8.89%	8.16%	8.05%	7.22%	5.84%	6.04%	6.25%	6.55%	5.97%	5.80%	6.66%	8.06%	8.36%	AW	People and Culture	tbc		
Responsive	5.1.1	RTT Incomplete pathways performance - median	All	8	8	8	9	9	10	10	9	10	10	10	9	10	10	11	11	11	12	12	11	13	RN	Resources	>10	08 - 10	<=8
Responsive	5.1.2	RTT Incomplete pathways performance - 92nd centile	All	44	43	41	40	40	41	41	41	42	43	43	43	44	43	44	44	44	45	44	42	44	RN	Resources	>24	18 - 24	<=18
Responsive	5.1.3	RTT Incomplete pathways - total	All	18156	19476	20631	21785	22168	22648	22423	22714	23464	23323	23900	23931	24714	25384	25134	25629	25564	25490	25437	25388	24951	RN	Resources	>15,000	14,000 - 15,000	<=14,000
Responsive	5.1.4	RTT Incomplete pathways - 52<104 weeks	All	1196	1082	993	968	932	1008	1037	1063	1130	1086	1107	1118	1176	1193	1260	1297	1297	1350	1285	1201	1228	RN	Resources	>0		0
Responsive	5.1.5	RTT Incomplete pathways - 104+ weeks	All	3	5	13	20	23	24	33	34	47	52	50	22	11	3	1	0	0	0	0	0	0	RN	Resources	>0		0
Responsive	5.2.1	RTT waiting times - by ethnicity	All																						RN	Resources			
Responsive	5.2.2	RTT waiting times - by level of deprivation	All																						RN	Resources			
Responsive	5.2.3	RTT waiting times - learning disabilities	All																						RN	Resources			
Responsive	5.3	Diagnostic waiting times - 6-week standard	All	79.7%	85.4%	79.2%	75.1%	74.0%	80.5%	79.7%	86.1%	82.4%	78.7%	81.9%	76.5%	66.0%	69.2%	59.8%	58.9%	55.3%	50.4%	62.0%	67.9%	62.7%	RN	Resources	<99%		>=99%
Responsive	5.4	Outpatient follow-up waiting list - number of follow up patients past due date	All																						RN	Resources			
Responsive	5.5	Data quality on ethnic group - inpatients	All	93.0%	95.3%	94.6%	94.3%	94.8%	93.6%	94.3%	94.5%	92.8%	92.5%	92.9%	92.5%	93.7%	93.4%	92.5%	92.1%	92.3%	91.5%	91.4%	92.0%	91.5%	RN	Resources	<97%		>=97%
Responsive	5.6	A&E 4 hour standard	LTUC	86.3%	82.7%	82.6%	79.4%	80.6%	83.7%	75.9%	76.0%	68.9%	71.5%	65.6%	61.9%	66.2%	68.1%	71.5%	71.4%	66.7%	63.9%	68.0%	66.2%	63.4%	RN	Resources	<90%	90-95%	>=95%
Responsive	5.7	Ambulance handovers - % within 15 mins	LTUC	92.8%	91.8%	86.5%	87.6%	89.1%	92.8%	86.1%	89.2%	88.4%	92.9%	89.8%	87.2%	90.3%	89.2%	83.2%	89.0%	88.6%	78.9%	67.0%	74.9%	71.5%	RN	Resources	<90%	90-95%	>=95%
Responsive	5.8	A&E - number of 12 hour trolley waits	LTUC	0	0	0	0	0	0	8	2	23	4	37	25	43	18	15	37	82	60	72	67	153	RN	Resources	>0		0
Responsive	5.9.1	Cancer - 62 day wait for first treatment from urgent GP referral to treatment	LTUC	85.5%	87.1%	93.5%	84.1%	91.7%	89.1%	81.8%	80.7%	84.8%	79.8%	83.2%	87.6%	78.3%	86.3%	80.9%	78.3%	82.5%	71.4%	78.2%	78.9%	80.8%	RN	Resources	<85%		>=85%

Domain	Indicator number	Indicator name	Clinical Directorate(s) metric is applicable to	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Exec Lead	Committee reported to:	Monthly RAG thresholds: Red	Amber	Green
Responsive	5.9.2	Cancer - 62 day wait for first treatment from urgent GP referral to treatment - number of 104 days waiters	LTUC	3	2	2	5	2	6	3	3	3	2	3	6	8	4	5	4	3	5	8	4	2	RN	Resources	>0		0
Responsive	5.10	Cancer - 14 days maximum wait from urgent GP referral for all urgent suspect cancer referrals	LTUC	81.7%	85.8%	88.2%	83.4%	86.0%	92.2%	83.8%	82.5%	87.3%	84.6%	92.5%	87.9%	85.9%	89.6%	73.6%	70.4%	47.3%	47.7%	47.4%	56.7%	74.9%	RN	Resources	<93%		>=93%
Responsive	5.11	Cancer - 28 days faster diagnosis standard (suspected cancer referrals)	LTUC	69.6%	71.7%	68.7%	70.3%	73.9%	73.4%	78.7%	77.0%	77.7%	74.6%	79.5%	80.6%	79.4%	76.1%	79.7%	74.6%	68.0%	54.4%	62.2%	72.8%	74.4%	RN	Resources	<70%	70-75%	>= 75%
Responsive	5.12	Cancer - 31 days maximum wait from diagnosis to treatment for all cancers	LTUC	97.0%	96.6%	100.0%	100.0%	98.9%	94.6%	99.1%	100.0%	97.5%	98.0%	98.1%	98.1%	97.3%	98.2%	97.4%	98.9%	98.9%	96.7%	98.9%	99.1%	100.0%	RN	Resources	<96%		>=96%
Responsive	5.13.1	Children's Services - 0-12 months caseload	CC	1457	1455	1459	1453	1545	1503	1876	1698	1871	1779	1642	1658	1531	1591	1726	1684	1728	1787	1852	1698	1842	RN	Resources	tbc		
Responsive	5.13.2	Children's Services - 2-3 years caseload	CC	1625	1591	1496	1583	1476	1536	1662	1762	1784	1857	1708	1918	1701	1806	1628	1788	1606	1703	1663	1734	1731	RN	Resources	tbc		
Responsive	5.14	Children's Services - Safeguarding caseload	CC	951	1026	1118	1006	727	1002	992	947	986	992	980	1278	910	1177	1103	1094	938	988	875	948	745	RN	Resources	tbc		
Responsive	5.15	Children's Services - Ante-natal visits	CC	85.9%	86.7%	89.8%	88.3%	89.4%	86.8%	86.0%	80.1%	80.0%	75.3%	78.7%	75.9%	83.1%	86.2%	87.9%	90.9%	90.9%	89.5%	89.9%	92.3%	94.9%	RN	Resources	<75%	75% - 90%	>=90%
Responsive	5.16	Children's Services - 10-14 day new birth visit	CC	95.4%	95.4%	95.4%	95.7%	95.4%	93.2%	94.0%	92.6%	95.7%	95.6%	95.4%	93.5%	95.4%	94.7%	95.7%	97.3%	96.8%	96.4%	95.9%	97.0%	97.1%	RN	Resources	<75%	75% - 90%	>=90%
Responsive	5.17	Children's Services - 6-8 week visit	CC	91.9%	92.4%	93.3%	93.3%	92.7%	90.1%	89.7%	89.7%	90.7%	91.4%	93.3%	93.4%	92.1%	93.8%	94.9%	95.2%	95.0%	93.6%	94.5%	92.8%	92.6%	RN	Resources	<75%	75% - 90%	>=90%
Responsive	5.18	Children's Services - 12 month review	CC	93.1%	91.2%	92.6%	94.0%	95.0%	93.5%	95.1%	93.8%	92.5%	92.8%	93.7%	90.9%	89.9%	91.2%	91.7%	93.2%	92.7%	94.6%	95.5%	95.5%	95.5%	RN	Resources	<75%	75% - 90%	>=90%
Responsive	5.19	Children's Services - 2.5 year review	CC	91.5%	91.7%	93.4%	92.3%	92.8%	92.2%	90.9%	91.7%	92.3%	91.5%	92.0%	91.7%	92.7%	91.6%	93.9%	95.6%	94.2%	94.1%	95.7%	95.7%	95.7%	RN	Resources	<75%	75% - 90%	>=90%
Responsive	5.20	Children's Services - % children with all 5 mandated contacts	CC																						RN	Resources	<75%	75% - 90%	>=90%
Responsive	5.21	Children's Services - Delivery of Immunisation trajectory	CC																						RN	Resources			
Responsive	5.22	Children's Services - OPEL level	CC									2/3	2/3	1/2/3	2/3	1/2/3	1/2/3	1/2/3	1/2/3	1/2/3	1/2/3	1/2/3	1/2/3	1/2/3	RN	Resources	tbc		
Responsive	5.23	Community Care Adult Teams - performance against new timeliness standards	CC																						RN	Resources	tbc		
Responsive	5.24	Community Care Adult Teams - Number of virtual beds delivered in Supported Discharge Service	CC																						RN	Resources			
Responsive	5.25	Community Care Adult Teams - Number of cancelled routine visits	CC																						RN	Resources			
Responsive	5.26	Community Care Adult Teams - OPEL level	CC									3	3	3	3	3	3	3	3	3	3	3	3	3	RN	Resources			
Responsive	5.27	Out of hours - telephone clinical assessment for URGENT cases within 20 minutes of call prioritisation	LTUC	36.7%	35.5%	39.9%	38.6%	34.5%	40.6%	40.3%	38.5%	28.5%	39.1%	41.1%	32.5%	30.8%	33.6%	32.0%	36.0%		32.7%	32.5%	30.5%	19.4%	RN	Resources	<95%		>=95%
Responsive	5.28	Home visit: Face to face consultations started for URGENT cases within 2 hrs	LTUC	78.6%	86.2%	75.9%	79.2%	88.5%	97.4%	90.5%	86.7%	83.3%	92.9%	94.4%	93.5%	97.2%	93.6%	93.1%	85.7%		82.9%	81.5%	96.2%	80.8%	RN	Resources	<95%		>=95%
Efficiency and Finance	6.1	Agency spend	All	£ 419	£ 307	£ 414	£ 517	£ 453	£ 429	£ 389	£ 485	£ 745	£ 685	£ 630	£ 829	£ 654	£ 752	£ 890	£ 798	£ 980	£ 991	£ 934	£ 873	£ 938	JC	Resources	>3% of pay bill	1% - 3%	<= 1%
Efficiency and Finance	6.2	Surplus / deficit and variance to plan	All	£ -	£ -	£ -	-	-	-	-	-	-	-	-	-	-£ 265	-£ 471	£ 157	-£ 282	£ 6	-£ 916	-£ 732	-£ 980	-£ 1,758	JC	Resources	>1% behind plan	0 - 1% behind plan	On plan
Efficiency and Finance	6.3	Capital spend	All	£ 518	£ 834	£ 1,856	£ 2,330	£ 3,188	£ 4,274	£ 8,006	£ 10,861	£ 11,503	£ 14,559	£ 17,301	£ 29,657	£ 500	£ 905	£ 1,506	£ 1,915	£ 1,829	£ 2,244	£ 2,974	£ 3,225	£ 4,728	JC	Resources	>25% behind plan	10% - 25% behind plan	On plan or <10% behind plan
Efficiency and Finance	6.4	Cash balance	All	£ 39,900	£ 34,587	£ 32,007	£ 32,386	£ 33,600	£ 42,000	£ 40,738	£ 40,119	£ 46,027	£ 44,921	£ 44,615	£ 42,004	£ 40,077	£ 40,671	£ 43,156	£ 38,660	£ 35,921	£ 36,042	£ 37,476	£ 36,067	£ 28,449	JC	Resources	>10% behind plan	0 - 10% behind plan	On plan
Efficiency and Finance	6.5.1	Long stay patients - stranded (>7 days LOS)	All	119	114	103	119	129	121	146	151	152	162	177	162	167	165	147	164	158	158	155	149	155	RN	Resources	>90	70-90	<=70
Efficiency and Finance	6.5.2	Long stay patients - superstranded (>21 days LOS)	All	48	44	40	42	51	47	56	67	65	71	86	79	83	79	67	76	74	77	69	58	71	RN	Resources	>40	30-40	<=30
Efficiency and Finance	6.6	Occupied bed days per 1,000 population	All	50.8	53.9	50.7	55.3	56.4	52.8	60.5	58.4	61.6	61.8	57.8	63.7	60.2	61.7	57.0	61.2	59.4	59.2	61.2	59.4	62.5	RN	Resources	>60	55-60	<=55
Efficiency and Finance	6.7.1	Length of stay - elective	All	2.26	2.60	2.57	2.66	2.76	2.31	2.22	2.35	2.78	3.17	2.24	2.43	2.25	1.84	2.56	2.41	2.94	2.85	2.49	2.41	2.72	RN	Resources	>2.75	2.5-2.75	<=2.5
Efficiency and Finance	6.7.2	Length of stay - non-elective	All	4.69	4.27	4.49	3.99	4.81	4.82	4.72	5.26	5.76	5.37	5.80	5.39	5.86	5.52	5.05	4.92	5.69	5.61	5.33	4.85	5.21	RN	Resources	>4.5	4-4.5	<=4.0
Efficiency and Finance	6.8	Avoidable admissions	All	189	219	242	263	228	206	240	267	229	222	202	238	261	256	261	211	215	242	223	233		RN	Resources	>270		<=270
Efficiency and Finance	6.9	Theatre utilisation (elective sessions)	PSC	81.2%	83.9%	83.4%	82.0%	83.7%	82.4%	80.4%	81.0%	84.7%	81.3%	75.7%	78.0%	79.8%	79.4%	85.0%	78.4%	79.4%	81.4%	80.0%	83.5%	81.2%	RN	Resources	<85%	85%-90%	>=90%
Efficiency and Finance	6.10	Day case conversion rate	PSC	2.2%	1.7%	1.9%	1.6%	1.6%	1.5%	1.9%	1.1%	1.7%	1.3%	1.9%	1.6%	1.8%	1.8%	2.4%	1.7%	1.9%	1.4%	1.5%	1.6%	1.4%	RN	Resources	>2%	1.5%-2%	<=1.5%
Activity	7.1	GP Referrals against 2019/20 baseline	All	95.4%	94.1%	113.1%	99.6%	101.1%	112.0%	97.1%	109.1%	111.5%	99.9%	109.7%	167.2%	99.6%	108.7%	110.8%	98.6%	115.1%	110.9%	103.0%	113.5%	99.9%	RN	Resources	<95%		>=95%
Activity	7.2.1	Outpatient activity (consultant led) against plan (new and follow up)	All	113.7%	106.9%	123.2%	84.2%	87.0%	93.3%	103.2%	111.6%	111.3%	96.1%	103.1%	110.9%	112.6%	133.5%	122.1%	76.3%	88.9%	89.5%	78.9%	99.5%	82.7%	RN	Resources	<95%		>=95%
Activity	7.2.2	Outpatient activity (consultant led) against 2019/20 baseline (new and follow up)	All	90.8%	86.5%	98.7%	85.3%	88.6%	95.2%	80.1%	100.6%	95.9%	84.7%	93.8%	117.7%	84.4%	115.1%	91.8%	84.0%	94.2%	90.9%	82.0%	103.1%	87.5%	RN	Resources	<95%		>=95%
Activity	7.3.1	Elective activity against plan	All	102.5%	97.3%	109.3%	77.4%	75.4%	84.9%	99.4%	104.1%	105.2%	95.8%	88.7%	101.6%	123.2%	111.8%	111.1%	70.5%	90.2%	102.8%	72.4%	80.0%	80.2%	RN	Resources	<95%		>=95%
Activity	7.3.2	Elective activity against 2019/20 baseline	All	74.8%	80.6%	90.4%	73.9%	69.6%	80.7%	72.9%	79.7%	84.9%	72.7%	73.3%	112.7%	76.1%	99.0%	78.5%	98.4%	75.4%	85.0%	76.1%	84.1%	85.9%	RN	Resources	<95%		>=95%
Activity	7.4.1	Non-elective activity against plan	All	96.5%	97.4%	105.2%	104.3%	94.5%	93.5%	95.2%	87.1%	89.4%	84.3%	85.2%	105.5%	100.5%	98.5%	104.3%	89.8%	95.9%	97.9%	97.1%	102.3%	97.6%	RN	Resources	<95%		>=95%
Activity	7.4.2	Non-elective activity against 2019/20 baseline	All	89.9%	98.6%	104.8%	98.3%	92.7%	90.6%	94.1%	84.1%	88.8%	84.7%	84.5%	119.1%	90.4%	97.8%	100.6%	88.3%	91.0%	91.8%	92.7%	95.6%	93.6%	RN	Resources	<95%		>=95%
Activity	7.5.1	Emergency Department attendances against plan	LTUC	98.9%	106.6%	111.2%	103.4%	104.0%	105.7%	101.5%	99.2%	91.9%	95.6%	94.4%	114.92%	92.1%	92.7%	91.3%	96.1%	91.0%	92.6%	90.9%	92.4%	99.3%	RN	Resources	<95%		>=95%
Activity	7.5.2	Emergency Department attendances against plan, 2019/20 baseline	LTUC	98.9%	106.6%	110.8%	103.7%	104.1%	105.7%	106.5%	104.3%	96.6%	98.3%	97.6%	149.7%	99.6%	108.8%	110.9%	98.8%	99.5%	102.8%	101.6%	101.1%	100.2%	RN	Resources	<95%		>=95%

Integrated Board Report - December 2022

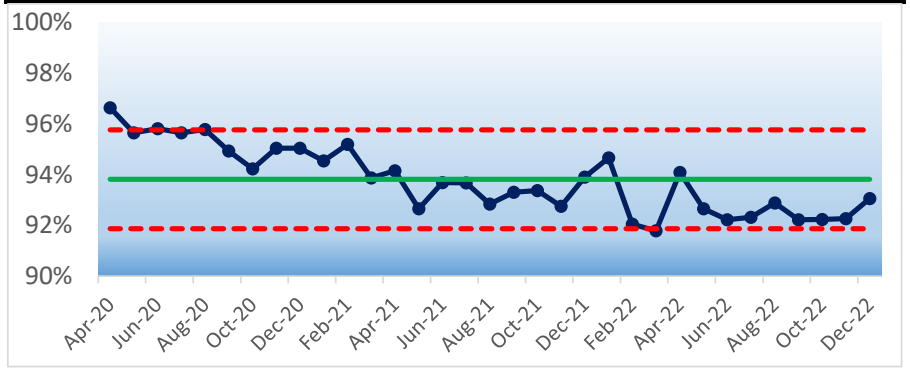
Domain 2 - Caring

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	Dec-22
Value / RAG rating	93.1%

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

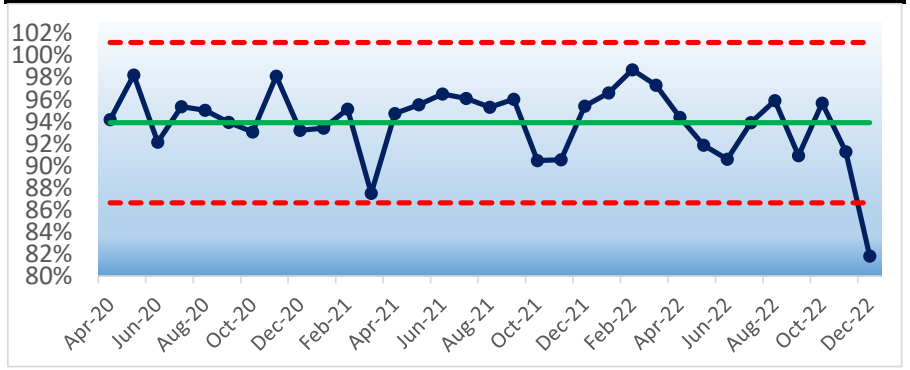
Performance against this standard continues to fluctuate but overall remains over 90% which is positive.

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	Dec-22
Value / RAG rating	81.8%

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

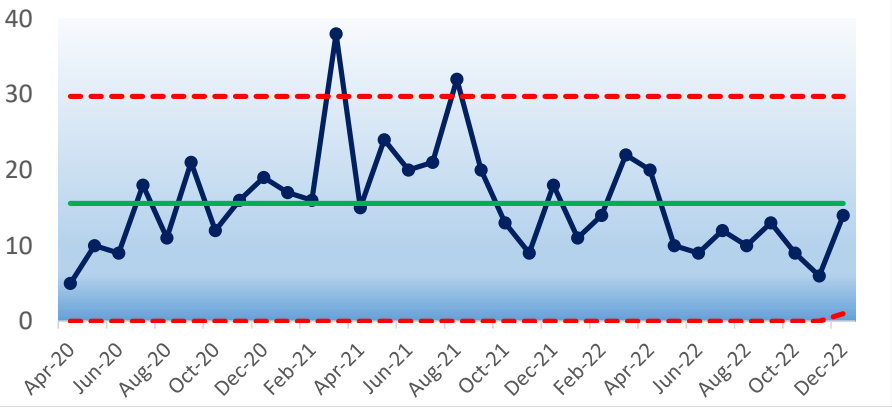
Unfortunately FFT performance for adult community services has deteriorated this month – this is mostly due to a number of negative responses related to the GP OOH service in Harrogate.

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	Dec-22
Value / RAG rating	14

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

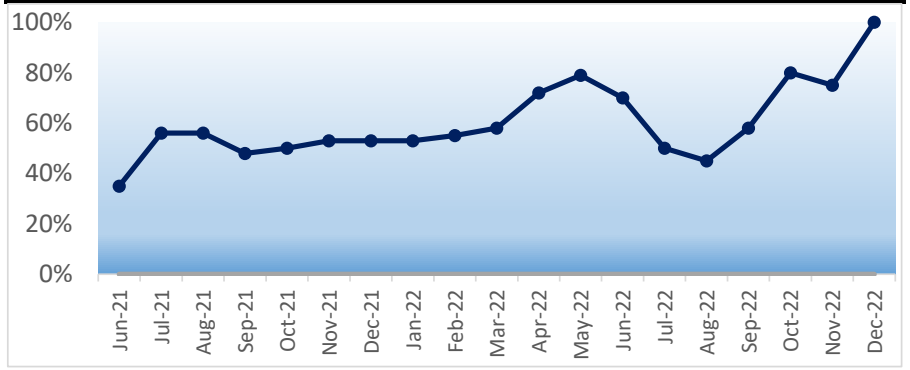
In total, there were 14 standard complaints received in December (number and response rate for our KPI which is the standard complaints-25 working days). 1 complaint came under CC Directorate, 9 complaints came under PSC and 4 complaints came under LTUC. Including Multi-agency and Complaints requiring a meeting, there were 18 complaints in total (4 multiagency). This is the 8th consecutive month that the number of complaints received by the Trust has fallen below the mean.

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	Dec-22
Value / RAG rating	100%

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

The complaint response rate had declined over the summer months (50% in July, 45% in August). This was closely monitored and weekly support given to all Directorates at their Quality Huddles. We have since seen significant improvement in these figures; the response rate for October 22 was 80%, the response rate for November 22 was 82% and the response rate for December was 100%. Weekly support continues across all Directorates.

Integrated Board Report -December 2022

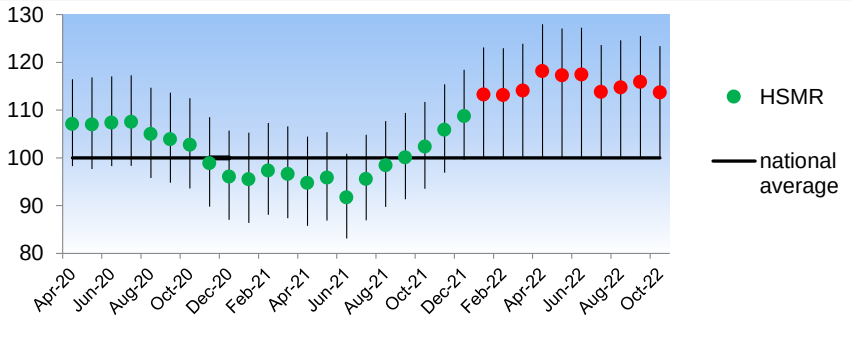
Domain 3 - Effective

Indicator	**3.1 - Hospital Standardised Mortality Ratio (HSMR)**
Executive lead	Jacqueline Andrews, Medical Director
Board Committee	Quality Committee
Reporting month	Oct-22
Value / RAG rating	113.67

Indicator description

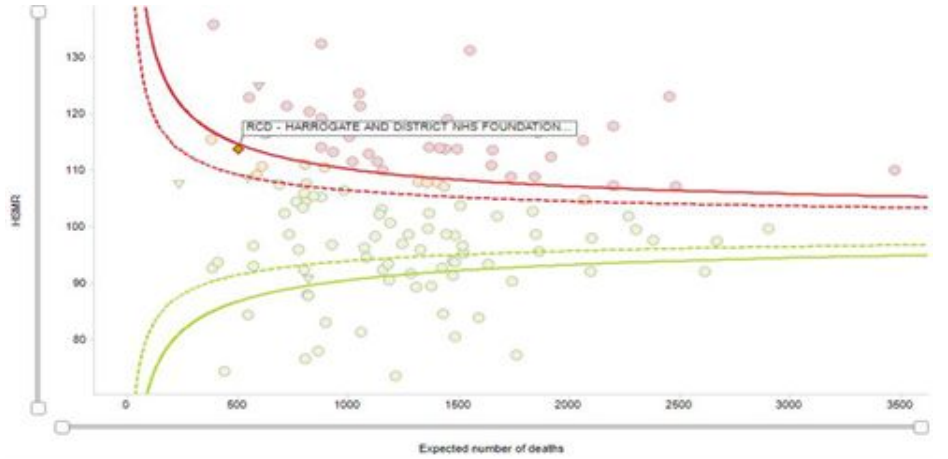
The HSMR looks at the mortality rates for 56 common diagnosis groups that account for around 80% of in-hospital deaths and standardises against various criteria including age, sex and comorbidities. The measure also makes an adjustment for palliative care.

Trend chart



Narrative

National average is 100. HDFT remains above the expected range - ongoing intense monitoring of possible causes, no quality concerns identified after discussion with NHS NEY. The funnel plot below shows HDFT as the diamond compared to similar Trusts (shown as a triangle) and all other Trusts.

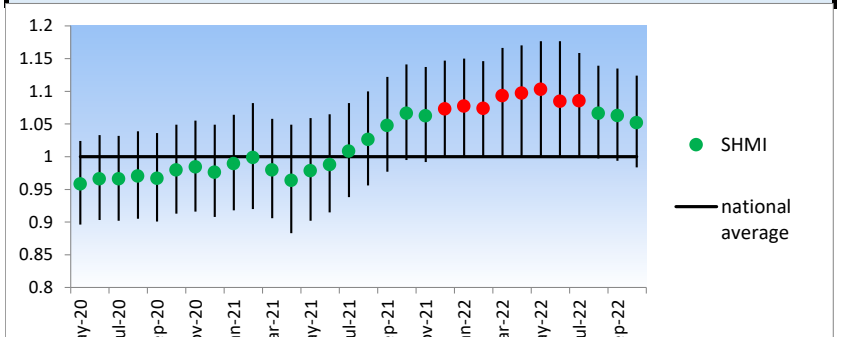


Indicator	**3.2 - Summary Hospital Mortality Index (SHMI)**
Executive lead	Jacqueline Andrews, Medical Director
Board Committee	Quality Committee
Reporting month	Oct-22
Value / RAG rating	1.052

Indicator description

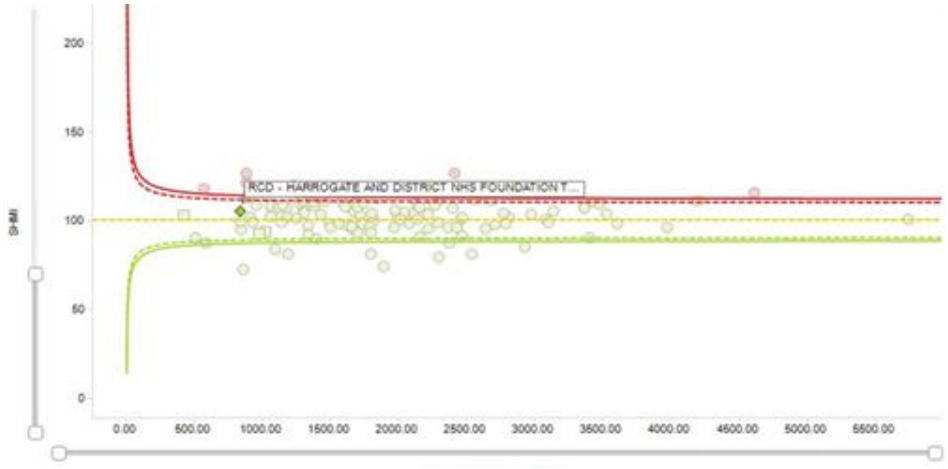
The SHMI looks at the mortality rates for all diagnoses and standardises against various criteria including age, sex and comorbidities. The measure does not make an adjustment for palliative care.

Trend chart



Narrative

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

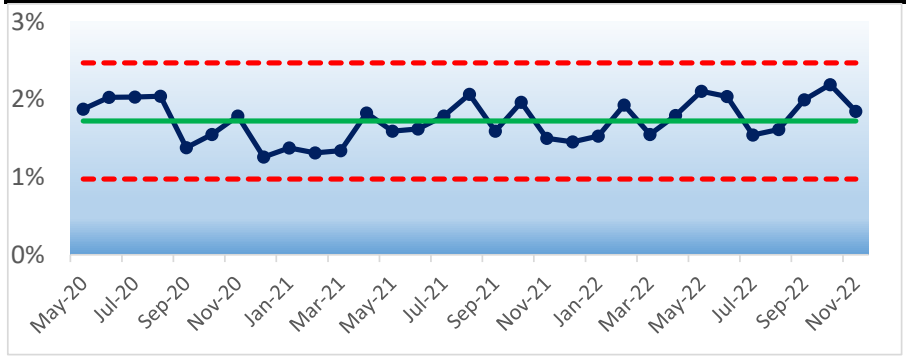


Indicator	**3.3.1 - Readmissions to the same specialty within 30 days - following elective admission**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Nov-22
Value / RAG rating	1.8%

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

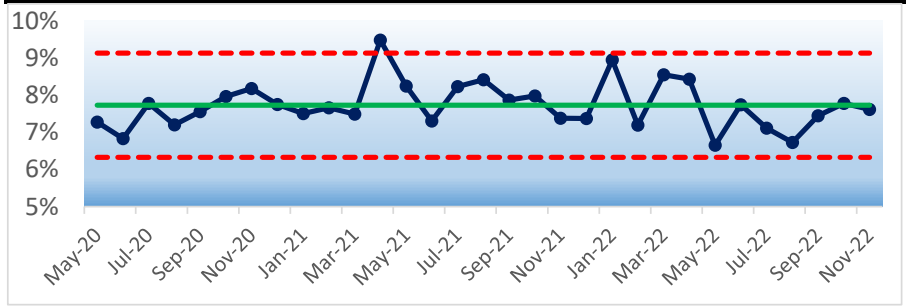
Readmissions following an elective admission reduced to 1.8% in November and remain within control limits and less than national average.

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	Nov-22
Value / RAG rating	7.6%

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 reduced to 7.8% in November and remain 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

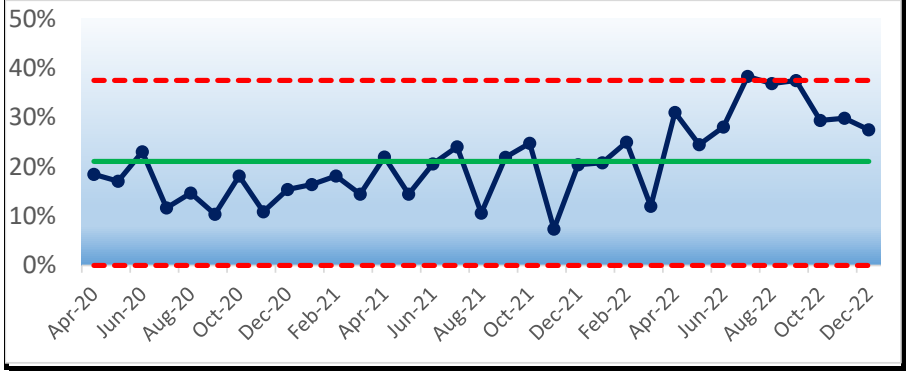
Narrative

Indicator	**3.5 - Delayed transfers of care**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Dec-22
Value / RAG rating	27.5%

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 November, remaining high. 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'. The Trust is about to enter the market as a care provider to deliver packages of care for patients on discharge to support the care market and ultimately improve flow out of hospital- the impact of which we hope to be seen in this metric in January/February.

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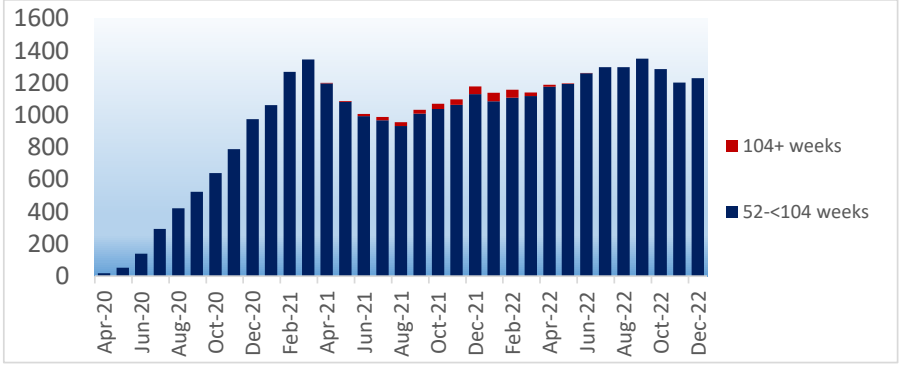
Domain 5 - Responsive

Indicator	**5.1 - RTT Incomplete pathways - 52+ weeks**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Dec-22
Value / RAG rating	1228

Indicator description

The number of incomplete pathways waiting over 52 weeks.

Trend chart



Narrative

The Trust reported no patients waiting over 104 weeks at the end of December. The number of over 52 week waiters increased to 1,228 (1,201 last month).

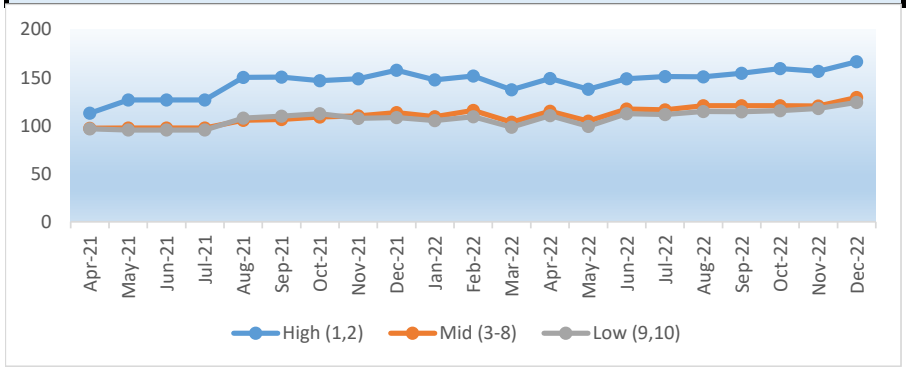
Risks remain in Community Dental (which accounts for a significant proportion of over 52 week waiters). Orthopaedics, the other main contributor, is proceeding well with backlog reduction and utilising weekend lists regularly. There are plans in place to reduce the number of over 52 week waiters to 750 by March 2023. 78 week waiting patients are on or close to trajectory for elimination by the end of March 2023. The most pressured specialties remain General Surgery, Gynaecology and Urology.

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

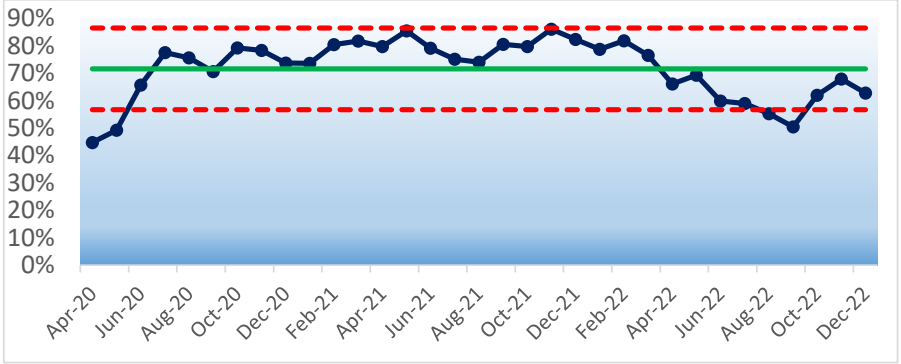
Work also continues in improving the recording of ethnicity and use of the learning disabilities flag across our clinical systems (this will improve further with the reinstatement of patient kiosks).

Indicator	**5.3 - Diagnostic waiting times - 6-week standard**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Dec-22
Value / RAG rating	62.7%

Indicator description

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

SPC chart



Narrative

The position on over 6 week waiters has deteriorated slightly this month (2,099 vs. 1,929 last month) after improvements in October and November. Of the 2,099 waiting over 6 weeks, this includes 1,072 DEXA (998 last month), 347 MRI (276 last month), 220 audiology (212 last month) and 176 ultrasound (319 last month). The first 2 weeks of January have delivered high numbers of scans again as part of recovering this position.

An improvement trajectory expected of DEXA has been hampered by breakdowns in the new machine followed by difficulty recruiting a specialist DEXA radiographer. DEXA scans per week have increased and a new trajectory and plan is being worked up over the next few weeks.

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

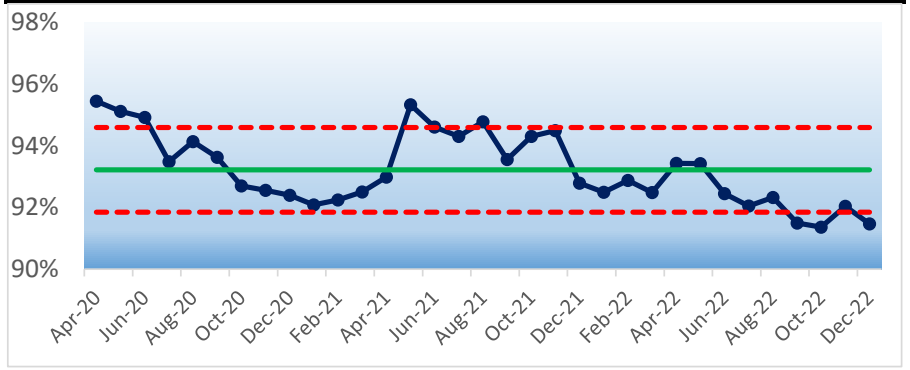
Narrative

Indicator	**5.5 - Data quality on ethnic group - inpatients**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Dec-22
Value / RAG rating	91.5%

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.

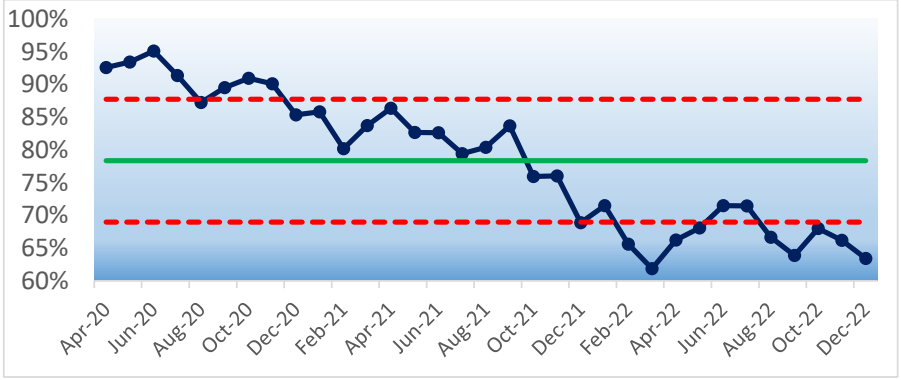
- Made contact with the lead at Central London Community NHS Trust (CLCH) who have improved their ethnicity recording rates on their patient records – they are organising a webinar to talk through their actions
- Reminded staff of the process regarding the collection of this data including reception 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	Dec-22
Value / RAG rating	63.4%

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

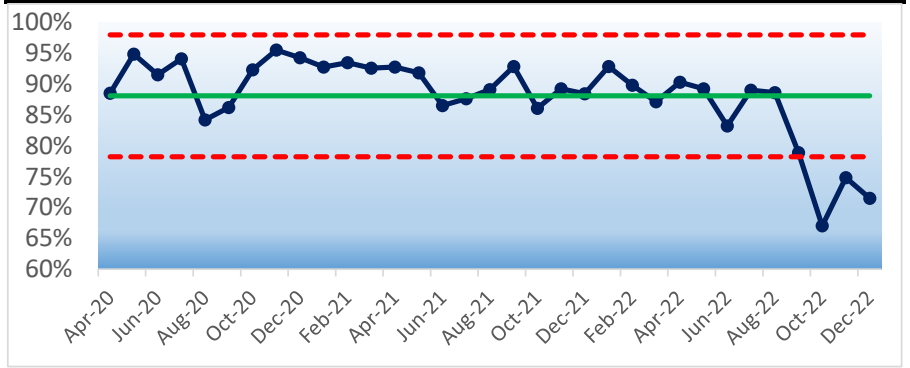
Performance against the A&E 4-hour standard remains below the 95% standard. Performance reflects the continuing significant pressures with high bed occupancy relating to discharge challenges and staff absenses, coupled with the current buidling works which is impacting ED capacity. The Trust continue to support the HNY system which is significantly pressured (OPEL 4) with regular diverts of ambulance patients to Harrogate - (over 1,000 YTD) this negatively impacts on HDFT's 4 hour performance and length of stay.
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 (Jan-23 full model in place);
- 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; (complete)
- implementing a 'fit to sit' area to improve flow; (complete)
- red2green methodology;
- criteria led discharge implemented;
-pharmacy attendance at board rounds;
- ward reconfiguration and specialty alignment; (completes December).
The last 10 days of January have seen an improvement to above 76% with streaming, ward reconfiguration beginning to deliver.

Indicator	**5.7 - Ambulance handovers - % within 15 mins**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Dec-22
Value / RAG rating	71.5%

Indicator description

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

SPC chart



Narrative

71% of ambulance handovers took place within 15 minutes in December, remaining well below the historical average. There were 183 over 30-minute handover breaches with 94 over 60-minutes in December. 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.

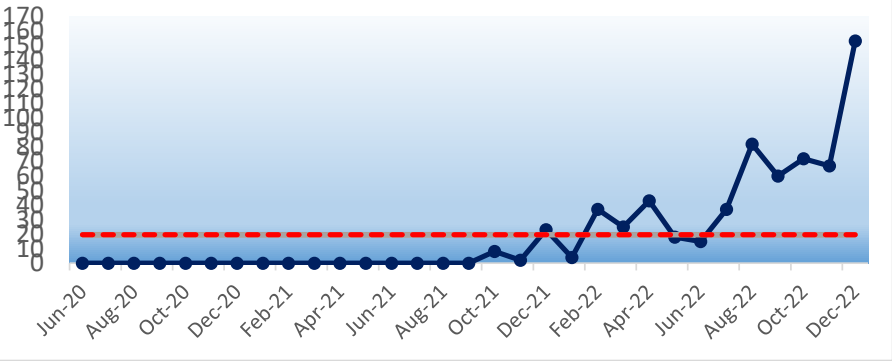
Much improved positon since the first week of January.

Indicator	**5.8 A&E - number of 12 hour trolley waits**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Dec-22
Value / RAG rating	153

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

153 over 12 hour trolley waits were reported in December. This is a partially validated position - 79 of the reported waits have been validated and confirmed as correct. The remaining 74 cases (for the period 14-29 December) have not yet been validated by LTUC colleagues due to a combination of sickness, annual leave and other operational pressures. RCAs have commenced and will be reviewed at internal quality and performance meetings.

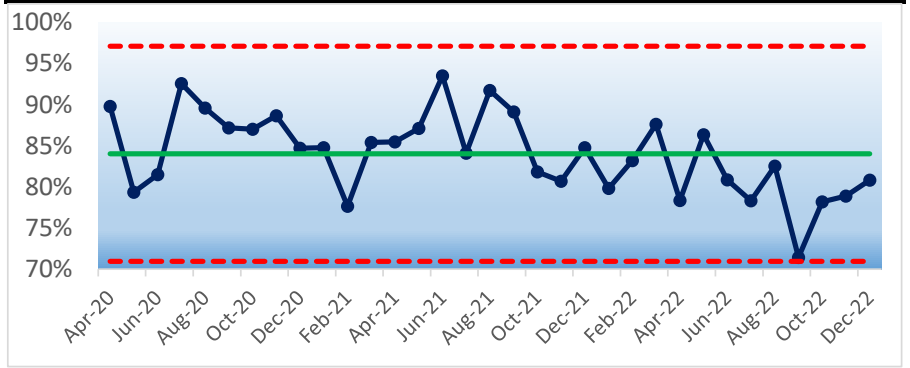
Much reduced over 12 hour trolley waits since the first week of January

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	Dec-22
Value / RAG rating	80.8%

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 December for the seventh consecutive month (80.8%). There were 49.5 accountable treatments (57 patients) in December with 9.5 treated outside 62 days. Of the 9 tumour sites treated in December, performance was below 85% for 5 (Colorectal, Gynaecology, Head and Neck, Lung, and Urology).

Provisional data indicates that 46.7% (7/15) of patients treated at Tertiary centres in December were transferred for treatment by day 38, compared to 40% (2/5) last month.

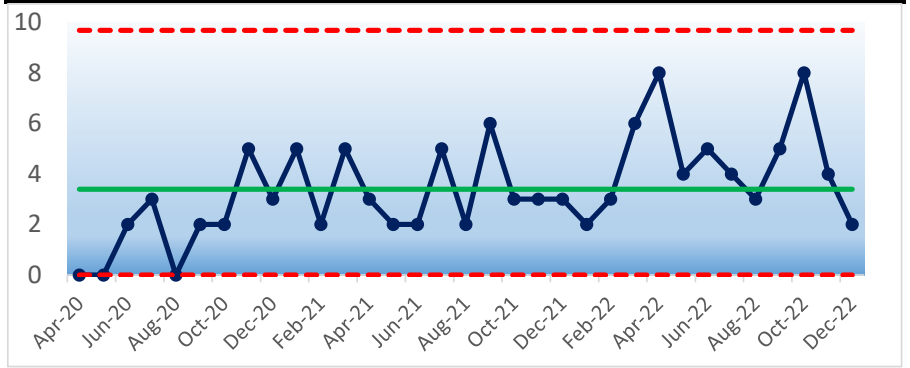
The latest published provisional data reports that national performance for the 62 day standard was at 60.3% in October. Of 138 providers, HDFT was the 22nd best performing Trust.

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	Dec-22
Value / RAG rating	2

Indicator description

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

SPC chart



Narrative

2 patients waited 104+ days for treatment in December (1 x York Head and Neck; 1 x Gynaecology at Harrogate).

The Head and Neck delay was due to elective capacity for treatment, and the Gynaecology delay was due to pathway complexity.

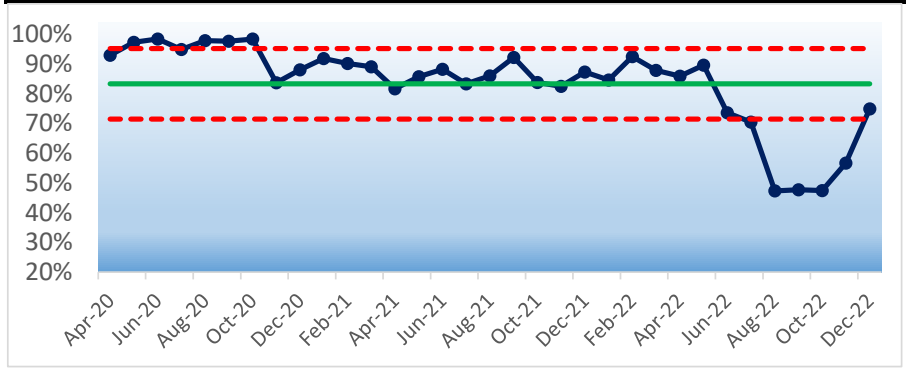
All patients have now received treatment. Following the implementation of a new cancer system in October (Somerset Cancer Registry) and the time constraints on the tracking team, it has been agreeed to stand down the October, November and December breach panel meetings. This means that the patients who breached in September, October and November won't be formally discussed. The next meeting will be held in January/February this year.

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	Dec-22
Value / RAG rating	74.9%

Indicator description

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

SPC chart



Narrative

892 patients attended their first appointment for suspected cancer in December which is a 24.6% decrease on last month (1,183). Of these, 224 were seen outside 14 days (74.9%) which is a significant improvement on recent months.

14 day capacity continues to be challenging in December with only 2 specialties acheiving the 93% standard (Head and Neck; SSNS). Performance was signicicantly below 93% (i.e. below 80%) in Breast (7.8% - includes 2 paediatric referrals), Gynaecology (76.6%), Other (0%), Upper GI (74.1%), and Urology (67.5%).

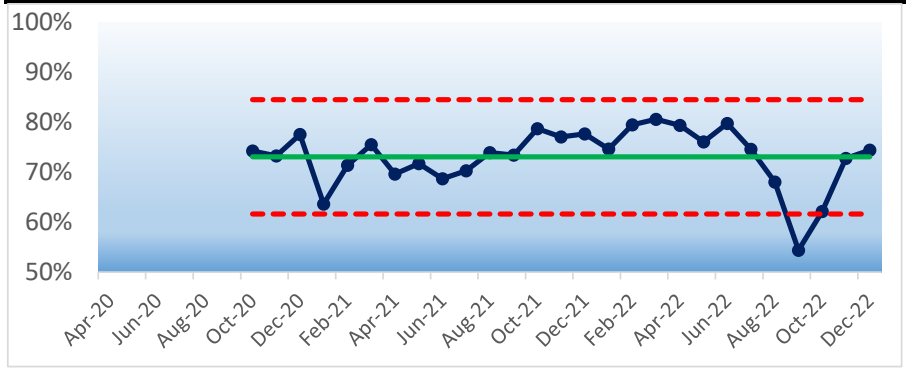
Performance in Dermatology improved significantly in December with 90.6% of patients seen within 14 days, compared to 39.8% last month, although there was also a 51.3% reduction in the number of referrals first seen (437 vs 213).

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	Dec-22
Value / RAG rating	74.4%

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

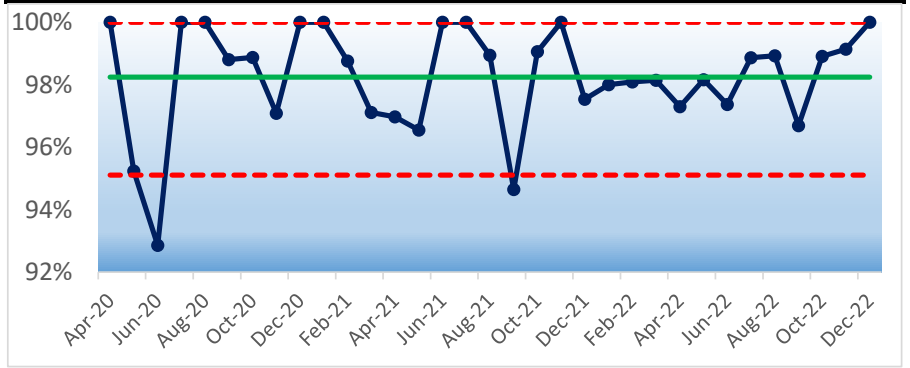
Provisional data indicates that in December combined performance for the three 28 days standards (2WW suspected cancer, 2WW non-cancer breast symptoms, Screening) continued to be below the proposed operational standard of 75% at 74.4%, although this is a slight improvement on last month (2WW cancer – 78.8%; 2WW Breast Symptoms – 90.3%; Screening – 23.3%).

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	Dec-22
Value / RAG rating	100.0%

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 72 patients received First Definitive Treatment for cancer at HDFT in December, with all treated within 31 days.

Overall performance 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	Dec-22
Value / RAG rating	

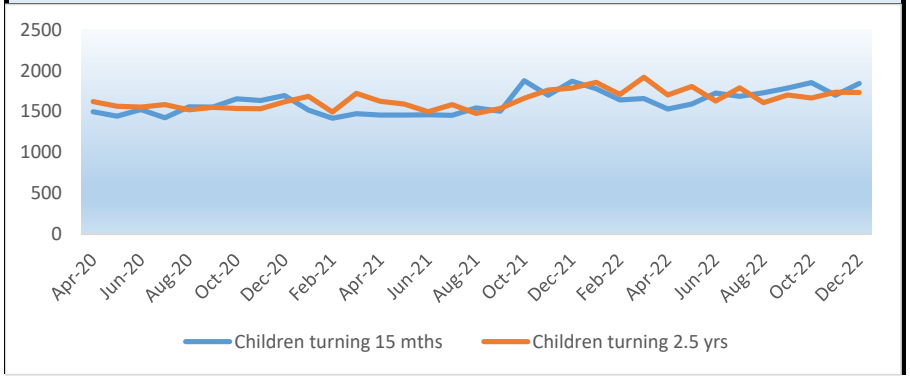
Indicator description

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

Narrative

Both caseloads remain fairly static.

SPC chart

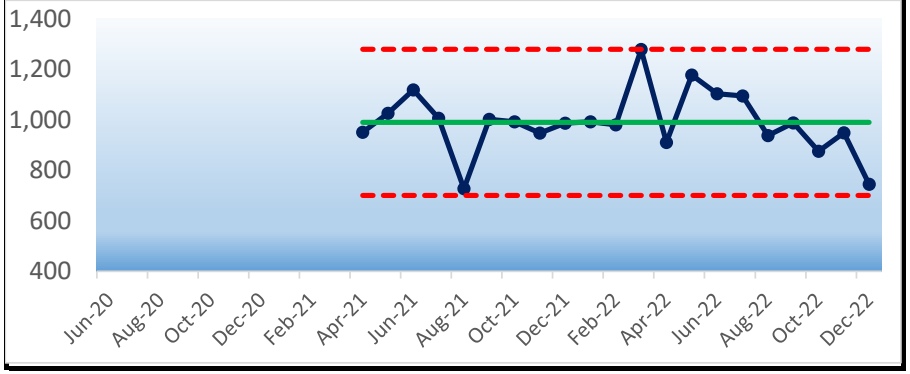


Indicator	**5.14 - Children's Services - Safeguarding caseload**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Dec-22
Value / RAG rating	745

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	Dec-22
Value / RAG rating	94.9%

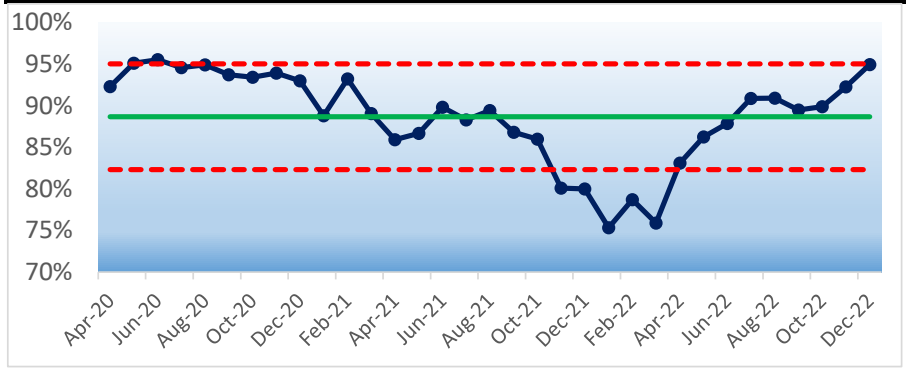
Indicator description

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

Narrative

95% of eligible pregnant women received an initial antenatal visit in December.

SPC chart

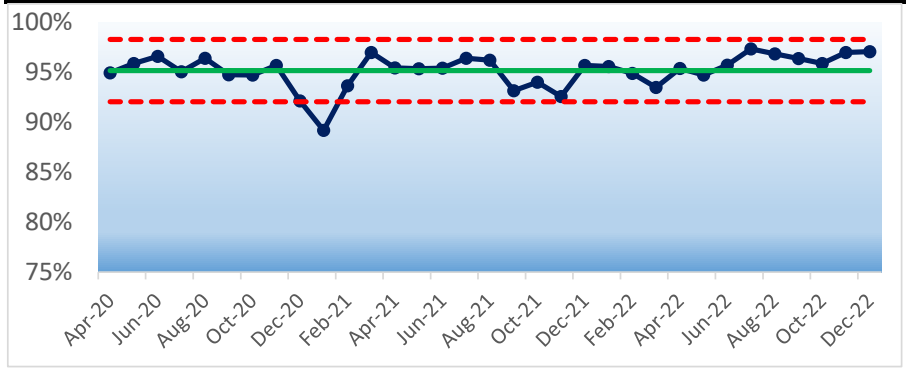


Indicator	**5.16 - Children's Services - 10-14 day new birth visit**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Dec-22
Value / RAG rating	97.1%

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

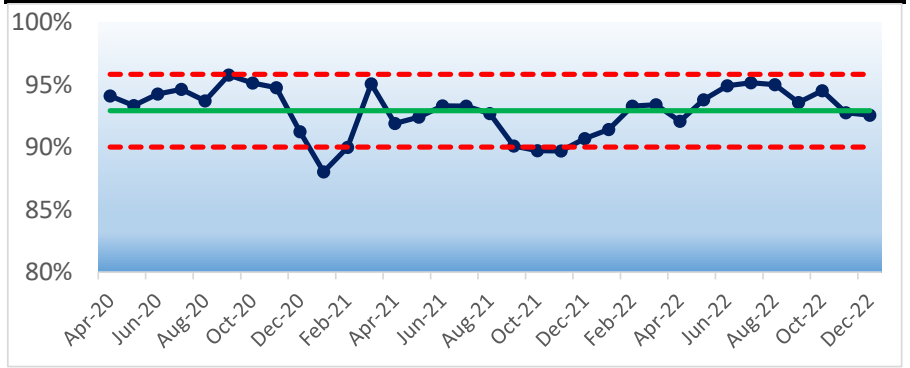
97% of infants received a new birth visit within 10-14 days of birth during December.

Indicator	**5.17 - Children's Services - 6-8 week visit**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Dec-22
Value / RAG rating	92.6%

Indicator description

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

SPC chart



Narrative

93% of infants received a 6-8 week visit by 8 weeks of age during December.

Indicator	**5.18 - Children's Services - 12 month review**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Dec-22
Value / RAG rating	95.5%

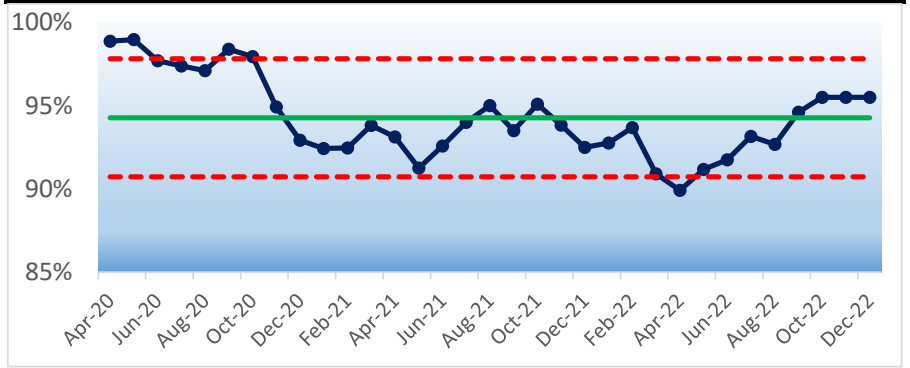
Indicator description

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

Narrative

96% of eligible children received a 12 month review by 15 months of age during December.

SPC chart

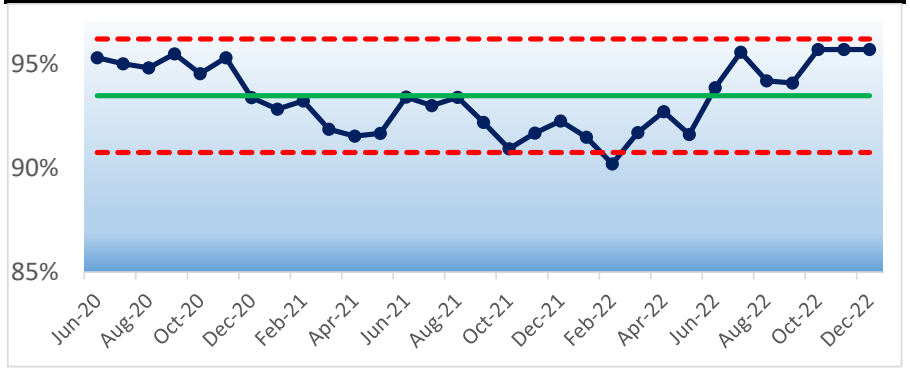


Indicator	**5.19 - Children's Services - 2.5 year review**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Dec-22
Value / RAG rating	95.7%

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

96% of eligible children received a 2 - 2.5 year review by 2.5 years of age during December.

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	1/2/3

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 December was:
Acute Paediatrics - Level 3
Darlington - Level 1
Durham - Level 3
Gateshead - Level 2
Immunisation DDT - Level 3
Immunisation NY - Level 3
Middlesbrough - Level 3
North Yorkshire - Level 2
Northumberland - Level 3
Safeguarding - Level 3
Stockton - Level 3
Sunderland - Level 3
Wakefield - Level 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 100% of eligible cases in December. This is the sixth consecutive month where we have reported 100% compliance.

Indicator	**5.20 - Community Care Adult Teams - Number of virtual beds delivered in Supported Discharge Service**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	
Value / RAG rating	

Indicator description

This indicator is under development.

SPC chart

Narrative

Indicator	**5.25 - Community Care Adult Teams - Number of cancelled routine visits**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	
Value / RAG rating	

Indicator description
This indicator is under development.

SPC chart

Narrative

Indicator	**5.26 - Community Care Adult Teams - OPEL level**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	
Value / RAG rating	

Indicator description
This indicator is under development.

SPC chart

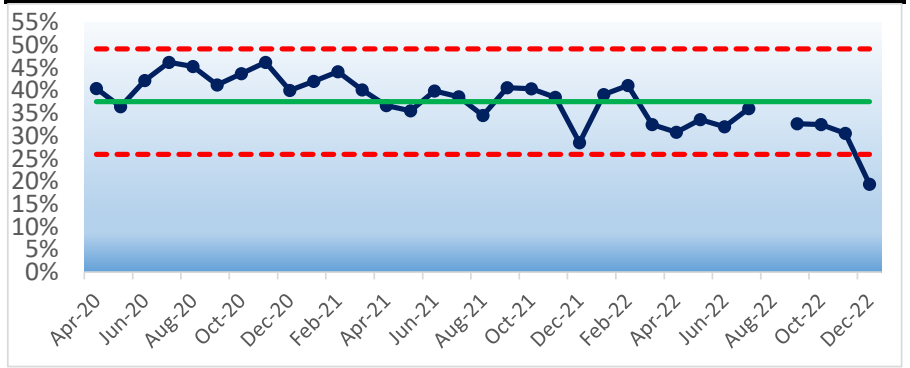
Narrative
CC Directorate have started to discuss and record OPEL levels for Adult Community Services at their Safety and Governance huddles. The overall position for December remained at level 3.

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	Dec-22
Value / RAG rating	19.4%

Indicator description

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

SPC chart



Narrative

Due to a national issue with the Adastra system used by the GPOOH service, we are unable to report August performance.

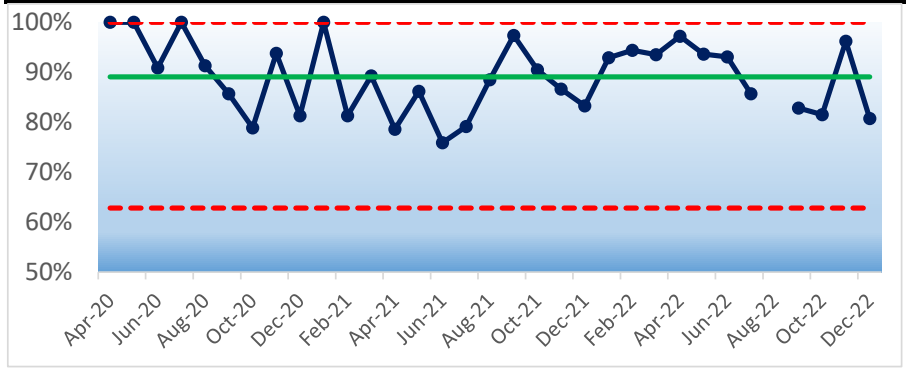
In December, 19% of urgent cases received a telephone clinical assesment within 20 minutes of call prioritisation, a deterioration on recent performance.

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	Dec-22
Value / RAG rating	80.8%

Indicator description

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

SPC chart



Narrative

Due to a national issue with the Adastra system used by the GPOOH service, we are unable to report August performance.

In December, 81% of urgent cases received a home visit within 2 hours, a decrease on the previous month.

Integrated Board Report - December 2022

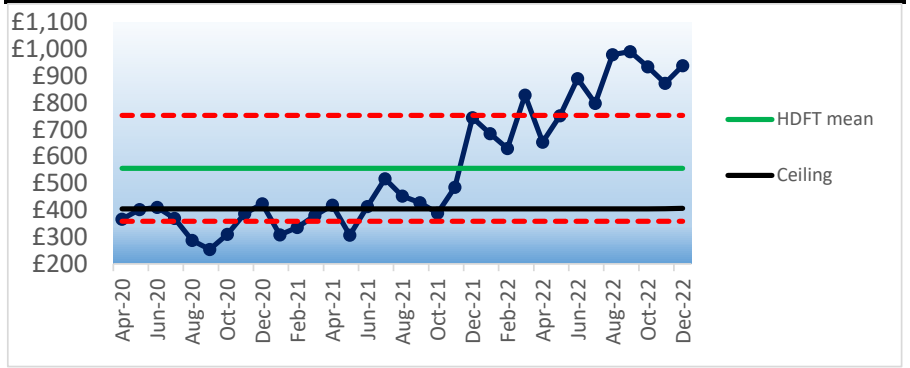
Domain 6 - Efficiency and Finance

Indicator	**6.1 - Agency spend**
Executive lead	Jordan McKie, Finance Director
Board Committee	Resources Committee
Reporting month	Dec-22
Value / RAG rating	£938

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

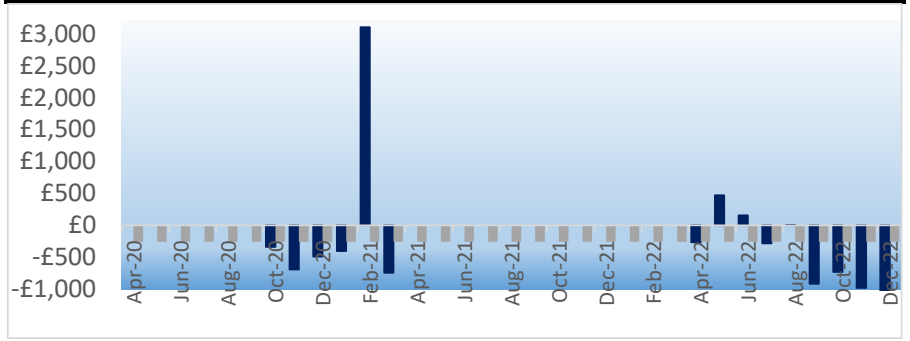
Agency costs to cover vacancies and escalation wards continue to drive pay pressure. YTD costs of £7,810 are now over the annual agency cap of £5,676. Actions and mitigations identified via the agency review meetings and directorate performance review discussed at SMT and Resource committee.

Indicator	**6.2 - Surplus / deficit and variance to plan**
Executive lead	Jordan McKie, Finance Director
Board Committee	Resources Committee
Reporting month	Dec-22
Value / RAG rating	-£1,758

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

Month 9 in month deficit of £1,758m takes the YTD position to £4,917m deficit. Key Drivers continue to be performance against Savings programme, Medical Staffing expenditure, ward expenditure, costs associated with the delivery of activity, inflation and escalation.

Indicator	**6.3 - Capital spend**
Executive lead	Jordan McKie, Finance Director
Board Committee	Resources Committee
Reporting month	Dec-22
Value / RAG rating	£4,728

Indicator description

Cumulative Capital Expenditure by month (£'000s)

Trend chart

Narrative

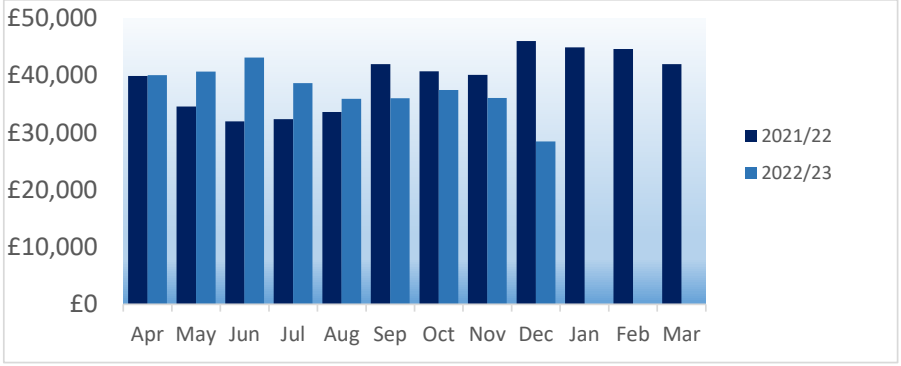
Capital spend is £4,728m to month 9. There is potential slippage following delays in some of the key schemes, in particular the plant room. Work ongoing to quantify the slippage and identify other schemes that could be carried out this year to utilise any slippage identified. The Trust also has confirmed funding for EPR and TIF2 capital schemes and spending plans are being progressed.

Indicator	**6.4 Cash balance**
Executive lead	Jordan McKie, Finance Director
Board Committee	Resources Committee
Reporting month	Dec-22
Value / RAG rating	£28,449

Indicator description

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

Trend chart



Narrative

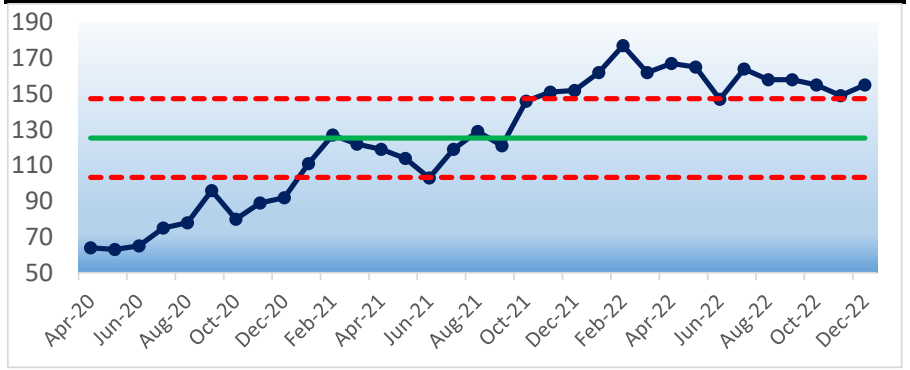
The Trust's cash balance remains positive.

Indicator	**6.5.1 - Long stay patients - stranded (>7 days LOS)**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Dec-22
Value / RAG rating	155

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

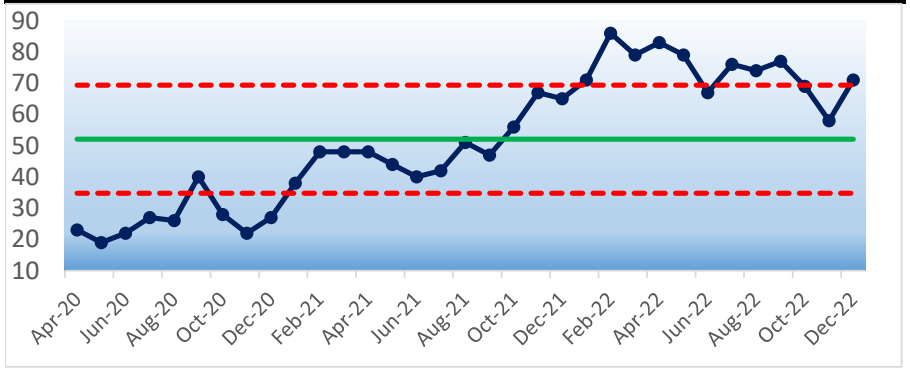
The number of long stay patients (> 7 days) was 155 in December, remaining high. This is being driven by the increase in COVID patients, COVID 'pop ups' at day 7 and patients requiring observation as COVID contacts alongside the impact of COVID on POC, residential and nursing home providers.

Indicator	**6.5.2 - Long stay patients - superstranded (>21 days LOS)**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Dec-22
Value / RAG rating	71

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

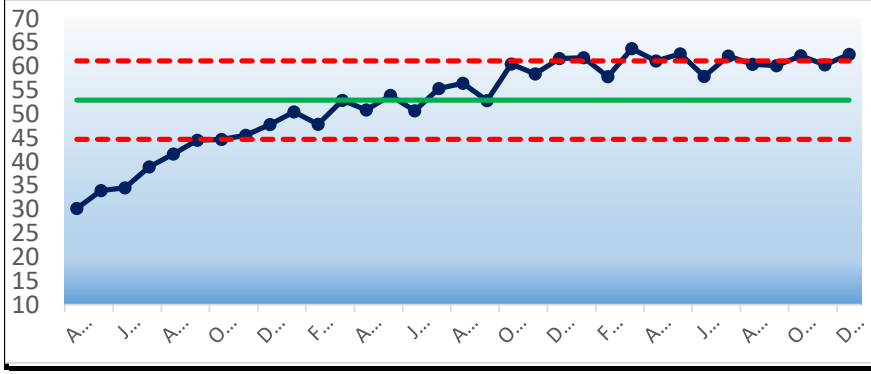
The number of long stay patients (> 21 days) was 71 in December, an increase on last month and remaining high. This is being driven by the increase in COVID patients, COVID 'pop ups' at day 7 and patients requiring observation as COVID contacts alongside the impact of COVID on POC, residential and nursing 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	Dec-22
Value / RAG rating	62.5

Indicator description

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

SPC chart



Narrative

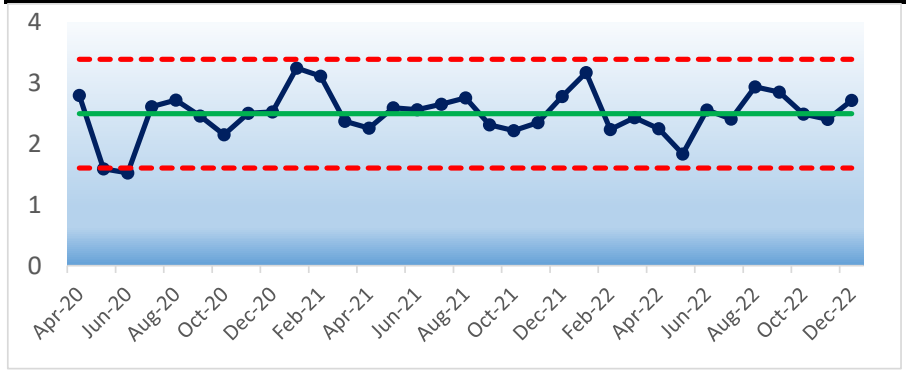
Occupied bed days per 1,000 population were at 62.5 in December. In the 2 years prior to the pandemic, occupied bed days per 1,000 population averaged 57.8, below the current level.

Indicator	**6.7.1 Length of stay - elective**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Dec-22
Value / RAG rating	2.72

Indicator description

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

SPC chart



Narrative

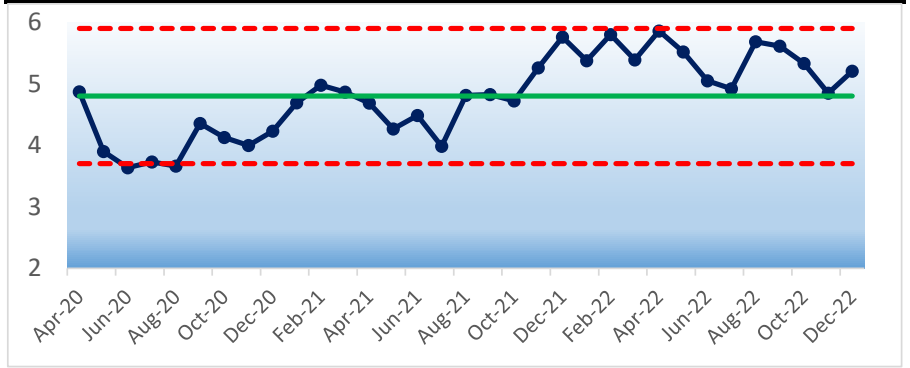
Elective length of stay increased in December and is above our local stretch target of 2.5 days.

Indicator	**6.7.2 Length of stay - non-elective**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Dec-22
Value / RAG rating	5.2

Indicator description

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

SPC chart



Narrative

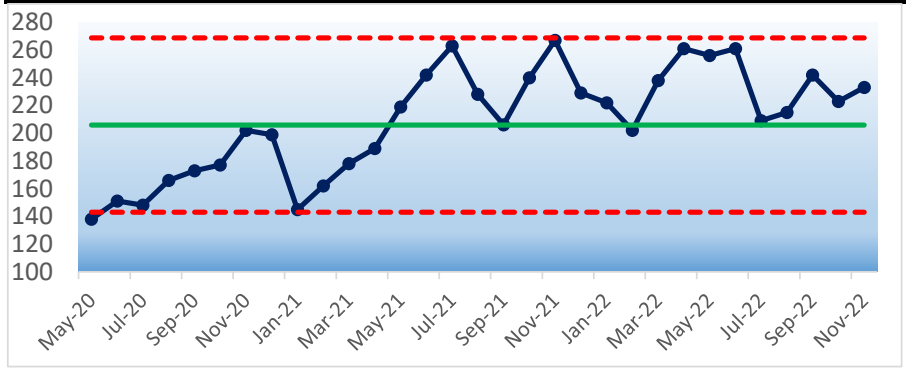
Non-Elective length of stay increased in December and remains above our local stretch target. There is a combination of factors affecting patient flow as described in indicators 6.5.1 - 6.7.1. Primarily driven by high numbers of patients remaining with no criteria to reside and patient extended stay whilst in isolation for Covid.

Indicator	**6.8 - Avoidable admissions**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Nov-22
Value / RAG rating	233

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

Provisional data indicates that there were 233 avoidable admissions in November, an increase on last month but remaining within the expected range. The most common diagnoses this month were respiratory conditions, including influenza, and urinary tract infections. Excluding children and admissions to SDEC, the November figure was 110.

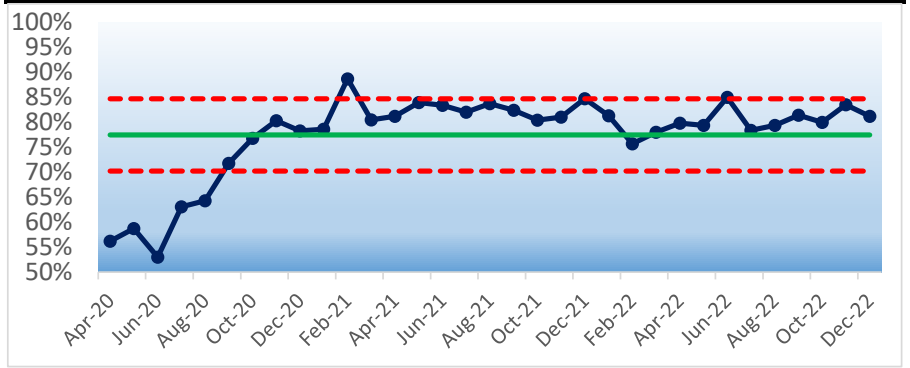
This is below pre-Covid levels - the average per month in 2018/19 was 270.

Indicator	**6.9 - Theatre utilisation (elective sessions)**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Dec-22
Value / RAG rating	81.2%

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

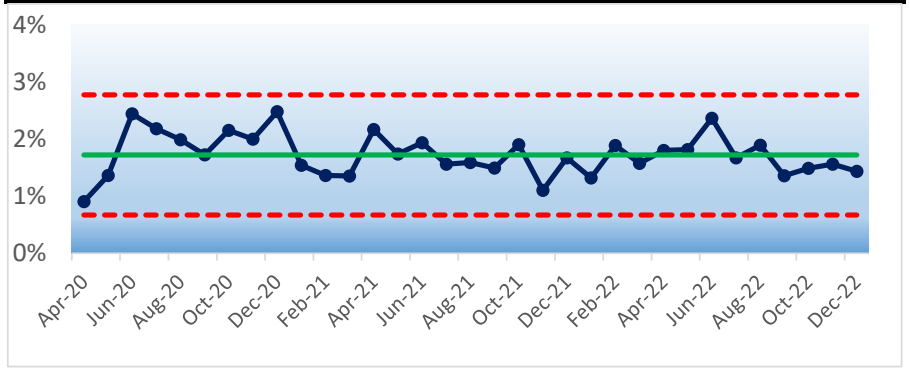
Theatre utilisation was at 81% in December, remaining below the local intermediate target of 90%. There is ongoing work across the board but focussed initial work with ophthalmology colleagues to understand how we achieve GIRFT productivity within HDFT.

Indicator	**6.10 - Day case conversion rate**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Dec-22
Value / RAG rating	1.4%

Indicator description

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

SPC chart



Narrative

1.4% (33 patients) of intended day cases stayed overnight or longer in December, a decrease on last month and remaining within the control limits.

Integrated Board Report - December 2022

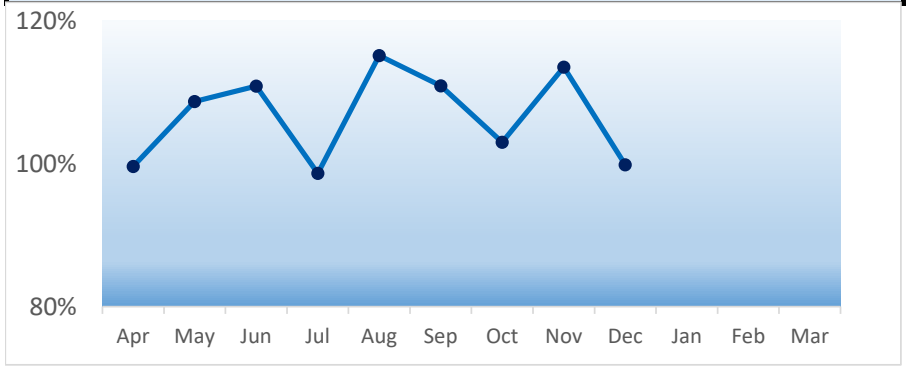
Domain 7 - Activity

Indicator	**7.1 - GP referrals against 2019/20 baseline**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Dec-22
Value / RAG rating	99.9%

Indicator description

GP referrals against 2019/20 baseline.

SPC chart



Narrative

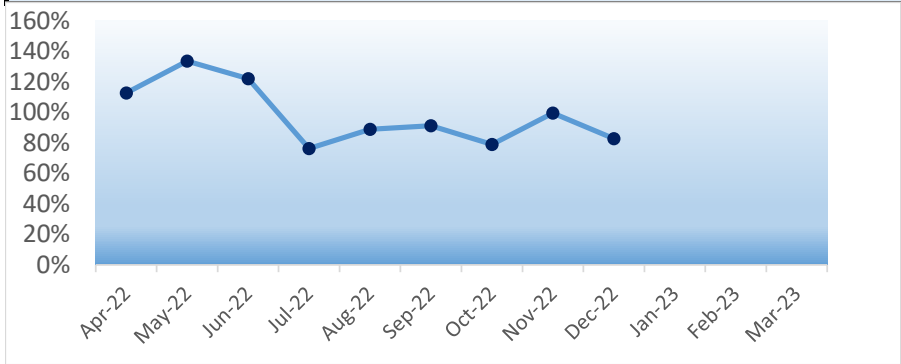
In December, GP referrals were at the same level as the equivalent month in 2019/20.

Indicator	**7.2 - Outpatient activity (consultant led) against plan**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Dec-22
Value / RAG rating	82.7%

Indicator description

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

Trend chart



Narrative

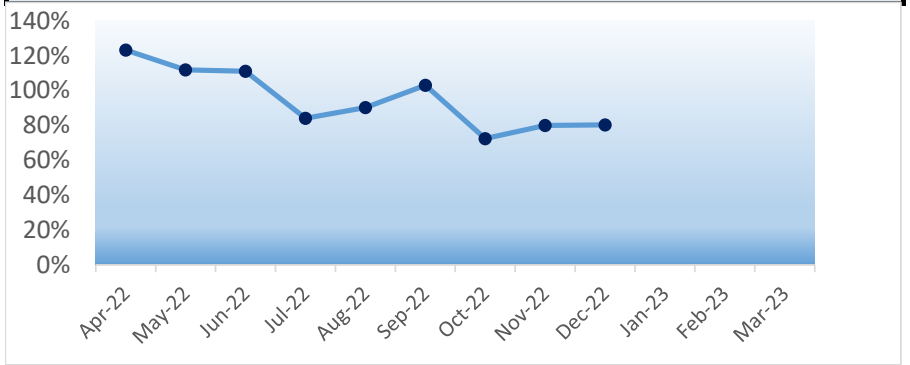
Outpatient activity was 17% below plan in December. New outpatient attendances were 33% below plan and follow up attendances were 8% below plan.

Indicator	**7.3 - Elective activity against plan**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Nov-22
Value / RAG rating	80.2%

Indicator description

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

Trend chart



Narrative

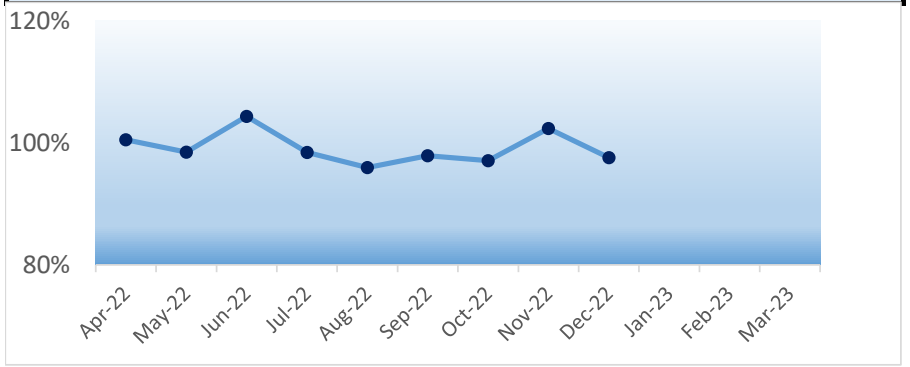
Elective admissions were 20% below plan in December. Elective day cases were 18% below plan and elective inpatients were 37% below plan.

Indicator	**7.4 - Non-elective activity against plan**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Nov-22
Value / RAG rating	97.6%

Indicator description

Non-elective activity against plan.

Trend chart



Narrative

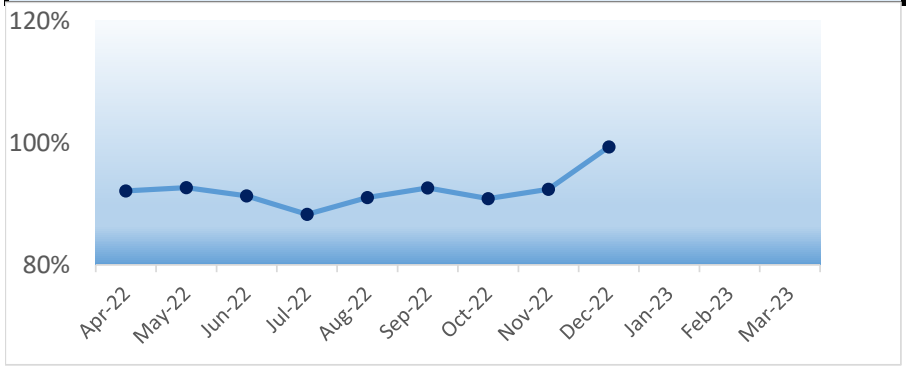
Non-elective activity was 3% below plan in December.

Indicator	**7.5 - Emergency Department attendances against plan**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Nov-22
Value / RAG rating	99.3%

Indicator description

Emergency Department attendances against plan.

Trend chart



Narrative

Emergency Department attendances were 1% below plan in December.

Integrated Board Report -December 2022

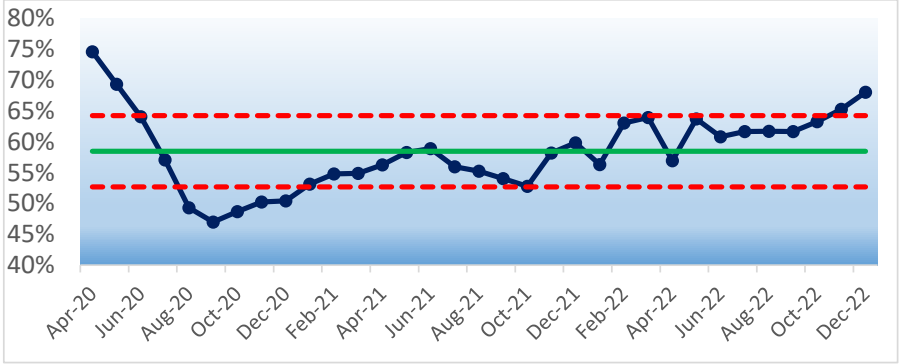
Domain 4 - Workforce

Indicator	**4.1 - Staff appraisal rate**
Executive lead	Angela Wilkinson
Board Committee	People and Culture Committee
Reporting month	Dec-22
Value / RAG rating	68.0%

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 December is 68.0%, which is an increase in comparison to November(65.3%). This remains a key area of focus and HR Business Partners are working with the Directorates to ensure recovery plans are in place.

PSC Directorate continue to see further significant increases in appraisal rate compared to the previous month, with an increase from 59.2% to 65.6%.

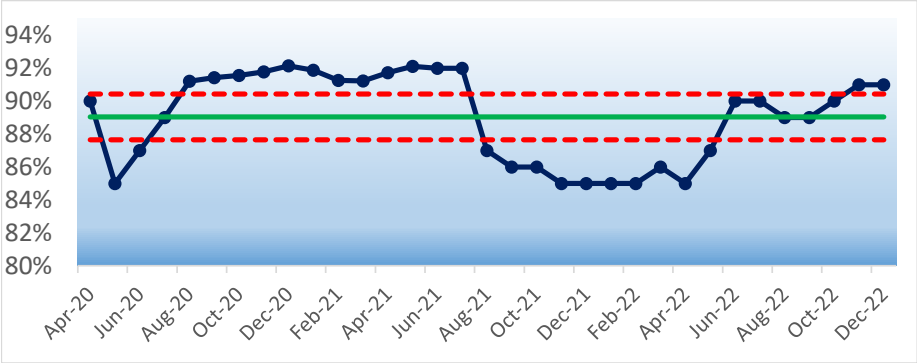
- Non-Medical appraisal % = 67.3% (previous month 64.6%)
- Medical appraisal % = 76.8% (previous month 73.5%)

Indicator	**4.2 - Mandatory training rate**
Executive lead	Angela Wilkinson
Board Committee	People and Culture Committee
Reporting month	Dec-22
Value / RAG rating	91.0%

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 December for the Mandatory Core elements of training. The overall compliance rate for substantive Trust staff is 91% and has remained the same since the previous month. The Mandatory Core overall compliance for bank staff is now 78% and remained the same since the previous month.

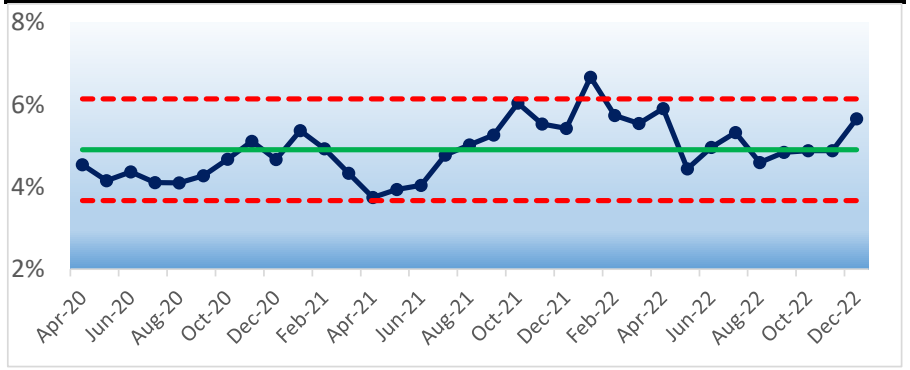
The overall compliance for Mandatory core and role based training for Trust substantive is currently 86% and has increased by 1% since the previous month.

Indicator	**4.3 - Staff sickness rate**
Executive lead	Angela Wilkinson
Board Committee	People and Culture Committee
Reporting month	Dec-22
Value / RAG rating	5.7%

Indicator description

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

SPC chart



Narrative

Sickness has increased in December from 4.9% to 5.7%. Covid sickness absence remains at a low level this month(0.3%). Winter flu season is primarily the reason for the increase to sickness this month, with absences due to 'Cold, Cough, Flu - Influenza' and 'Chest & respiratory problems' increasing by 58% compared to absences in November due to these reasons.

Sickness has increased across all Directorates, however LTUC saw the greatest increase of sickness from 4.0% in November to 5.5% this month. CC Directorate continues to see the greatest sickness levels and has a rate of 6.8% in December. The services within LTUC which have seen greater levels of sickness in December and contribute to the increase in the Directorate sickness are the Medical wards, medical staffing and MIUs.

Long term sickness has increased this month from 2.6% to 3.0% and short term sickness has also seen an increase from 2.3% to 2.6%.

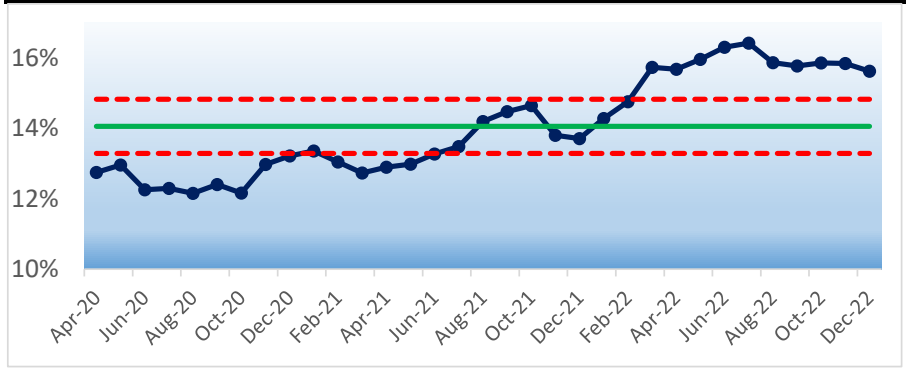
"Anxiety/stress/depression/other psychiatric illnesses" remains the top reason for sickness this month and contributes to 26.1% of the overall sickness. 114 employees were absent due to this reason in December. We continue to push Occupational Health, EAP and Wellbeing Services to support staff.

Indicator	**4.4 Staff turnover rate**
Executive lead	Angela Wilkinson
Board Committee	People and Culture Committee
Reporting month	Dec-22
Value / RAG rating	15.6%

Indicator description

The staff turnover rate excluding trainee doctors, bank staff and staff on fixed term contracts. The turnover figures include both voluntary and involuntary turnover. Data from the Times Top 100 Employers indicated a turnover rate norm of 15%.

SPC chart



Narrative

The Trust has seen a general decreasing trend and is 15.6% in December. (This incorporates voluntary and involuntary turnover). Voluntary turnover has decreased from 12.4% last month to 12.1% in December.

All clinical Directorates have seen a decrease in turnover rates in December. Turnover remains high in PSC Directorate in December, with a rate of 17.9%, however this is a decrease from the previous month of 18.3%.

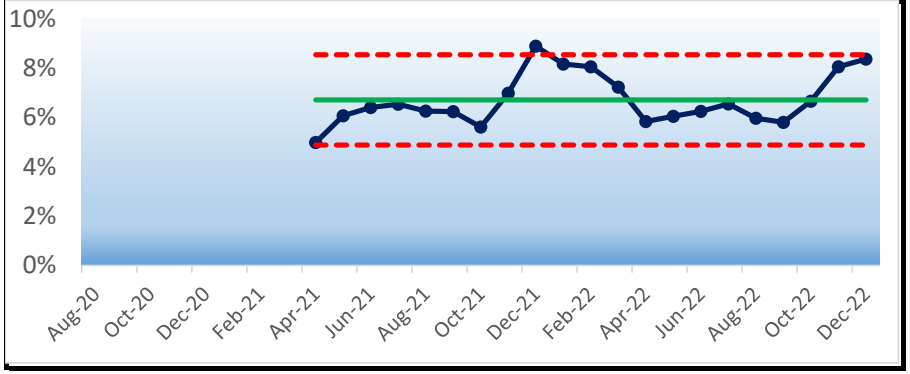
Of the December leavers (a total of 39.52wte), 6.91wte were Health Visitors. With the exception of a 0.60wte retirement, all Health Visitor leavers were voluntary resignations.

Indicator	**4.5 - Vacancies**
Executive lead	Angela Wilkinson
Board Committee	People and Culture Committee
Reporting month	Dec-22
Value / RAG rating	8.4%

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 December is 8.4%, which is an increase from 8.1% in the previous month. This equates to 370.31wte vacancies.

The reason for the increase in vacancies is due to an increase in budget this month of 20.07wte. Compared to last month, the number of staff in post has increased by 4.90wte.

HARROGATE AND DISTRICT NHS FOUNDATION TRUST
STANDING ORDERS
July 2022

1.0 PURPOSE

To approve those matters reserved to the Trust Board in accordance with the Trust's Standing Orders and Standing Financial Instructions.

2.0 APPROVAL OF SIGNING AND SEALING OF DOCUMENTS

The Trust Board is requested to authorise the use of the Trust seal as follows:

SEAL	DESCRIPTION OF DOCUMENTS SEALED	DATE	DIRECTORS
No 182	North Yorkshire County Council and Harrogate and District NHS Foundation Trust – Section 75 Partnership Agreement	July 2021	Angela Scofield (Chairman) and Steve Russell (Chief Executive)
No 183	Debra Wright (Trading as A&J Properties) and Harrogate and District NHS Foundation Trust	November 2021	Angela Scofield (Chairman) and Steve Russell (Chief Executive)
No 184	IMTECH Engineering Services North Limited (Outgoing Party), IMTECH Carbon Solutions LTD (Incoming Party) and Harrogate and District NHS Foundation Trust	December 2021	Angela Scofield (Chairman) and Steve Russell (Chief Executive)
No 185	Lease of Suite 6 Beehive, Linghead Point and Harrogate and District NHS Foundation Trust	March 2022	Angela Scofield (Chairman) and Jonathan Coulter (Chief Executive)
No 186	Hornbeam Lease and Harrogate and District NHS Foundation Trust	July 2022	Sarah Armstrong (Chair) and Jonathan Coulter (Chief Executive)

3.0 RECOMMENDATIONS

The Trust Board is requested to:

- Authorise the use of the Trust's seal

Kate Southgate
Associate Director of Quality and Corporate Affairs
July 2022

West Yorkshire Association of Acute Trusts (WYAAT) Programme Executive Meeting Notes and Actions

Date	**06/12/22**	**Location**	MS Teams
Chair	**Julian Hartley (items 1-3)** **Brendan Brown (items 4-11)**	**Minutes prepared by**	Hayley Conlon
Attendees	Lucy Cole, Brendan Brown, Foluke Ajayi, Mel Pickup, Trudie Davies, Jonathan Coulter & Phil Wood. Julian Hartley from 9.30 – 10am. Lauren Witton (observing from WYAAT).		
Apologies	Apologies from Julian Hartley (from item 4) and Len Richards.		

Agenda

ITEM		WHO
1	Attendance & Apologies	Chair
2	System issues and operational pressures	JH
3	WYAAT interim arrangements (JH departure) • Programme Exec Chair and ICB rep • Cancer Alliance Co-Chair • NEY Elective Taskforce	JH
4	Minutes & Actions	All
5	Collaborative Report	LC
6	WY HCP Report	LC
8	NSO Next steps to progress model	JP
9	Changes to the Provider Licence	LC
10	Provider Collaboratives: Innovators scheme	LC
11	AOB	All

PREVIOUS MEETING ACTION POINTS

Category	Action	Status/Update	Lead
	See Action Log. Actions 74, 75 and 76 were noted as completed and closed.		

	Action 71 (LC to bring a draft of the WYAAT Strategy) remains open with target completion date of 10 January 2023.		

By Agenda Item	Main Points and Decisions from Discussions	Agreed Actions
System issues and operational pressures	MYHT • Hit OPEL 4 last week, but this was beyond an OPEL 4 and concerns with patient safety. Yesterday there were numbers hitting 975 through ED causing pressures, this was mainly primary care presentations. CHFT • Discussed the anticipated effect the £500 Million social care investment on the hospital and discharge pressures. BTHFT • Record breaking day yesterday, 515 patients, this is a primary care and paediatrics issue. Having conversations around the £500 Million and how this will impact in Bradford District and Craven. Planning underway for strike action. ANHST • Experiencing same pressures, 2 weeks ago the trust was at OPEL 4 for 4 days, hit 260 last Monday which was a 50% increase. Last weekend, paediatrics was under a lot of pressure. HDFT • York having difficulties with CQC – had to close 30 beds previously and 30 beds recently due to safety. A&E capacity has gone down at York due to buildings. All directly impacting demand pressures at HDFT. HDFT nursing colleagues did not ballot to strike. Plans to increase beds in the community through the social care funding, however, given current capacity constraints this is unlikely to result in further capacity in the system. LTHT • Similar position, paediatrics hugely pressured. Currently at 315 no reason to reside patients. Ambulance handovers held a good position, but TCI waits in ED is challenging. Planning underway for strike action. Lucy Cole said a discussion at WYAAT COOs were held this morning, Clare Smith & Saj Azeb are keeping people up to date on derogations and therefore the impact of the strike action. LC noted that there was acknowledgement that other trusts not directly impacted by strike action may need to stand down elective activity in order to support primary services run from LTHT and BTHFT. Reflections were shared on the system coordination centre which launched on 1 December 2022.	**ACTION: Lucy Cole to check with Julian re System Leadership Tactical Meeting and feedback re SCC.**

West Yorkshire Association of Acute Trusts (WYAAT) Programme Executive Meeting Notes and Actions

WYAAT interim arrangements (JH departure) • Programme Exec Chair and ICB rep • Cancer Alliance Co-Chair • NEY Elective Taskforce	Julian Hartley leaves his role on the 1st February. The following interim arrangements were agreed by Programme Executive: • Cancer Alliance – Len Richards • NEY Elective Taskforce – Foluke Ajayi • Interim chair of Programme Executive WYAAT representative on the ICB – Brendan Brown Lucy Cole will confirm with ICB the interim arrangements.	**ACTION: Lucy Cole to contact ICB and confirm interim arrangements.**
Minutes & Actions	The minutes from the previous meeting were accepted as a true record and the action log had no further update.	
Collaborative Report	• Workforce – Portability agreement has been re-drafted to include cross site working from a virtual and physical perspective. HRDs have signed this off, the process will be carried out to ensure this is well communicated with HR teams and that application is consistent. • Theatre Workforce – Sub groups are established covering the core workstreams. • S4S – inventory management system is live in MYHT, LTHT & CHFT. This will then be rolled out to ANHST & BTHFT and HDFT before the end of the financial year in the first areas of deployment. • Planned Care - GIRFT visit on Monday to take place virtually. • 78-week position – only 48 behind planned position with a good reduction in the preceding week. 52-week position – 1000 behind plan but continuing to make reductions to the numbers of patients waiting. • Focus on re-establishing clinical networks – focus the six high volume, low complexity (HVLC) specialties in the first instance. Group established around right procedure right place. • Pathology – Due to have ANHST / BTHFT go live in November in the LIMS for blood transfusion – trusts made no-go decision after identifying an issue in testing. First go live will now be cellular pathology in January. • Pharmacy Aseptics – been working through process in terms of finance – preference to try get under £25M. Mel Pickup asked if BTHFT unit is in £25M, LC confirmed it was. • Diagnostics – Imaging – Image sharing solution now got live feed from 4 of 6 trusts, other 2 to go live in the next couple of months. Now into testing dummy patients in system. • CDCs – official confirmation that money will be broken nationally and will be available next year. Trying to work through and understand what the capital ask is for future years for each Place.	

	• Endoscopy – put forward collective bids for £27m, including significant works in Bradford. Bids from MYHT, CHFT & LTHT which will be around supporting capacity and availability across sites.	
WY HCP Report	• Rachel Gillott joined YAS as System Director and therefore will be the link for West Yorkshire. Rachel Gillott will be invited to COOs and this will be an open invite. • Financial Position changes – positive and additional funding from specialised commissioning has been supportive to the ICS plan to breakeven. • UEC programme – established with clear priorities and working closely with discharge programme.	
NSO Next steps to progress model	*Jason Pawluk joined the meeting.* • Jason Pawluk (JP) provided a summary of the current position on the NSO programme including the progression of work in both the North and South sector. JP noted that Len Richards had highlighted the key issues for resolution. Three main points needed to clarify on are: o Commitment to the long-term direction of travel that was stated in the original model. o Need for an equitable model. o Assurance that services are sustainable. • CEO & MD meeting needed for this work. Brendan Brown added he thinks COOs should be involved. • Mel Pickup said her primary concern is how is she going to substitute the medical inpatient provision to that that is lost to the centre, as a system how can we support additional need to BTHFT? Investment case going forward also needs to be carefully considered to ensure affordability. • JP noted that the advice currently is that it is unlikely a statutory public consultation is required, but significant engagement work is required which needs to progress. On the investment case, JP clarified that many of the 'new roles' required will come from the existing cost base but that the workforce model needs to be finalised. • Phil Wood said we came into this due to workforce shortage therefore any model that is about recruiting into a national shortage of workforce is something we need to carefully think about. • LC noted that it would be helpful to have some clear inputs into the CEO / MD / COO session to work through the assumptions and identify any areas which required further work to provide assurance that the model would be effective.	**ACTION: CEOs, COOs & MDs to meet to discuss. PMO to arrange for early January 2023.** **ACTION: JP to provide inputs requested for that session.**
Changes to the Provider Licence	LC noted that she had received feedback from the trusts on their own Boards' views on the proposed changes to the provider licence and noted the following: • No major objections – most provisions were supported. • View that independent sector should be subject to provisions same as NHS Trusts and FTs, particularly in relation to duty to collaborate and on sustainability. • Recognition of additional resources required for FTs to maintain a Governing Body – now the only distinction between FTs and non-FTs	**ACTION: LC to update ICB and submit a WYAAT response to the consultation.**

West Yorkshire Association of Acute Trusts (WYAAT) Programme Executive Meeting Notes and Actions

	• Practically, no single document had been published containing all of the provisions of the licence.	
Provider Collaboratives: Innovators scheme	LC highlighted the key elements of the WYAAT application to join the Innovator programme: • Request for support on developing the governance around operational networks and the associated accountability arrangements between organisations • Taking a data science approach to longer-term planning, particularly focused on planned care, future waiting list demands and therefore informing service model design in the future. • LC noted that there was support from the four ICB Chief Executives in the NEY region for WYAAT to be the nomination on behalf of the region.	**ACTION: LC to share with Rob Webster and Ian Holmes and to submit through the national application process.**
AOB	• Staff Awards for collaboration across organisational boundaries – Group all agreed this was a good idea and to share their trust lead on this with LC.	**ACTION: CEOs to inform Lucy of trust representatives for awards.**

OTHER ISSUES TO NOTE

NA

NEW RISKS/ISSUES RAISED

NA

Next Meeting	**WYAAT Programme Executive**		
Date	10/01/23	**Location**	MS Teams

Humber and North Yorkshire
Health and Care Partnership

Collaborative of Acute Providers (CAP) Board Meeting
19th December 2022 10.00-11.30
Via Teams

Those Present: Chris Long (CL), CEO, HUTH (Chair)
Wendy Scott (WS), CAP MD
Jonathan Coulter (JC), Acting CEO, Harrogate Hospital NHS Trust
Matt Graham (MG), Director of Strategy, Harrogate Hospital NHS Trust
Andy Bertram (AB), Chief Financial Officer, York Hospital NHS Trust
Peter Reading (PR), CEO, NLaG (PR left the meeting at 11.00)
Simon Morritt, CEO, Y&STFT
Ivan McConnell (IM), Director of Strategic Development/Director NLaG
Shauna McMahon (SM) Chief Information Office NLaG
Stephen Eames (SE) Chief Executive, HNY Health & Care Partnership
Kate Wood (KW) Chief Medical Officer (NLaG)

In Attendance: Lynne Cheesman (LC) PA (Note Taker)

1 Apologies:
Amanda Bloor, Shaun Stacey, Shaun Jones

2 Minutes of the meeting held on the 28.11.22
The minutes were approved as an accurate record of the meeting.

CL confirmed his meeting with Stephen Eames but advised that he did not discuss the ICB consultation process.

3 Action Log from 19.11.22
Action log updated.

4 Elective Reporting

WS confirmed since the last meeting the following items have been circulated:

1. A summary that Anil has prepared on the current position around electives.
2. A highlight report giving a lot more information on the delivery of the CAP programmes.

5 CAP Governance Paper

WS confirmed that the draft CAP governance documents have been shared with Trust governance leads. The CAP governance group has had meetings with Robert McGough from Hill Dickinson. The proposed draft CAP governance board papers have been circulated to the governance leads to socialise within the organisations and a request was made for comments or amendments to be made and shared with the governance working group. The plan is to submit finalised governance documents for Board sign off at Boards at the end of January/beginning of February.

Humber and North Yorkshire
Health and Care Partnership

6 UEC

WS – the issue of where the HNY UEC Programme 'sits' i.e. who leads it has not been resolved yet, however Wendy has spoken with Amanda Bloor and she is planning to have the discussion about it at the next ICB committee. Jonathan Coulter is chairing the HNY Winter Assurance Board that's been set up. Sue Rogerson the HNY Programme Director leaves this week and there's a question about what happens to the pieces of work that will not be taken forward until the new UEC Programme Director Rebecca Elson starts in post on 16th January.

CL then suggested Stephen Eames presented his vision of the ICS and CAP and this would follow with a Q&A session.

7 Stephen Eames - ICS & CAP Vision

Amanda Bloor was not present at the meeting as she was involved in the preparations for what is happening with the current strike action during the course of the week.

Key summary of the discussion areas and points that Stephen raised:

Key challenge is balancing the here and now and operational pressures with achieving longer term ambitions of ICS's – triple aim/ambitions of ICS's.

Need to level the challenges we want to make – left shift to preventative care, care in the community and addressing health inequalities. However, this has to be 'second order to delivery'.

Still some uncertainty about where accountabilities lie – NHSE/ICS – National, Regional, Local – Hewitt review might help to clarify this. One of the challenges relates to the lack of uniformity of ICSs. All at different stages of development and evolving at a different pace.

5 years from now SE would want his legacy to be – the ICS has shifted the dial to close the gap in relation to life expectancy in different parts of the patch and shifted resources to support this.

The model to support strategic commissioning isn't 'cooked yet' – need to work out what we mean by commissioning

ICS role is to support and assist collaboratives and provide the 'right environment' for providers to flourish.

SE believes that in 5 years' time the provider landscape will look very different – providers needs to work out the best way of organising themselves.

He has chosen to go 'down the sector collaborative route – we have 5 collaboratives with a 6th pending (EOL) – it's important that collaboratives link up otherwise they become isolated. We may want a different collaborative model over time.

Collaboratives need to have a compelling vision, a compelling strategy for the services they deliver and do 'things once' – he also referenced a single waiting list, a mobile workforce and rationalisation of back office functions.

Humber and North Yorkshire
Health and Care Partnership

He recognises that the balance between Place and Collaboratives is an area that needs further work- potentially a workshop in 2023 to discuss this?

There is a national push to accelerate the role of collaboratives

He referenced the importance of professional leadership and the need to develop this

He talked about collaborative members needing to hold each other to account for delivering their agreed objectives.

He referenced his view that there should potentially be a CAP CEO linked in to the ICB Executive Team

He talked about the development of the collaborative being for the collaborative to decide…..what we do and how we do it is for us to get on with.

He also referenced the NHSE workforce reconfiguration and efficiency requirements and the potential ripple effect of this into ICSs.

SE reminded everyone that the 1st submission of the Hewitt Review had been made on Friday 16th December, this was a first cut and completed within 3 weeks, but the real review and the bigger outcomes will be published in March. The aim is to try to reduce the burden whilst increasing the delegation of authority and responsibility to ICBs. This is being done across 42 ICS's which all have different levels of maturity. SE said he had raised the question of this at a recent meeting, challenging the theory that nationally they view all ICS's as the same, when in fact they all very different.

SE raised the recent ministerial visits to HNY and referenced Mary Colefield Minister for mental health and maternity who is meeting with every ICS chair over Christmas. This he thinks will reemphasise the point of the political focus on ICBs.

With relation to Peter's comment in relation to engaging with LAs and 'deals', he advised that in the end place is important from a local authority point of view, so what collectively can we do? We can collectively lobby on the inequalities point, but the real deal is probably local. With reference to resources, there should be a review focused around priorities in each of those places. This requires the NHS putting all its money on the table and the local government doing the same. That is the aim, albeit potentially very difficult to achieve. Whilst the 18 million extra money has been released to support discharge, there is well over 70-80 million wrapped up in BCF's across the ICS and maximising the potential of this can only be achieved with the right relationships with local leaders. There's a lot ICS's need to do to demonstrate their worth for a local government perspective.

IM confirmed he spends a lot of his time agreeing deals with local government, but asked is there something to consider about how the ICS can work with local partners and government on capital; where that can take place locally, because capital is a big issue There are also issues around people and resources. We only have £65 million capital monies, so the issue is how can we mobilise them to get the best out of these resources..

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SE referenced the work happening re NHSE functions and workforce.The commissioning dimension may move quicker than planned. In our region alone there are 350 people working on specialist commissioning, and we need to be mindful how we shave things down between collaboratives and place. There are lots of resources at higher grades i.e., 8A, B, C, D and 9 which is probably too many. To that end, we established regionally our 4 into 1 approach, so we tried to coordinate that together for the North East and Yorkshire, but we need to do the same in our ICB, so coming back to ICB leaders these are the sort of issues that will be on our mind.

CL asked for any questions.

MG asked regarding the balance between place and collaboratives - how will that work in the future?

SE agreed this is a good question and is an area that needs further clarity. Place needs to be about integrating people and resources wherever they are: in the voluntary sector, in primary care, local government in health to get that premium i.e. can we get better outcomes for our patients by organising differently at place. How that will look in our 6 places will be interesting. North Yorkshire is challenging, very complex and geographically much bigger, but if you look at the link between place and collaboratives, i.e., older people services, the interface between primary and secondary care, we can create the framework and the support and development for that, but how do the leaders within the collaboratives come together to achieve better outcomes and to create efficiencies?

Examples:

1. Do you all need a HR department?
2. Can you articulate a compelling strategy for the next 5-7 years?
3. Could you have a single waiting list with a mobile workforce of surgeons who go to various locations?
4. Where can you get a premium from working together that you could not get otherwise?

PR - the pullback towards commissioning at place is very strong. It's difficult for people who have worked in CCG's to work differently and ICS's aren't CCGs .

SE – I do not like the word commissioning either, but one of the big responsibilities of collaboratives will be commissioning, but it becomes much more of an integrated team provider responsibility, the ICB will commission some things but through the operating model of place and collaboratives. A lot of work is still required to how this is done, and how we will ensure that we do it well.

CL asked what the strategic commissioning model is i.e. what will look like across the ICS? SE advised that it's not entirely clear yet.

SM – Asked about accountability and CAP. " I will use Wendy's role as an example, i.e., where does the accountability lie? Is Wendy helping achieve that premium you were talking about, is she performance managing my team in Scarborough, is she accountable for all acute providers across ICB with a lead into NHS England and the ICB or is it all 3, because if it is we need to think carefully about this" There has been some confusion and different asks and levels of understanding about CAP and the CAP MD role.

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SE – Nationally the ambition is to accelerate the role of collaboratives and their development. The Collaborative Director is accountable to the collaborative CEOs, not the ICS. I think it's for you to decide what Wendy does and what she is responsible/accountable for, (and you can't actually do that without determining what's the role of the CAP Chief Executive).

SE – when referencing the potential need to achieve a 20% reduction in the ICS headcount across 2023/24 (2 years) - we need to decide what we do with people within our remit and how we apply that 20%. One of the options is where people are actually employed; this will be a discussion for the new year.

WS and IM Presentation – High Level Planned Care Strategy – Proposed Approach

Wendy explained they are aiming for a high-level plan by end of April 2023.

IM – Asked if everyone is in agreement to tender the analytics work - this was agreed.

9 AOB
Nothing raised.

Date and time of next meeting: Monday 16th January 10.00 – 12.00 by Teams