Board of Directors Meeting (Public)
will be held on Wednesday 29th September from 9.00am – 1.00pm
at the Pavilions, Great Yorkshire Show Ground,
Harrogate North Yorkshire, HG2 8QZ

AGENDA

Item No.	Item	Lead	Action	Paper	Time
SECTION 1: Opening Remarks and Matters Arising					
1.1	**Welcome and Apologies for Absence**	Chairman	Note	Verbal	9.00
1.2	**Patient Story**	Deputy Director of Nursing	Note/ Discuss	Verbal	
1.3	**Declarations of Interest and Register of Interests** *To declare any new interests and any interests in relation to open items on the agenda*	Chairman	Note	**Attached**	
1.4	**Minutes of the Previous Board of Directors meeting held on 28th July 2021**	Chairman	**Approve**	**Attached**	
1.5	**Matters Arising and Action Log**	Chairman	Discuss/ Note/ Approve	**Attached**	
1.6	**Overview by the Chairman**	Chairman	Discuss/ Note	Verbal	9.30
SECTION 2: CEO Updates					
2.1	**Chief Executive Report**	Chief Executive	Discuss/ Note	**Attached**	9.40
2.2	**Corporate Risk Register**	Chief Executive	Discuss/ Note	**Attached**	
SECTION 3: Patients and Service Users (Quality and Safety)					
3.1	**Quality Committee Chair's Report**	Quality Committee Chair	Note	**Attached**	9.50
3.2	**Integrated Board Report –** Indicators from Safe, Caring and Effective domains	Executive Directors	Note/ Discuss	**Attached**	
3.3a	**Director of Nursing Report**	Director of Nursing, Midwifery and AHPs	Note/ Approve	**Attached**	10.00
3.3b	**Freedom To Speak Up Annual Report**	Freedom to Speak Up Guardian	Discuss / Note	**Attached**	10.10
3.3c	**Strengthening Maternity and Neonatal Safety**	Director of Nursing, Midwifery and AHPs	Note	**Attached**	10.20
3.4a	**Medical Director Report**	Executive Medical Director	Note	**Attached**	10.30
3.4b	**Guardian of Safe working Quarterly Report**	Guardian of Safe Working	Note	**Attached**	10.40

3.4c	**Learning from Deaths Quarterly Report – Quarter 1 2021-22**	Executive Medical Director	Note	**Attached**	10.50
3.4d	**IPC Service Annual Plan and Progress 2020-21**	Executive Medical Director	Note	**Attached**	
Comfort Break (11.00 – 11.15)					
SECTION 4: People and Culture					
4.1	**People and Culture Committee Chair's Report**	People and Culture Committee Chair	Note	**Attached**	11.15
4.2	**Integrated Board Report –** Indicators from Workforce domain	Executive Directors	Note/ Discuss	**Attached**	
4.3	**Workforce Report**	Director of Workforce and Organisational Development	Note/ Approve	**Attached**	
SECTION 5: Strategy & Partnerships					
Board Reports					
5.1	**Board Assurance Framework**	Chairman	Note	**Attached**	12.00
5.2	**Healthy Partnership 0-19 Services**	Chief Executive	Note	**Attached**	
SECTION 6: Use of Resources and Operational Performance					
6.1	**Resource Committee Chair's Report**	Resource Committee Chair	Note/ Discuss	**Verbal** *(timing of meeting)*	12.15
6.2	**Integrated Board Report –** Indicators from Responsive, Efficiency, Finance and Activity Domains	Executive Directors	Note	**Attached**	
6.3	**Director of Finance Report**	Deputy Chief Executive / Finance Director	Note/ Approve	**Attached**	
6.4	**Chief Operating Officer's Report**	Chief Operating Officer	Note/ Approve	**Attached**	
6.5a	**Organisational Development Report**	Director of Workforce and Organisational Development	Note	**Attached**	
6.5b	**Workforce Race Equality Standards (WRES) Annual Report**		Approve	**Attached**	
6.5c	**Workforce Disability Equality Standards (WDES) Annual Report**		Approve	**Attached**	
6.5d	**Gender Pay Gap Report**		Approve	**Attached**	
6.5e	**Ethnicity Pay Gap Report**		Approve	**Attached**	

SECTION 7: Governance Arrangements					
7.1	**Audit Committee Chair's Report**	Committee Chair	Discuss	**Attached**	12.30
7.2a	**Senior Management Team Report 18 August 2021**	Senior Management Team Chair	Note	**Attached**	
7.2b	**Senior Management Team Report 22nd September 2021**				
7.3	**2021-22 Board Workplan**	Chairman	Note	**Attached**	
8.0	**Any Other Business** *By permission of the Chairman*	Chairman	Note/ Discuss/ Approve	Verbal	12.45
9.0	**Board Evaluation**	Chairman	Discuss	Verbal	12.55
10.0	**Date and Time of next meeting** Wednesday, 24th November 2021				
Confidential Motion – the Chairman to move: *Members of the public and representatives of the press to be excluded from the remainder of the meeting due to the confidential nature of business to be transacted, publicly on which would be prejudicial to the public interest.*					

NHS
Harrogate and District
NHS Foundation Trust

Board of Directors Register of Interest
As at 29th September 2021

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

				3. Lead Chief Executive for Workforce in Humber Coast and Vale ICS (October 2020) and ongoing) 4. Chair of Non-Surgical Oncology Steering Group (April 2021 and ongoing) 5. NHS Employers Policy Board Member (September 2020 and ongoing) 6. Chair of Humber Coast and Vale ICS BAME Network (August 2020 and ongoing) 7. Joint SRO for planned care West Yorkshire and Harrogate ICS (June 2020 and ongoing)

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

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

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

NHS
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Board of Directors Meeting
Wednesday, 28th July 2021 from 9.00am – 1.00pm
at the Pavilions, Great Yorkshire Show Ground, Harrogate North Yorkshire, HG2 8QZ

Present
Angela Schofield, Chairman
Sarah Armstrong, Non-executive Director
Andy Papworth, Non-executive Director
Laura Robson, Non-executive Director/Senior Independent Director
Richard Stiff, Non-executive Director
Maureen Taylor, Non-executive Director
Wallace Sampson OBE, Non-executive Director
Steve Russell, Chief Executive
Jacqueline Andrews, Executive Medical Director
Jonathan Coulter, Finance Director/Deputy Chief Executive
Russell Nightingale, Chief Operating Officer
Emma Nunez, Interim Director of Nursing, Midwifery and Allied Health Professionals (*from minute 4.1)*
Angela Wilkinson, Director of Workforce and Organisational Development

In attendance
Laura Angus, NExT Non-executive Director
Gemma Gregory, Matron (via MS Teams for Minute 2)
Kat Johnson, Clinical Director for Planned and Surgical Care Directorate
Natalie Lyth, Clinical Director for Community and Children's Directorate
Matt Shepherd, Acting Chief Operating Officer/Clinical Director for Long Term and Unscheduled Care Directorate
Kate Southgate, Company Secretary

Observing
One member of the public

Item No.	Item
BD/7/21/1	**Welcome and Apologies for Absence**
1.1	The Chairman welcomed everyone to the meeting. It was noted that Kate Southgate, Company Secretary had joined the Trust and this was her first formal Board meeting.
1.2	It was noted that Emma Nunez, Interim Director of Nursing, Midwifery and Allied Health Professionals had been delayed in traffic.
1.3	Apologies for absence were noted from Jeremy Cross, Non-Executive Director.
BD/7/21/2	**Patient Story**
2.1	The Chief Executive introduced the patient story and the Chairman welcomed Gemma Gregory to the meeting.
2.2	Gemma Gregory, Matron joined the meeting virtually to present the story of a patient who had sadly fallen three times during their stay with the Trust. She explained that there had been a multi-agency complaint from the family of the patient who had agreed for the story to be shared.

2.3	The patient sustained fractures including to the left neck of femur as well as testing positive for Covid-19 during her inpatient stay. The family were concerned and upset about some aspects of care received. During the episodes of care, it was noted that communication between teams and with the family, was not as it should have been on occasion. Gemma Gregory discussed the impact on the patient and her family, and reported that, over time, a very positive relationship developed with the patient's family. They had expressed their appreciation for the efforts that had been made to improve the care for their relative.
2.4	The board members discussed with Gemma Gregory the impact of Covid-19 on the case as well as the impact the case had on the family and the teams. Schwartz rounds were introduced on the Covid-19 wards to support team members and facilitate the sharing of learning.
2.5	Matt Shepherd highlighted the impact and dedication Gemma Gregory had on this patient's care. The Board thanked her for commitment and care.
2.6	The Board noted the emotional impact on the family and the teams involved in the patient's care. In addition, the importance of effective and reliable communication and trust were highlighted.
2.7	The Chairman thanked Gemma Gregory for sharing the patient story.
2.8	**Resolved:** the patient story was noted.
BD/7/21/3	**Declarations of Interest and Register of Interests**
3.1	The register of interests was received and noted.
3.2	It was noted that Jonathan Coulter is Interim Chief Executive of HIF. Sarah Armstrong is a Director of Harrogate Integrated Facilities (HIF). Wallace Sampson is Chief Executive of Harrogate Borough Council, Emma Nunez is seconded from NHS Improvement and England (NHSE/I) and Angela Wilkinson and Russell Nightingale are Directors of the ILS and IPS Pathology Joint Venture.
3.3	**Resolved:** the declarations were noted.
BD/7/21/4	**Minutes of the Previous Board of Directors meeting held on 26th May 2021**
4.1	*Emma Nunez joined the meeting.*
4.2	**Minute 18.5 –** It was noted that Andy Papworth was a Non-Executive Director not an Executive Director.
4.3	**Resolved:** the minutes of the last meeting held on 26th May 2021 were agreed as an accurate record subject to the change noted above.
BD/7/21/5	**Matters Arising and Action Log**
5.1	There were no matters arising from the previous meeting that were not noted on the action tracker or included on the agenda.
5.2	BoD/05/21/8.2 – The title of the action was amended to reflect that the action related to the Modern Slavery declaration. A review of safeguarding training was currently being undertaken and modern slavery would be included in it. It was agreed that further information would be submitted in September 2021.
5.3	The following actions were agreed to be closed:

	BoD/01/21/11/10 – It was noted that the metrics for 0-19 services had been agreed and data would be included in subsequent IBRs. Closed. BoD/03/21/11.4 – It was noted that the update on the internal audit report was provided and that the report would now be monitored through internal governance channels and via the Audit Committee. Closed BoD/05/21/23.2 – Limited assurance reports were now included as a standing agenda item at Private Board. Closed. BoD/07/20/17.7 – QI methodology was included as a Board workshop in June 2021. Closed. BoD/11/20/13.3 and BoD/03/21/9.3 – A revised style of IBR was presented at the July 2021 Board. Closed. BoD/11/20/16.2 – Learning from Deaths, Mortality and Morbidity was included as a Board workshop in June 2021. Closed. BoD/01/21/17.9 – Maternity was included as a Board workshop in June 2021. Closed.
5.4	**Resolved:** sufficient assurance was received to update and / or close actions as detailed.
BD/7/21/6	**Overview by the Chairman**
6.1	The Chairman reminded all present of the topics discussed at the Board workshop that was held in June 2021. The discussions held in relation to amending the Board agenda and report styles had been taken forward and were reflected on the agenda today. All were thanked for their contribution.
6.2	The Chairman noted that an anonymous email had been submitted to the Trust. It alleged that some colleagues were concerned to "speak up". This was reported to NHSI/E by the Trust. The Non-Executive Directors had agreed to undertake an investigation in accordance with the Speaking Up Policy. They had met with individual members of the Senior Management Team to discuss the comments made. Further communication would be circulated in due course.
6.3	A new Freedom to Speak Up process had been put in place and Charly Gill would be the interim Freedom to Speak Up Guardian.
6.4	The revised BAF and new style of IBR were noted. All were thanked for their contributions. It was noted that training on the IBR and SPC Charts would commence in due course.
6.5	The outcome of the Secretary of State's Local Government Review had been concluded. A new North Yorkshire Unitary County Authority would be created and York Unitary Authority would remain. Wallace Sampson noted that the focus for the next 18 months was on a smooth transition and to ensure the wellbeing of staff involved. Transitional arrangements were being implemented. First elections would be in May 2022. The Chairman thanked Wallace Sampson for his continued contribution to the board and recognised that this would be a very busy time for him.
6.6	On the 1st September 2021, Harrogate Hospital Radio will receive an FM licence.
6.7	**Resolved:** The Chairman's report was noted.

BD/7/21/7	**Chief Executive Report**
7.1	The Chief Executive noted the contents of his report as read.
7.2	Since the last Board meeting there has continued to be a significant focus on the priorities in relation to (i) recovery of our 0-19 services, (ii) recovery of our elective services, (iii) caring at our best and (iv) the health and wellbeing of colleagues
7.3	The community Covid-19 case rate had been high and was 473 per 100,000 population for the 7 day period ending 15th July 2021. Community Covid-19 cases had now seen a reduction in rates. It was noted however, that there was a potential lag in terms of hospital admission. This was being monitored closely at a senior level. Although legal restrictions which were introduced during the pandemic had been lifted from 19th July 2021, all of the measures the organisation put in place to protect patients and colleagues remained in place. The organisation would continue to follow the guidance for self-isolation, and risk assessments were in the process of being developed in relation to service continuity. 68 colleagues were currently absent from work in relation to Covid.
7.4	Andy Papworth queried compliance levels in relation to PPE. It was noted that internally within the organisation, compliance was good.
7.5	Richard Stiff queried the numbers for Covid cases and staff risk assessments. It was noted that 8 of the Trust's current inpatients were admitted due to Covid. Risk assessments for clinical staff returning to work when contacted by the national track and trace app would be completed on the basis of patient safety.
7.6	Elective activity had continued to recover; the waiting list was growing because referrals had not only returned to previous levels but were greater than in 19/20. In addition, attendances at the Emergency Department were now 11% higher than in 2019/20 and emergency admissions were 5% higher which was placing considerable pressure on acute services.
7.7	Andy Papworth, raised an issue in relation to funding availability and the increase in pressures. It was noted that the level of Covid funding would potentially reduce. Information about the funding arrangement for the second half of the year had not yet been received.
7.8	CQC had completed their consultation on the approach to their inspections. Some elements would occur immediately; others would impact from 2022. The CQC would continue a risk based approach and would change the way ratings are completed. **Action:** This would be discussed further at a future Board workshop.
7.9	It was noted that NHS Providers had called on the Government to provide stability on the following: – discharge to assess, access to the Elective Recovery Fund (ERF), funding the pay award, making requirements for the second half of the year reasonable, making available capital for winter and elective recovery.
7.10	At the recent WYAAT Committee in Common the process of reflecting on the WYAAT vision and purpose had been undertaken. It was confirmed that the focus remained on the benefits for patients benefits resulting from collaborative working.
7.11	Sarah Armstrong, noted the launch of the teamHDFT App. It was confirmed that approximately 600 colleagues had downloaded the app to date. Further information would be provided to the People and Culture Committee.
7.12	Angela Schofield raised the Inpulse survey. It was confirmed that 14 questions were included on the survey and some related to values and behaviours. 250 colleagues had current completed the survey. In addition, it was confirmed that on the teamHDFT app,

	once a colleague had completed the survey, the wider results to each question were displayed. Once the survey had closed, line managers would receive a bespoke report.
7.13	There had been positive progress in 0-19 services. There had been a successful over-recruitment of Band 5 nurses as part of the mitigation to the vacancies in school nursing and health visiting and the new safeguarding resources were coming into place alongside the internal mutual aid. There remains growing demand in safeguarding and much higher requirements for targeted support so there continued to be challenges, but the staffing situation was forecast to improve in September.
7.14	Laura Robson raised a query relating to an increase in safeguarding cases. It was noted that safeguarding children cases had seen an increase, but this was starting to level off although it was not at pre Covid levels.
7.15	**Resolved:** The Chief Executive's Report was noted.
BD/7/21/8	**Corporate Risk Register**
8.1	The Chief Executive outlined the changes made to the Corporate Risk Register since the last meeting, including the mitigation of risks. The following risks were discussed in greater detail:
8.2	**CRR34 – Autism Assessment**. The current position was that a further increase in referral rate had meant that baseline capacity was less than demand (It currently stands at 590 (an increase from 576 last month and the longest wait is currently 71 weeks. The Trust was developing a proposal to reduce the recovery timescales, and to support the service sustainably, this was due to be completed by September 2021.
8.3	Jeremy Cross, via the Chairman, queried if early triage was conducted for autism referrals. It was noted that it was in place and that the Trust was going to pilot early advice and guidance.
8.4	Wallace Sampson queried the numbers and the national benchmarking for waiting times. It was noted that national benchmarking was not currently available. It was confirmed that additional non-recurrent funding had been provided to increase capacity but the risk remained with the further growth in referrals.
8.5	Sarah Armstrong noted the information available on HDFT websites. She queried if other national and local organisations were at capacity. It was confirmed that it was not known if this was currently the case.
8.6	Richard Stiff queried if the waiting times meant delays in Educational Health and Care Plans (EHCPs). It was confirmed that this was not the case as EHCPs are based on need not diagnosis and support was available..
8.7	**CR41 – RTT**. This risk remained scored as 12. The controls in place meant that 87% of P2 patients were waiting under 28 days, with those waiting longer largely being due to patient choice.
8.8	Andy Papworth, queried patient choice if they choose to defer. It was confirmed that the patient would remain within the P2 category. If patients, changed their mind and wished to be reviewed / treated they would be offered a date for treatment.
8.9	The Chief Executive highlighted two new risks added to the corporate risk register: **CR48 – Mental Health services for ED patients.** This relates to the risk to patient and staff safety due to long delays in accessing beds for patients who needed mental health care and were at high risk.

	CR63 – Violence and aggression from patients in ED. This relates to the risk of physical and/or psychological harm to staff or other patients arising from the increasing number of incidents relating to violence or threat of violence to staff from patients attending ED.
8.10	Richard Stiff queried what a designated security responder was. It confirmed that they were drawn from the current porter team and they have an enhanced level of training.
8.11	Jeremy Cross, via the Chairman noted his support for the action being taken.
8.12	The Chief Executive highlighted that the following risks had been removed from the Corporate Risk Register because they were re-scored and are below 12. CR66 – Aseptic Unit. CR67 – COVID testing platform. CR2 – Medical staffing vacancies
8.13	**Resolved:** the updates were noted.
BD/7/21/9	**Integrated Board Report**
9.1	Jonathan Coulter noted the revised process, with the intention to create a clear and reflective IBR. Triggers and additional reporting, including deep dives would be reflected in the revised process.
9.2	89 indicators had been agreed and grouped around the CQC domains. In addition, the NHS Single Oversight Framework was included as a regulatory requirement. A summary of performance against indicators was provided and would be noted by each Executive Director as part of their Board Escalation Reports. **Action** The NHSI Team to be invited to a future Board Workshop to provide training on reading and understanding revised formats and SPC Charts.
9.3	Sarah Armstrong noted the clarity and content of the IBR was much improved.
9.4	Angela Scofield noted the design of the SPC Chart. It was confirmed that Upper and Lower confidence limits reflected the historic performance of an indicator and represented the range within which performance would be expected to vary.
9.5	Maureen Taylor queried the information that the Board would receive for each indicator. Jonathan Coulter confirmed that each indicator would have their own slide that provided clear narrative.
9.6	Andy Papworth, echoed the sentiment that the re-design had shown significant improvement. It was queried whether there would be a periodic review of indicators. It was confirmed that this would be built into the process.
9.7	Sarah Armstrong noted 2.2.1 and 2.2.2 Caring Indicators. It was noted that the compliance with complaints had significantly improved.
9.8	**Resolved:** the revised format and style of the IBR was approved.

BD/7/21/10	**Quality Committee Chair Report**
10.1	Laura Robson as Chair of the Quality Committee, noted that two meetings of the Quality Committee had been held since the previous Board meeting (June and July 2021). A new format, structure and membership had been implemented for the Committee.
10.2	The Committee received a presentation from Podiatry to discuss their project to achieve silver quality improvement accreditation. They had introduced a system of peer support in their professional group. They had identified that newly qualified practitioners, in particular, were in need of support and mentorship until they gained confidence. The approach was now being rolled out across the service.
10.3	Two limited assurance internal audit reports were presented to the Committee. The first related to Community Dental 18 week Referral to Treatment. This was being managed through the operational services and action to address the improvements required was in hand. The second was a follow-up audit of Clinical Waste management which had important quality implications.
10.4	A discussion was held on the midwifery Continuity of Care model. The level of investment required was noted as potentially 17 additional midwives.
10.5	MIU attendances had increased in previous months and the pressures this had on the system had been discussed.
10.6	**Resolved:** The Board noted the content of the report**.**
BD/7/21/11	**Director of Nursing Report**
11.1	The Interim Director of Nursing, Midwifery and Allied Health Professionals noted her report as read and highlighted the following issues in relation to the indicators in the IBR.
11.2	Pressure ulcers (1.1 and 1.2 IBR indicators) had seen a 10% increase in hospital acquired pressure ulcers. 85% related to patient heels and further work was being undertaken to mitigate against this. A 19% decrease in community acquired Pressure Ulcers was noted.
11.3	Inpatient falls were highlighted (1.3 IBR indicator) due to the increased in numbers. Triangulation was ongoing to determine themes and trends.
11.4	A Quality Steering Group had been launched and work relating to Pressure Ulcers and Falls would be incorporated into its work programme.
11.5	Safe staffing levels (1.8) were highlighted as the thresholds had been revised and brought in line with other organisations. The indicator was now rated as Amber, a reduction from the Red rating in previous months. The safer staffing review was ongoing and further work would take place and reported to the September 2021 Board meeting **Action:** Safer Staffing Report to be submitted to September 2021 Board Meeting
11.6	It was confirmed that indicators 1.13 – 1.15 in relation to VTE and Sepsis would be reviewed under the new Quality Steering Group. Sepsis was not flagging as an overall concern for the Trust, however, it was triggering in ED at the present time. This was being reviewed.
11.7	The Friends and Family indicators (2.1.1 and 2.1.2) were highlighted as adult community services was flagging as a red indicator although there appeared to be a good level of feedback. This was linked to benchmarking with other organisations

11.8	It was confirmed that Complaints were now at 57% compliance which was an improvement from the 38% which was noted in the paper.
11.9	Wallace Sampson questioned 2.2.1 and the spike seen in March 2021. A review of the backlog of complaints and communication during the Covid pandemic was noted as a key driver for the spike.
11.10	Wallace Sampson noted the progress on 2.2.2 Complaints.
11.11	**Resolved:** the report and updates against IBR were noted and assurance against progress was confirmed.
BD/7/21/12	**Medical Director's Report**
12.1	The Executive Medical Director noted the ongoing work with the Digital Aspirant Programme and the work with an external company AHLC/CoStratify which was nearing completion. Cancer and Maternity electronic systems were currently at procurement stage.
12.2	As discussed at the Board Workshop in June 2021, the clinical audit and effectiveness programme had been reviewed and a consolidated annual programme for 2021-22 had been created.
12.3	It was noted that there were ongoing pressures of the Covid pandemic with the effect of the 4th wave on workforce and clinical capacity locally and regionally. An increased level of exception reporting for junior doctors related to Covid system pressures had been noted by the Guardian of Safe Working.
12.4	3.1 and 3.2 mortality IBR indicators were highlighted and it was noted that the Board Workshop had received information on the interpretation of these in June 2021. 3.1 HSMR and 3.2 SHIMI were following the trend of below average but within normal limits.
12.5	1.4 C.diff and MRSA were highlighted as no hospital acquired infections had occurred.
12.6	**Resolved:** the report and updates against IBR were noted and assurance against progress was confirmed.
BD/7/21/13	**Maternity Incentive Scheme**
13.1	The Interim Director of Nursing, Midwifery and Allied Health Professionals noted her report as read.
13.2	**Resolved:** The Board declaration against compliance was noted and confirmed**.**
BD/7/21/14	**Strengthening Maternity and Neonatal Safety**
14.1	The Interim Director of Nursing, Midwifery and Allied Health Professionals noted her report as read.
14.2	Maureen Taylor queried the nature of the 'Ockenden' funding. It was noted that this would be recurrent funding. Andy Papworth highlighted the risks in relation to staffing and the funding arrangements as the resources provided are lower than the estimated requirement.
14.3	Laura Robson queried if HSIB reports would come in their entirety to Private Board. It was confirmed that they would.
14.4	**Resolved:** The Board noted the updated content of the report**.**

BD/7/21/15	**People and Culture Committee Chair's Report**
15.1	Andy Papworth presented the report on behalf of the People and Culture Committee in Jeremy Cross' absence.
15.2	The Committee had received an update on the Cultural Programme and against the Deloitte report actions from last year. The majority of actions were closed, and significant progress has been made against the remainder.
15.3	The Committee had met with members of the North Yorkshire 0-19 team. They presented openly and honestly around some of the issues that they had been facing.
15.4	The Committee had received an update on turnover of staff, and in particular on learning from Exit interviews. Whilst the number of interviews performed is relatively low (approximately 20%), there was still a range of data for the committee to consider and it reinforced a number of the actions already in track.
15.5	Angela Schofield queried what opportunities colleagues had for exit interviews. Two key opportunities were noted as the leavers form and the conversations between employee and line manager. It was noted that there was further work taking place to strengthen the approach which People & Culture Committee would oversee.
15.6	Black history month in October 2021 was noted as taking place.
15.7	**Resolved:** The Board noted the content of the report**.**
BD/7/21/16	**Director of Workforce and Organisational Development Report**
16.1	The Director of Workforce and Organisational Development presented the IBR indicators and escalation report. An update was provided on current workforce and organisational development issues
16.2	The IBR indicators contained in section 4 of the report linked to Workforce and OD. It was noted that 0-19 workforce was considered in detail at the Resources Committee and the indicator composition would be included in the IBR moving forward.
16.3	The sickness target had not been met in 2 years, but in the last 3 months this has been at the threshold. Significant progress was noted as having been made. Turnover had increased slightly, with no concentrated areas noted. Appraisal rates were currently rated as Red. A new appraisal system had launched on 1st June with Thrive Wellbeing Conversations being launched alongside. Anecdotal feedback had been positive. A substantial amount of training sessions for managers had been offered with low or moderate update noted in some areas. Bespoke sessions had therefore been introduced for teams that require it.
16.4	A large programme of work continues on transforming the workforce and culture programmes. The Allyship Programme linked to the EDI Anti-Racist Organisation Programme has commenced.
16.5	A full root and branch review had been conducted in relation to keeping staff safe during the ongoing Covid pandemic following the changes in the legal restrictions.
16.6	It was noted that it had not yet been possible to fill the posts which support EDI. There were risks associated with this which were noted. In addition, the core HR functions were seeing an increased level of complex cases.
16.7	Sarah Armstrong noted the level of work that was being required of the team. In addition, Long Covid was raised as a potential issue moving forward.

16.8	Sarah Armstrong asked how colleagues accessed Inpulse if they do not have the app. It was confirmed that there were other ways to access it including via a web link and the Intranet.
16.9	Laura Robson queried the management restructure highlighted in the report. It was confirmed that the structures within the directorates and some corporate support structures were currently being reviewed. This would be considered at a Board workshop when more work had been undertaken **Action:** This would be included as an item at a future Board Workshop.
16.10	Laura Robson queried the trade unions opposition in relation to retire and return. Angela Wilkinson noted that this policy was part of the Trust's resourcing plan. The process to agree retire and return arrangements required review in order to ensure working arrangements continued to reflect the needs of the service. Clear criteria for evaluation of fixed term arrangements have been put in place. The Trade Unions had raised through the Partnership Forum their concerns. Data was being shared with Trade Unions to provide assurance on the impact of the policy change.
16.11	Wallace Sampson queried why the e-leave system was only for medical staff. It was confirmed that the management self service system via ESR would be used for all other staff and leave would be authorised and reviewed electronically. Medical staff remained on a separate system as it linked to the Job Planning module.
16.12	Wallace Sampson queried if the business case for medical annual leave system included cash releasing benefits. It was confirmed that this would seek to manage the Trust's people resource and productivity gains rather than cashable gains were more likely to be achieved.
16.13	Maureen Taylor queried rostering concerns highlighted in the report. It was noted that Healthroster is the name for the roster system. The concerns linked to the use of the previous system had led to a lack of visibility of a number of rostering practices. This would be rectified in the new system.
16.14	**Resolved:** the report and updates against IBR were noted and assurance against progress was confirmed.
BD/7/21/17	**Medical Revalidation Annual Statement of Compliance**
17.1	The Executive Medical Director noted that the Trust was required by NHS England to complete an annual Statement of Compliance with regulatory procedures in relation to medical revalidation. The Trust remained fully compliant with all the requirements of a Designated Body.
17.2	Andy Papworth queried the medical appraisal rate. Full percentage compliance was not known, however, the rate was noted as significantly higher amongst medical colleagues than other professional groups. **Action:** figures for medical appraisals to be provided at the next meeting
17.3	In addition, an escalation system was in place for colleagues that had not received an appraisal.
17.4	Richard Stiff queried the threshold for compliance. It was confirmed that the organisation aimed for 100%, but it would be impacted on by circumstances such as maternity leave.
17.5	**Resolved:** The Board declaration against compliance was noted and confirmed**.**

BD/7/21/18	**Humber Coast and Vale Health and Care Partnerships Strategic Objectives**
18.1	The Board considered and noted the ICS Strategic Objectives.
18.2	It was noted that HCV ICS was currently in a recruitment process for a Chairman.
18.3	Wallace Sampson noted that there were discussions taking place to remove "Harrogate" from the name of the West Yorkshire & Harrogate ICS due to the Trust formally being part of HCV. It was noted that there was a view that name of HCV should be changed to ensure it was more reflective of the communities within its boundaries.
18.4	Richard Stiff queried the east coast acute service review. It was confirmed that this was not related to HDFT.
18.5	**Resolved:** The Board noted the HCV ICS objectives.
BD/7/21/19	**Resources Committee Chair's Report**
19.1	Maureen Taylor as Chair of Resources Committee noted the two meetings that have taken place since the last Board meeting (June and July 2021).
19.2	Month 3 performance was noted (June 2021). The Trust had continued to maintain its planned break-even position in June. Elective performance recovery meant that the Trust would benefit from Elective Recovery Fund of around £1.7m for Months 1 & 2. However, in the second half year there would be an expectation of efficiencies, with an indication that the Trust would receive 3% less funding in the second half of the year.
19.3	The ERF target for July had been increased nationally from 85% to 95% of 2019/20 activity. Favourable variances were reported overall from directorates however this position included some significant overspends when seen alongside service delivery and therefore presented a risk going forwards. Work was still taking place on rostering of ward nurses.
19.4	The capital programme spend was £5m behind plan at the end of the first quarter. £3.8m of this relates to the Salix programme. A revised forecast had reduced the programme from £32m to £25.5m for 2021/22 and a capital recovery plan was in place to ensure delivery was maximised. There was potential to bring forward schemes from 2022/23 if required.
19.5	High levels of demand continued especially in relation to 2 week wait, RTT and ED.
19.6	Workforce vacancy rate in children's services was a focus for the Committee as was non-recurrent posts. These were posts that are funded through sources such as Covid funding that is expected to cease in the future. These were both escalated to the Board as a current area of concern.
19.7	**Resolved:** The Board noted the content of the report**.**
BD/7/21/20	**Finance Report**
20.1	The Finance Director discussed with the Board the points raised in relation to the Month 3 position, the ERF target and the capital programme as highlighted by the Resources Committee Chair.
20.2	Andy Papworth queried if the capital plan was behind, did any of the programmes relate to cost efficiencies. It was confirmed that there were some elements of productivity but not cash releasing.

20.3	**Resolved:** the report and updates against IBR were noted and assurance against progress was confirmed.
BD/7/21/21	**Chief Operating Officer's Report**
21.1	The Chief Operating Officer highlighted key themes from his report and IBR indicators.
21.2	In relation to performance against A&E 4 hour standard, the Trust remained below the 95% standard with 82.6% performance noted in June 2021. It was noted that 6 hours 21 minutes was the average waiting time. The numbers attending the department continued to be high with 208 attendances on Sunday 25th July 2021. This was the highest number ever recorded. There had not been any 12 hour breaches June 2021.
22.3	At the Board Workshop in June 2021, the Board discussed the Kaizen event that had taken place in relation to ED. The new process was being piloted at weekends and on the 18th July there had been 90% compliance. Further work was ongoing to build upon this. An action plan had been developed and was currently being embedded.
22.4	The 62 day cancer standard was delivered in June 2021 with a 91% compliance. The two week wait standard did not meet compliance and the June data showed 88.1%. The number of breast two week wait and non-cancer related breast symptomatic referrals received continued to be higher than the number of weekly slots available
22.5	Wallace Sampson noted 5.2 indicator which was RTT waiting times by levels of deprivation. The Trust had carried out analysis by deprivation, ethnicity and for patients with learning disabilities. It was confirmed that early analysis did not indicate significant differences. **Action:** The RTT by deprivation report that was discussed at the July 2021 WYAAT meeting would be circulated to Board members for information.
22.6	Laura Angus queried if 6.8 avoidable admissions indicator, was on a trajectory of concern. It was noted that further analysis was required to indicate the impact of Covid and admission numbers. **Action:** Further information would be included in future reports.
22.7	Maureen Taylor queried indicators 3.3.1 and 3.3.2 in relation to readmission following elective admission. It was noted that the number of elective admissions remained static at 1.5%, however the graph visually indicates that this a problem. It was confirmed that this was not a problem. **Action:** Visual representation of the graphs would be considered for future meetings.
22.8	Wallace Sampson thanked Russell Nightingale for the additional information on the 4-hour standard provided in the report
22.9	Laura Robson queried the ambulance handover time. It was confirmed that the patients were within the ED not remaining in ambulances, however the patient had not been handed over from the ambulance team. No incidents of harm have been noted. Six 60 minute breaches had occurred in June 2021.
22.10	Angela Schofield thanked the teams for the work that was continuing during a period of sustained pressure.
22.11	**Resolved:** the report and updates against IBR were noted and assurance against progress was confirmed.

BD/7/21/23	**Board Assurance Framework and Risk Management**
23.1	The Chief Executive presented the updated Board Assurance Framework and confirmed the revised process for review. Updates were provided as follows:
23.2	BAF1:To be an outstanding place to work – a large number of controls were in place, significant changes have been implemented, the impact was not currently known in its entirety.
23.3	BAF2: To work with partners to deliver integrated care – an area to focus on was how the risks related to BAF2.1 developed in relation to the local authority changes and the development of place.
23.4	BAF3: To deliver high quality care – significant work was ongoing that was currently being implemented systematically. BAF3.5 was framed around recruitment and retention of school health visitors which will become even more important in the changes with 0-19 plans. This would be reviewed to ensure a clear strategic focus.
23.5	BAF3: To ensure clinical and financial sustainability – controls were in place at the moment, this was a risk that needed to have more focus in the future as funding would become tighter going forward. It was noted however that it was difficult to predict what will happen and therefore what mitigation would be needed.
23.6	Andy Papworth confirmed that deep dives in Board Workshops would be of benefit.
23.7	Angela Schofield confirmed that the BAF would be taken quarterly to the relevant sub committees to ensure greater scrutiny.
23.8	**Action** It was agreed that one of the BAF risks should have a focus at each Board Workshop.
BD/7/21/24	**Audit Committee Chair's Report**
24.1	Richard Stiff confirmed that the Annual Report and Annual Governance Statement were discussed at the June 2021 meeting. The Committee had concerns in the past on the internal audit programme delivery. 10 limited assurance reports had been received in year. The Committee noted that the overall opinion was that the Trust was not in as good a position as it had been in previous years.
24.2	The annual counter fraud report was of concern in relation to the increase across the NHS. It was however noted that no significant issues were raised at HDFT.
24.3	It was noted that External Audit services would be re-procured at the end of the current year when the Trust's contract with KPMG expired.
24.4	**Resolved:** The Board noted the content of the report**.**
BD/7/21/25	**Senior Management Team Report**
25.1	The Chief Executive noted the contents of the SMT report as read.
25.2	Maureen Taylor questioned the revised peer review process. It was noted that informal arrangements were in place in LTUC. A paper was discussed at SMT that provided greater consistency across the organisation. This would ensure a fresh eyes approach to reviewing fundamental standards of care. This would also link to the ward accreditation programme.
25.3	Laura Robson questioned what further work was required for Continuity of Care. It was confirmed that a Business Case would be prepared.

25.4	**Resolved:** The Board noted the content of the report
BD/7/21/26	**Any Other Business**
26.1	There were no other areas of business raised.
BD/7/21/27	**Board Evaluation**
27.1	The Chairman posed the question about what had worked well and not as well with the revised format of the reports presented.
27.2	Wallace Sampson confirmed that the approach towards the IBR and the quality of the information was an improvement on previous meetings.
27.3	Maureen Taylor confirmed that the approach towards the presentation of the IBR and the escalation grid worked well. The summary report on the Corporate Risk Register was well received and would work well for the BAF.
27.4	Andy Papworth noted that he supported the previous comments. Cross referencing in the grid to the IBR would be useful.
27.5	Executive Director colleagues confirmed that the revised approach had worked well, some minor amendments to process would be included for future reports. It was confirmed that going forward the IBR would be split into the relevant sections on the agenda.
27.6	**Action:** that Board Reports for approval would be included in an assurance / governance section of the agenda at the next meeting.
BD/7/21/28	**Date and Time of the Next Meeting**
28.1	The next meeting would be held on Wednesday, 29th September 2021 at 9am.
BD/7/21/29	**Confidential Motion**
29.1	**Resolved:** to exclude members of the press and public in accordance with the Health Services Act 2006 (Schedule 7, Section 18 (E)) (as amended by the Health and Social Care Act 2012) and in view of publicity being prejudicial to the public interest.

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

Minute Number	**Date of Meeting**	Subject	**Action Description**	**Responsible Officer**	**Due Date**	**Comments**	**Status -** completed is defined as confirmation received from ED responsible lead that the proposed action is completed as described in the comments column. Completed actions will not be closed until the Board has confirmed that action taken is satisfactory.
BoD/05/21/8.2	26 May 2021	~~CEO Report - Corporate Manslaughter Annual Statement~~ Modern Slavery Decleration	Safeguarding training for all staff to cover Modern Slavery	Director of Nursing	29 September 2021	**Previous Update** At the July 2021 Board Meeting, the action was revised to reflect the action required. I.e. that modern slavery be included in Safeguarding Training	Open
BoD/7/21/7/7.8	28 July 2021	CQC Inspection Regime	For a Board Workshop to be held on the CQC inspection Framework	Director of Nursing	01 December 2021	**Update September 2021** Action agreed at the September 2021 Board. Not yet due.	Open
BoD/7/21/9/9.2	28 July 2021	IBR - Interpreting SPC Charts	For a Board Workshop to be held on interpreting statistical processing charts - invitation to be extended to NHSI	Director of Finance	01 December 2021	**Update September 2021** Action agreed at the September 2021 Board. Not yet due.	Open
BoD/7/21/11/11.5	28 July 2021	Safe Staffing Report	Safer Staffing Report to be submitted to the September 2021 Board	Director of Nursing	~~29/09/2021~~ 24 November 2021	**Update September 2021** Report required to be submitted through internal governance systems. To be submitted to the November 2021 Board	Open
BoD/7/21/16/16.9	28 July 2021	Management Restructure	For a Board Workshop to be held on the management restructure	Director of Workforce and OD	01 December 2021	**Update September 2021** Action agreed at the September 2021 Board. Not yet due.	Open
BoD/7/21/22/22.6	28 July 2021	Avoidable Admissions	Further information to be provided on 6.8 Avoidable admissions in the IBR	Chief Operating Officer	29 September 2021		Open
BoD/7/21/22/22.5	28 July 2021	RTT	The RTT by deprivation report that was discussed at the July 2021 WYATT meeting would be circulated to Board members for information	Chief Operating Officer	29 September 2021		Open
	27 January 2021	Guardian of Safe Working Quarter 3 Report	Jackie Andrews agreed that she would request that a collection of verbatim comments is included in future reports	Medical Director	~~26/05/2021~~ 29/09/21	**Recommendation to Close** **Update September 2021** The GSW is included on the agenda for the September 2021 Board meeting. A range of comments are included in the report. **Update July 2021** - The GSW report is due at the September 2021 board meeting. Appropriate verbatium comments will be included as appropriate (information that could identify an individual will not be included). Action to close once GSW report received in September 2021	Completed

Board of Directors (Public)
29th September 2021

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

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

Board of Directors

29th September 2021

Report of the Chief Executive

Introduction

1.1 Since the Board last met, there has been a significant announcement in respect of NHS and social care funding, and the priorities for this additional funding. Recovery of elective waiting times as a major priority now has significant financial backing, and there are significant expectations about delivery of reduced waiting times.

1.2 This is however, set against significant challenges in terms of staffing, and the propensity of colleagues to undertake additional activity post-pandemic and as such we need to consider measures to boost supply which will take effect in 2-3 years time as well as other pathway transformation and collaborative working to meet the expectation of a 10% increase in activity in each year.

1.3 It is positive that steps are being taken in respect of social care, but the policy to date focuses on one part of the challenges in the social care sector and it does not yet address the issues in the care market. These are particularly challenged at the current time and represent a major risk for the local health and care system, increasing as we head into the winter period which is expected to be very testing.

1.4 In the context of major challenges with workforce supply in social care, the Trust has started to consider how any mutual aid or support may be provided, albeit this is very challenging given the staffing constraints that exist within the Trust. It is important that as an organisation we place as much priority on those who need care in their homes as those in hospital and act as a strong partner in this context.

1.5 The guidance for establishing Integrated Care Systems has now been published and arrangements are in place to appoint to the Chair, Chief Executive and the wider executive team of the NHS Integrated Care Board (ICB).

1.6 There are currently significant pressures on staffing, with rises in short term sickness, as well as the ongoing and currently heightened impact of COVID isolation – which is largely driven by increased household contacts. The Government has decided that healthy 12-15 year olds should be offered a single dose of Pfizer vaccine, and as a major provider of school age immunisation services this is a major programme of work for the Trust.

1.7 The Trust has continued to focus on becoming an anti-racist organisation with further workshops taking place for colleagues across the Trust, and a dedicated workshop for the Senior Management Team. This continues to identify distressing examples of the experience some colleagues have working in our organisation.

Recovery of services

1.8 The major constraints on the recovery of elective services in the short and medium term are (i) theatre nursing staffing, (ii) the uptake of weekend working by Consultant colleagues, and (iii) physical theatre capacity 'in-week'.

1.9 The current vacancy rate in theatre nursing is around 25% which is significantly impacting on the number of lists that can be supported. In addition to this a number of other factors have been identified within theatres which may inhibit effective team working. Additional dedicated support is being provided through a triumvirate of a medical lead, an operational lead and a nursing lead to manage theatres and to develop a comprehensive plan. This will be supported by a cultural review.

1.10 There are a number of factors which act as a barrier to additional discretionary weekend working taking place in elective care, some of which are local factors (such as pay rates and the comparative opportunity for earnings in other sectors), and some of which are broader (such as the ongoing pension impact of additional earnings and work-life balance adjustments post pandemic).

1.11 The Trust is currently considering short term options to address these barriers as well as more sustainable solutions. In light of the significant challenges across Trusts in West Yorkshire Association of Acute Trusts (WYAAT), a more robust approach to collaborative working is being developed as a key WYAAT programme. The SRO's for the programme are Jo Webster, Accountable Officer for Wakefield CCG and Steve Russell. Similarly, the Trust continues to work collaboratively in Humber, Coast and Vale, particularly in the context of the use of the Independent Sector.

Urgent two hour community response

1.12 From April 2022, the NHS is expected to be able to provide a two hour urgent community service response, and dedicated national funding has been made available to systems. A proposal to enhance community teams has been developed and agreed and will provide a much needed enhancement to our hard working community teams. It is in line with our strategic intention to focus more of our resources on keeping people well and supporting them within their own homes. Alongside the investment in the ARCHs service there is an important opportunity to consider the strategy for community based services and frailty under the umbrella of our HARA partnership.

0-19 services

1.13 Safeguarding activity continues at a high level, but overall the level of pressure for 0-19 services in August was at OPEL2 (with one being the lowest level of pressure and 4 being the highest). The development of new roles within the safeguarding teams continue to come into place to help mitigate the risks of high demand and the challenge on SCPHN capacity.

1.14 Five welcome events have been held in Northumberland for colleagues who are due to join the Trust on 1st October. It has been a privilege to meet our new colleagues, and to seek to reassure them about questions they have about the transfer to the Trust. Overall, these events have been well attended and feedback has been positive.

COVID19

1.15 Whilst overall COVID19 inpatient numbers remain broadly static, it is important to consider this in the context of the wider pressures in emergency care and as we move into the winter period. The number of people needing hospital treatment for COVID19 is around 10, but overall emergency pressure is high compared to the same period in 2019, both in terms of the number of emergency presentations but also the acuity of illness. The need to isolate patients means that there are challenges with the current pathway through the emergency assessment unit and this means that waiting times, whilst improved, remain higher than we would wish for.

1.16 Staff absence is now around 50 and has risen from the mid thirties at the beginning of September.

1.17 The recent decision to offer vaccination to healthy 12-15 year olds is a major piece of work for us across the North East and North Yorkshire where we provide school age immunisation services (SAIS). School age immunisation services are the default provider for the 12-15 programme and there has been a huge amount of work undertaken by our immunisation team to prepare. The expectation is the majority of vaccination is undertaken before half term and is a material undertaking. To support this, our 0-19 clinical advisory group has considered how to prioritise activity in order to redeploy some colleagues to the vaccination effort. There remains risk in this programme of work.

1.18 The Trust will launch the combined flu and COVID19 booster programme on 4th October. All colleagues will be encouraged to have a flu and COVID19 jab at the same time. Arrangements for colleagues in the North East to access local providers are also being made, as they were in the previous campaign.

Winter

1.19 There are understandable concerns about the potential upcoming pressures across health and care during Winter. The Trust has started to plan for different scenario's and this will be brought back to the Board.

At our best – our cultural programme

1.20 The first Inpusle survey has completed and results have been made available to managers of teams. Managers have a support process guiding them through understanding the results and will be engaging with colleagues over the next few weeks.

1.21 Every colleague can now expect to see the results for their team, and to have a discussion within the team, facilitated by their manager to explore the changes that can be made and consider who can support these changes and when can we expect them to have an impact. The Inpulse tool also helps guide managers through the process.

1.22 Whilst we had some really positive feedback, some people are feeling stressed and frustrated, and there are a number who are also feeling unappreciated. Many colleagues do feel motivated, valued and committed; and are satisfied with the quality of care, service or work being delivered. The detail that was provided in the text comments is really helpful and will help guide conversations around what we need to do to have more great days at work.

1.23 In total, we had 668 submissions which equates to about a 15% response. Whilst this is lower than we would have liked, it is probably indicative of a) the level of work pressure in all areas, b) emails and general communications not reaching the intended audience, and c) cynicism that things will change. Moving forward, it is the intention to have regular local surveys with the actions owned by teams and supported by their managers, so that we can have a really positive impact for colleagues.

1.24 October is Speak Up Month and we will use this as a major relaunch of our Freedom To Speak Up arrangements. In addition to the Freedom to Speak Up Guardians, contacts continue directly to members of the Executive Team. There are some common themes about the fairness of recruitment processes, and training and development which triangulate with feedback from the workshops that have taken place. The 'Meet the Executive Team' events are also becoming well used opportunities for discussion with colleagues in an informal setting.

1.25 October is also Black History Month and we will be marking this in a number of different ways over the month.

1.26 SMT had a very significant workshop session in September on leading the Becoming and Anti-Racist organisation work.

Planning for 2021/22

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

1.28 Nationally, the NHS will receive an extra £5.4bn over the next six months to support its ongoing response to the COVID-19 pandemic. This is broken down into:

- £2.8bn for COVID-19 costs including infection control measures
- £600m for day-to-day costs
- £478m for enhanced hospital discharge
- £1.5bn for elective recovery, including £500 million capital funding.

1.29 The financial framework for 2022/23 is not yet know, but it is being signalled that there will be move back towards a 'needs based allocation' rather than a 'cost based allocation'. The Board will be aware of the risks that this poses in the context of the work that was undertaken in the local system to identify the drivers of financial challenges, much of which is related to the application of the needs based formula against the utilisation of healthcare due to demography. As such, there is a possible future risk, the scale of which is as yet not known.

Recommendation

The Board is asked to note this report, and identify any areas in which further assurance is required, which is not covered in the Board papers.

Board of Directors (Public)
29th September 2021

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

Purpose of the report and summary of key issues:	The report provides the Trust Board with key updates and actions since the previous meeting held on 28th July 2021. All Corporate Risks have been reviewed via the Directorate Review Meetings, the Executive Risk Review Meeting and the Senior Management Team meeting. Details of key indicators, mitigation, target risk ratings and current risk ratings are detailed in the report. One risk has been reduced via mitigation and due to the risk rating falling below 12, it was agreed at SMT that this risk would be removed from the Corporate Risk Register and managed via the Directorate Risk Register. This risk is CRR52 Two Week Wait (Breast).	
BAF Risk:	AIM 1: To be an outstanding place to work	
	BAF1.1 to be an outstanding place to work	X
	BAF1.2 To be an inclusive employer where diversity is celebrated and valued	X
	AIM 2: To work with partners to deliver integrated care	
	BAF2.1 To improve population health and wellbeing, provide integrated care and to support primary care	X
	BAF2.2 To be an active partner in population health and the transformation of health inequalities	X
	AIM 3: To deliver high quality care	
	BAF3.1 and 3.4 To provide outstanding care and outstanding patient experience	X
	BAF3.2 To provide a high quality service	X
	BAF3.3 To provide high quality care to children and young people in adults community services	X
	BAF3.5 To provide high quality public health 0-19 services	X
	AIM 4: To ensure clinical and financial sustainability	
	BAF4.1 To continually improve services we provide to our population in a way that are more efficient	X
	BAF4.2 and 4.3 To provide high quality care and to be a financially sustainable organisation	X
	BAF4.4 To be financially stable to provide outstanding quality of care	X

Corporate Risks	All
Report History:	Previous updates submitted to Public Board meetings. The September 2021 report has been reviewed at the Executive Risk Review Meeting (16th September 2021) and the Senior Management Team meeting (22nd September 2021).
Recommendation:	The Board is asked to note this report, and identify any areas in which further assurance is required, which is not covered in the Board papers.

Harrogate and District NHS Foundation Trust
Trust Board
September 2021

Corporate Risk Register

1.0 INTRODUCTION

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

2.0 CORPORATE RISKS

2.1 CRR5 – Nursing Shortages

This risk remains at the same level. There are 19.24WTE RN and 8.75WTE CSW vacancies for in-patient wards (compared to 17.29WTE and 9.83WTE the previous month). The control mean overall fill rate has remained above 90%. Additional controls are planned with a programme of work focused on retention.

There are 6.68WTE vacancies in school nurses and 30.36WTE in health visiting (compared to 7.58 and 26.41WTE vacancies the previous month). The controls put in place mean there is an over-recruitment to Band 5 roles of 14.15WTE.

Cohort recruitment continues on a rolling basis, and on-line recruitment events have been expanded to 0-19 services and the initial event was successful with 4 applications following.

In adult community nursing, only 74% of funded hours are available to rotas with pressure forecast over the summer arising from complexity of demand and the gap of 11.23 WTE. 7.03 vacancies, with sickness and maternity leave the remainder). 4.8WTE are due to commence in post in September/October. In consideration of controls exit interviews were reviewed and show the main reasons for resignation related to relocation and promotion. Controls in place include staff being supported to prioritise caseloads, thrive conversations are taking place, additional Band 7 roles (moving from 2.67 to 4.67WTE) interview taking place 20th September and incentivisation of bank shifts over the summer.

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

The Current Risk is 12 (3x4) – this is the same rating as August 2021

2.2 CRR6 – Wellbeing of Staff

Both ward based and community colleagues are experiencing high demand and pressure. Patient acuity has increased with a large number of patients with dementia requiring 1:1 support which is not available, leading to increase in falls. Emotional toll on colleagues is challenging. Annual leave over the summer months is increasing the pressures – but we are not asking clinical colleagues to cancel leave. We are also not taking the step other Trusts have done of incentivising long shifts, as we believe this will lead to burn-out.

Following review of the July 2021 information the risk has been redefined as agreed. The risk now reads: Risk of both short and long term mental and physical impacts on staff due to impact of COVID19 pandemic and increased activity during recovery phase.

Increased sickness absence levels, both short and long term, and high staff turnover rates, impact on quality of care and service delivery.

The indicators for this risk are in development in relation to the Staff Survey, Inpulse, Attrition Rate, employee systems programme and Datix incidents. These will be reported on from September 2021 onwards.

Improved access to Health and Wellbeing services has been reviewed. Credit cards with Trust values and ways to access services have been distributed around the organisation.

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

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

2.3 CRR34 – Autism Assessment

The current rate of referral would see a reduction by 5. Baseline funded capacity is 47 assessments Additional non-recurrent 12 months of an extra 14 assessments per month is expected to come on line in July 2021.

- Numbers on the waiting list: 550 (decrease from 576 in June 2021 and 550 in July)
- Referral rate: 6 month rolling average is now 51 (reduced from 57 in July 2021).
- Longest wait: 71 weeks (same as July 2021)

If referral rates remain the same and no further increase in complexity, it would leave the waiting list at 490 at the end of the 12 month waiting list initiative (Q2 2022). A proposal is being developed to reduce recovery timescales and to support the sustainability of the service. The target risk has been amended to March 2022.

All additional capacity will be in place from end of Sept with the finical posts now having been recruited to and starting their roles by the end that month.

Session set up with professional leads on the 17th September 2021 to work through the proposal detail to address the longer term capacity vs demand issue. This will identify the additional resource required to deliver a sustainable waiting list recurrently.

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

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

2.4 CRR41 – RTT

Due to the Covid-19 pandemic and the ceasing of elective work, waiting times have risen significantly. The over 52 weeks waiters peaked in March 2021 at 1,345. There has been a further decline to 955 in August with a combination of grip around the booking process and theatre efficiency, as well as the increase of elective work now underway. Risks remain in two main specialties of T&O and Community Dental (which together account for 78% of the over 52 week waiters). Current end of financial year target is to reduce this figure to below 800 patients.

- The Trust had 22,168 patients waiting at the end of August, this is an increase of 377 patients on the July position.
- There are 955 patients waiting over 52 weeks, this is below the trajectory of 1,058 and a 3.3% decrease from the July position.

- The 92nd centile and median wait in July is 40 weeks and 9 weeks respectively highlighting grip on the scheduling process.
- Of the 4,686 patients waiting for a procedure, 37% are Orthopaedics, 19% General Surgery and 12% Ophthalmology.
- Between 01/04/2021 and 16/09/2021 we have received 29 complaints / concerns relating to waiting times for outpatient appointment and / or surgery

Clinical prioritisation and review continues for elective patients with 98.5% of patients waiting having been allocated a P1-6 national classification. The majority of those yet to be classified (61/68) have been waiting <=2 weeks and are urgent endoscopy referrals. This information is tracked weekly. 77% of P2 patients have been waiting less than 28-days and there is still a large element of patient choice owing to Covid-19. An RCA is completed for every patient not booked within the required time parameters with a subsequent harm review if a breach.

The target risk date has been amended to March 2023.

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

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

2.5 CRR48 – Mental Health Services for ED Patients

In the 12 weeks up to the 7th December 2020 there were 56 breaches awaiting MH review. Between 07/12/20 and 10/06/21 there were 89 breaches awaiting MH review. In May 2021 the two longest waits were 14hr and 12 hr 10 mins- waiting for MH act assessments.

The number of mental health breaches increased significantly in August 2021 to 19. 11 over 6 hours and 2 over 12 hours. Sept 12th saw the Trusts longest ever mental heath ED breach at 28 hours in the department. The patient declined admission to a medical ward and mental health team were unable to find a bed so were unable to complete her Section 2 (detention application).

Planning discussions underway for the new ED footprint which will incorporate designs to improve facility for mental health patients.

The Target Risk is 9 (3x3) – October 2021

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

2.6 CRR52 – Two Week Wait (Breast)

Indicators include: Baseline Capacity: 40 per week, Current level of referrals: 50 per week since February 2021, Number of patients awaiting first appointment – all booked no patients on TAL and Booking at 13 days for new referrals.

It is anticipated that this risk will be meet its target in September 2021

The Target Risk is 3 (3x1) – changed to September from July 2021

The Current Risk is 3 (3x1) – September 2021. This is a reduction in risk rating from 12 (3x4) in August 2021.

Recommendation: to confirm removal from the corporate risk register and mange through the directorate risk register as the risk rating now falls below 12 at a rating of 3.

2.7 CRR57 – Safeguarding Demand

The risk relates to patient safety, quality of care and staff welfare due to increased levels of domestic abuse and children's safeguarding. Decreased opportunity for monitoring and observation of children and young people by professionals, increased demand on social care and other community services for safeguarding work, shielding and vulnerabilities. Failure to protect children, failure to apply clinical policies / guidance in relation to safeguarding and failure to meet national requirements in relation to safeguarding. Delivery of safeguarding policy and guidance impacting on 'preventative' 0-19 team home visits & ability to break the safeguarding cycle

Safeguarding Activity data is noted as: April 2020 to February 812 per month which has increased to an average of 1,000 per month in March to May 2021 (19% increase).

The has been a slight decrease in the number of Safeguarding Strategies in July and August in comparison to June but it is still significantly higher than the same period last year.

OPEL Framework for 0-19 and actions now completed and shared with teams. Has also being shared with LA for any comment. This will allow 0-19 teams flexibility to act in line with the agreed actions during times of pressure. This is now in place and being used on a daily basis to manage services.

Three staff have been identified within the acute Trust to support with strategies who all come into post in July 2019. Training needs analysis to be completed Anne Brock Named Nurse to Lead on this. Business case vacancies are in the process of recruitment. Band 8A now appointed to, Band 7 Specialist Child protection nurse appointed to, Band 7 Floating Child Protection Nurse interviews w/c 19th July, 3wte Band 6 floating safeguarding nurses closing date 14th July 21.

Sunderland, Gateshead, and Middlesbrough strategy nurses have all now completed 6 week induction/preceptorship/competency programme.

Original Risk was 9 (3x3)

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

Current risk is 16 (4x4) which is an increased risk from July 2021, and the same level of risk noted in August 2021.

2.8 CRR61 – ED 4 hour Standard

Indicators include: A&E 4 hour standard – remained below the 95% standard in June 2021 at 82.6%, 95th percentile wait – 6 hours and 21 minutes in June 2021, 12 hour breaches – 0 in June 2021, 6 Hour breaches/ week (Number needed to harm 102) 131,104,126, 89,103 - mean 110 - weekly 1 patient would be expected to have 'harm' from extended ED stay.

ED attendances have continued to increase since February 2021. May and June attendances were both above the upper control limits and 2019-20 levels. This continues to be a real challenge to flow through the department.

The Kaizen ED workshop took place at the end of June 2021. It was well attended with positive outcomes for change process and approaching the problem through a different lens. An action plan has been produced and is currently being worked through. Pilot of new model for August Bank Holiday weekend.

An Urgent and Emergency Care (UEC) dashboard has been developed that supported the workshop and has enabled monitoring of ED flow and performance to increase visibility.

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

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

2.9 CRR63 – Violence and Aggression (ED)

This relates to the risk of physical and/or psychological harm to staff or other patients arising from the increasing number of incidents relating to violence or threat of violence to staff from patients attending ED. 12% of incidents reported in LTUC relate to this issue. The current controls rely on support from the general portering team and the police. There were 31 datix incidents relating to aggression through July – mostly episodes of verbal aggression but at least 3 episodes of physical aggression to staff or other patients. Police response is referenced as being unsupportive or lacking timeliness.

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

The number of incidents relating to violence and aggression – in August 2021 55% of incidents reported in the Directorate related to violence and aggression in the ED.

Datix incidents for aggression in the ED – 29 episodes through August, of which 8 were physical assaults.

There are some remaining gaps in control relating to the ability to secure specific parts of the site which is being reviewed and in the timeliness of the police response on occasions.

Body camera's and the associated processes have been sourced and procured. The operational go live is scheduled for the last week of September.

With some delays to the implementation of Mitigating actions (body cams, bystander training) the date for achieving target risk score has been amended to October 2021.

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

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

2.10 Health and Safety

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

Health and Safety Law states that employers must:

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

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

Under the Corporate Manslaughter and Corporate Homicide Act 2007, an offence will be committed where failings by an organisation's senior management are a substantial element in any gross breach of the duty of care owed to the organisation's employees or members of the public which results in death.

The maximum penalty is an unlimited fine and the court can additionally make a publicity order requiring the organisation to publish details of its conviction and fine.

At the present time, HDFT does not have a Health and Safety Manager. This is impinging on the organisations ability to fulfil all requirements of Health and Safety Law.

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

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

3.0 RECOMMENDATIONS

It is recommended that the information is noted for assurance.

Kate Southgate
Company Secretary

September 2021

Board Committee Report to the Board of Directors

Committee Name:	Quality Committee
Committee Chair:	Laura Robson, Non-executive Director
Date of meeting:	15th September 2021
Date of Board meeting this report is to be presented	29th September 2021

Summary of key issues

- The Quality Committee met via teleconference. The meeting was observed by Doug Masterton and Mary Kelly, Public Governors
- Charlotte Gill, Quality Matron attended the meeting to give an update on her work in quality improvement and its fit with the Caring at Our Best programme. She updated the committee on a number of items that have been subject to our scrutiny over recent months. These were: Falls and Falls prevention, Tissue Viability, Enhanced Care, VTE, Continence, Matron assurance of ward standards, the introduction of an App based process for the 'perfect ward'. All of these will be brought together through one quality steering group rather than all having their own steering group to try and improve attendance. This will ensure appropriate links between these quality items. Charlotte also highlighted a piece of work in the community to improve allocation of staff, ensuring best care for patients. The process uses a module on System One. The update was well received and there was considerable discussion about the progress being demonstrated and the confidence this gave that patient care was top priority. The committee was pleased to see the investment that has been made in improving quality through additional posts in the area. A VTE practitioner is to be appointed which is a post the Quality Committee had previously supported.
- An update was provided regarding progress on limited assurance audit into waste management. The nursing team are working with HIF to improve the standards and achieve the actions. The team highlighted that a PLACE audit is to be undertaken which looks at the environment as well as other aspects, for example meals. Although this is not mandated it is good to note that the audit is to take place and that the teams are working well together.
- The Quality Report is almost complete and will be received by the committee in October. There is however no mandated date for its completion.
- The Medical Director highlighted the current shortage of blood bottles and the potential impact. Action had been taken and use has reduced by 25% which is a considerable achievement. Work is ongoing regarding the sustainability of this position and an audit will be completed to indicate whether the reduction has any impact on patient care.
- The plan to vaccinate children between the ages of 12- 15 was discussed. This is a significant challenge to community vaccination teams. The expectation is for the task to be completed by the October half term. Consent is a significant issue. Fortunately the Trust has electronic consent in place which will be more effective than the paper based system. There is a wide range of issues to resolve and 92000 children fall into the bracket who are in the Trust catchment. The target is 100% achievement.

- The Medical Director updated the committee with regard to 5000 Glaucoma patients, waiting for follow up. It is estimated that it will take 12 months to clear the backlog but the team are working on a range of measures to see about 120 patients per week. The committee was concerned about the potential impact this may have on patients and their treatment. We were assured that the patients were prioritised, high risk patients will be seen as soon as possible.
- Progress in response to complaints continues to improve and the committee were pleased to note that improvement.
- Work is taking place with Health Watch to devise a process for gaining more information about patients' experience. The Making Experience Count group is designed to ensure that we have real time information and are using that to inform the planning and quality work of the Trust. A conversation took place about the possible involvement of a governor in the group. However, as this is not explicitly the role of governors, we would seek the Boards advice on that involvement.
- We received an update on the CQC action plan and were pleased to note the progress. Directorate representatives present explained that they are on target to complete their actions for the end of September. Some changes have been made to the actions as so long has elapsed since the action plan was formulated but we were assured that the recommendations had not altered.
- Liam Dodds, Programme Manager for the Caring at our Best Programme, attended the meeting and gave an explanation of his role and the work to ensure progress on the programme as well as gathering the evidence to support completion and improvement.
- Update on Serious Incidents, their investigation and progress was noted and discussed. No themes were identified.
- The Quality Committee items from the IBR were considered. The committee noted significant overlap with a number of items allocated to the Resource committee, that have impact on quality of the patient experience. We also request that the items not currently populated be given a target date for completion.
- The Role of Patient Safety Champions was discussed. All Boards have been requested to have a seminar on their role. The Trust Patient Safety Champions are the Deputy Director of Nursing, Simon Riley-Fuller, the Deputy Medical Director, Dave Earl, and the Patient Safety Manager, Andrea Leng.
- World Patient Safety Day is 17/9/21. The theme is Safer Maternity and Neonatal Services. The Trust will use the opportunity to raise the profile of the work being undertaken in this area.

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

The Board is requested to note the significant challenge and risk associated with the COVID vaccination of 12- 15 year olds.

The Board is also requested to consider the risk associated with delay for follow up of Glaucoma patients.

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

The Board is requested to advise regarding the role of Governors attending other groups where it is not part of their role but it is considered they can add value.

Board of Directors held (Public)
29th September 2021

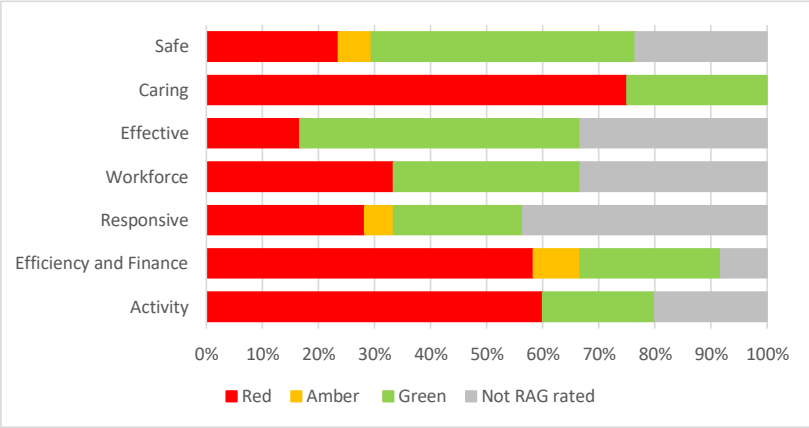
Title:	***Integrated Board Report***
Responsible Director:	Executive Directors
Author:	Head of Performance & Analysis

Purpose of the report and summary of key issues:	The Trust Board is asked to note the items contained within this report. This month's report presents data for the set of indicators proposed for the new style Integrated Board Report. This month's report includes charts and narrative for each indicator as previously agreed with Trust Board.	
BAF Risk:	AIM 1: To be an outstanding place to work	
	BAF1.1 to be an outstanding place to work	X
	BAF1.2 To be an inclusive employer where diversity is celebrated and valued	X
	AIM 2: To work with partners to deliver integrated care	
	BAF2.1 To improve population health and wellbeing, provide integrated care and to support primary care	X
	BAF2.2 To be an active partner in population health and the transformation of health inequalities	X
	AIM 3: To deliver high quality care	
	BAF3.1 and 3.4 To provide outstanding care and outstanding patient experience	X
	BAF3.2 To provide a high quality service	X
	BAF3.3 To provide high quality care to children and young people in adults community services	X
	BAF3.5 To provide high quality public health 0-19 services	X
	AIM 4: To ensure clinical and financial sustainability	
	BAF4.1 To continually improve services we provide to our population in a way that are more efficient	X
	BAF4.2 and 4.3 To provide high quality care and to be a financially sustainable organisation	X
	BAF4.4 To be financially stable to provide outstanding quality of care	X
Corporate Risks	None	
Report History:	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 - August 2021

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

		RAG ratings			
Domain	**Total indicators**	**Red**	**Amber**	**Green**	**Not RAG rated**
Safe	17	4	1	8	4
Caring	4	3	0	1	0
Effective	6	1	0	3	2
Workforce	6	2	0	2	2
Responsive	39	11	2	9	17
Efficiency and Finance	12	7	1	3	1
Activity	10	6	0	2	2
Total	**94**	**34**	**4**	**28**	**28**



NHS System Oversight Framework (SOF) 2021/22

1. NHS England and NHS Improvement recently published their approach to oversight for 2021/22.

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

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

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

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

6. In total, there are 81 metrics in this year's framework, 47 of which are applicable to Trusts. The technical guidance documents that provide the detail around these metrics were expected in August but have not yet been published.
7. A significant number of the metrics are already included in this report.
8. Going forward, we will provide an overview of the Trust's performance on all applicable metrics within the framework.

Integrated Board Report - Summary of Aug-21 performance

Domain	Indicator number	Indicator name	Latest position
Safe	1.1	Pressure ulcers - hospital acquired - cat 3 or above - per 1,000 bed days	0.88
Safe	1.2	Pressure ulcers - community acquired - cat 3 or above - per 1,000 patient contacts	1.15
Safe	1.3	Inpatient falls per 1,000 bed days	7.0
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	18.95
Safe	1.7.1	Incidents - comprehensive serious incidents (SI)	2
Safe	1.7.2	Incidents - Never events	0
Safe	1.8.1	Safer staffing levels - fill rate	90.1%
Safe	1.8.2	Safer staffing levels - CHPPD	7.9
Safe	1.9	Maternity - % women seen by a midwife (or healthcare professional) by 12w 6d	100.0%
Safe	1.10	Maternity - % women with Continuity of Care pathway	
Safe	1.11	Infant health - % women smoking at time of delivery	3.0%
Safe	1.12	Infant health - % women initiating breastfeeding	79.2%
Safe	1.13	VTE risk assessment - inpatients	96.6%
Safe	1.14.1	Sepsis screening - inpatient wards	92.5%
Safe	1.14.2	Sepsis screening - Emergency department	88.0%

Domain	Indicator number	Indicator name	Latest position
Caring	2.1.1	Friends & Family Test (FFT) - Patients	92.8%
Caring	2.1.2	Friends & Family Test (FFT) - Adult Community Services	95.3%
Caring	2.2.1	Complaints - numbers received	32
Caring	2.2.2	Complaints - % responded to within time	56%
Effective	3.1	Mortality - HSMR	91.94
Effective	3.2	Mortality - SHMI	0.96
Effective	3.3.1	Readmissions to the same specialty within 30 days - following elective admission	44
Effective	3.3.2	Readmissions to the same specialty within 30 days - following non-elective admission	171
Effective	3.4	Returns to theatre	
Effective	3.5	Delayed Transfer of Care	
Workforce	4.1	Staff appraisal rate	55.2%
Workforce	4.2	Mandatory training rate	87.0%
Workforce	4.3	Staff sickness rate	5.0%
Workforce	4.4	Staff turnover rate	14.2%
Workforce	4.5.1	Children's Services - 0-5 Service - vacancies	
Workforce	4.5.2	Children's Services - 5-19 Service - vacancies	
Workforce	4.6.1	Workforce Race Equality Standard (WRES) - Relative likelihood of staff being shortlisted across all posts	
Workforce	4.6.2	Workforce Race Equality Standard (WRES) - Relative likelihood of staff being appointed from shortlisting across all posts	

Domain	Indicator number	Indicator name	Latest position
Responsive	5.1.1	RTT Incomplete pathways performance - median	9
Responsive	5.1.2	RTT Incomplete pathways performance - 92nd centile	40
Responsive	5.1.3	RTT Incomplete pathways - total	22168
Responsive	5.1.4	RTT Incomplete pathways - 52-<104 weeks	932
Responsive	5.1.5	RTT Incomplete pathways - 104+ weeks	23
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	74.0%
Responsive	5.4	Outpatients lost to follow-up - number of follow up patients past due date	
Responsive	5.5	Data quality on ethnic group - inpatients	95.7%
Responsive	5.6	A&E 4 hour standard	80.4%
Responsive	5.7	Ambulance handovers - % within 15 mins	90.4%
Responsive	5.8	A&E - number of 12 hour trolley waits	0
Responsive	5.9.1	Cancer - 62 day wait for first treatment from urgent GP referral to treatment	91.2%
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	86.0%
Responsive	5.11	Cancer - 28 days faster diagnosis standard (suspected cancer referrals)	80.2%
Responsive	5.12	Cancer - 31 days maximum wait from diagnosis to treatment for all cancers	98.8%

Domain	Indicator number	Indicator name	Latest position
Responsive	5.13.1	Children's Services - 0-12 months caseload	
Responsive	5.13.2	Children's Services - 2-3 years caseload	
Responsive	5.14.1	Children's Services - Safeguarding caseload - number of strategy meetings	
Responsive	5.14.2	Children's Services - Safeguarding caseload - number of initial Child Protection case conferences	
Responsive	5.14.3	Children's Services - Safeguarding caseload - number of court reports	
Responsive	5.14.4	Children's Services - Safeguarding caseload - number of Looked After Children	
Responsive	5.15	Children's Services - Ante-natal visits	89.4%
Responsive	5.16	Children's Services - 10-14 day new birth visit	96.2%
Responsive	5.17	Children's Services - 6-8 week visit	92.7%
Responsive	5.18	Children's Services - 12 month review	95.0%
Responsive	5.19	Children's Services - 2.5 year review	93.4%
Responsive	5.20	Children's Services - % children with all 5 mandated contacts	
Responsive	5.21	Children's Services - Delivery of Immunisation trajectory	
Responsive	5.22	Children's Services - OPEL level	
Responsive	5.23	Community Care Adult Teams - performance against new timeliness standards	
Responsive	5.24	Community Care Adult Teams - Number of virtual beds delivered in Supported Discharge Service	
Responsive	5.25	Community Care Adult Teams - Number of cancelled routine visits	
Responsive	5.26	Community Care Adult Teams - OPEL level	
Responsive	5.27	Out of hours - telephone clinical assessment for URGENT cases within 20 minutes of call prioritisation	45.9%
Responsive	5.28	Home visit: Face to face consultations started for URGENT cases within 2 hrs	88.5%

Domain	Indicator number	Indicator name	Latest position
Efficiency and Finance	6.1	Agency spend	£ 453
Efficiency and Finance	6.2	Surplus / deficit and variance to plan	-
Efficiency and Finance	6.3	Capital spend	£ 3,188
Efficiency and Finance	6.4	Cash balance	£ 33,600
Efficiency and Finance	6.5.1	Long stay patients - stranded (>7 days LOS)	129
Efficiency and Finance	6.5.2	Long stay patients - superstranded (>21 days LOS)	51
Efficiency and Finance	6.6	Occupied bed days per 1,000 population	56.5
Efficiency and Finance	6.7.1	Length of stay - elective	2.77
Efficiency and Finance	6.7.2	Length of stay - non-elective	4.81
Efficiency and Finance	6.8	Avoidable admissions	248
Efficiency and Finance	6.9	Theatre utilisation (elective sessions)	83.7%
Efficiency and Finance	6.10	Day case conversion rate	1.9%

Domain	Indicator number	Indicator name	Latest position
Activity	7.1.1	GP Referrals against plan	
Activity	7.1.2	GP Referrals against 2019/20 baseline	
Activity	7.2.1	Outpatient activity (consultant led) against plan (new and follow up)	86.7%
Activity	7.2.2	Outpatient activity (consultant led) against 2019/20 baseline (new and follow up)	88.3%
Activity	7.3.1	Elective activity against plan	72.3%
Activity	7.3.2	Elective activity against 2019/20 baseline	69.1%
Activity	7.4.1	Non-elective activity against plan	94.5%
Activity	7.4.2	Non-elective activity against 2019/20 baseline	92.6%
Activity	7.5.1	Emergency Department attendances against plan	104.0%
Activity	7.5.2	Emergency Department attendances against plan, 2019/20 baseline	104.1%

Integrated Board Report - List of indicators

Domain	Indicator number	Indicator name	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	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	1.03	0.73	1.08	0.64	0.45	0.28	0.28	1.22	1.17	0.99	0.78	0.71	0.37	0.00	0.61	1.01	0.88	EN	Quality	tbc		
Safe	1.2	Pressure ulcers - community acquired - cat 3 or above - per 1,000 patient contacts	1.04	1.44	1.16	1.26	1.10	1.06	1.15	0.62	1.48	0.95	1.28	1.29	1.31	1.36	0.77	0.99	1.15	EN	Quality	tbc		
Safe	1.3	Inpatient falls per 1,000 bed days	12.5	9.7	8.7	5.4	6.2	5.0	6.0	6.4	6.5	7.4	11.0	7.3	5.1	6.1	4.9	5.9	7.0	EN	Quality	above HDFT average for 2020/21	0-20% below HDFT average for 2020/21	>20% below HDFT average for 2020/21
Safe	1.4	Infection control - C.diff hospital acquired cases due to a lapse in care	0	0	0	0	1	1	0	0	0	0	0	0	0	0	0	1	0	EN	Quality	>19 YTD		<=19 YTD
Safe	1.5	Infection control - MRSA hospital acquired cases due to a lapse in care	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	10.02	10.38	13.52	14.34	14.66	18.71	19.92	14.72	10.10	14.13	10.11	16.38	17.60	21.29	19.98	27.63	18.95	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)	0	0	1	0	0	2	1	2	0	0	1	1	3	1	4	1	2	EN	Quality	>0		0
Safe	1.7.2	Incidents - Never events	0	0	0	0	0	0	0	0	0	0	1	0	0	1	0	0	0	EN	Quality			
Safe	1.8.1	Safer staffing levels - fill rate	NA	NA	NA	NA	NA	NA	95.4%	93.3%	95.3%	95.3%	95.3%	93.9%	93.8%	93.1%	92.5%	92.6%	90.1%	EN	Quality	<80%	80% - 95%	>=95%
Safe	1.8.2	Safer staffing levels - CHPPD	NA	NA	NA	NA	NA	NA	10.1	9.9	9.7	9.4	9.0	8.7	8.6	8.4	8.6	8.0	7.9	EN	Quality	tbc		
Safe	1.9	Maternity - % women seen by a midwife (or healthcare professional) by 12w 6d	97.2%	100.0%	99.3%	100.0%	100.0%	99.3%	100.0%	100.0%	100.0%	100.0%	100.0%	99.5%	99.4%	100.0%	100.0%	100.0%	100.0%	EN	Quality	<90%		>=90%
Safe	1.10	Maternity - % women with Continuity of Care pathway																		EN	Quality			
Safe	1.11	Infant health - % women smoking at time of delivery	5.7%	7.6%	5.3%	3.0%	2.8%	6.4%	6.7%	3.7%	6.3%	4.6%	8.1%	4.5%	6.6%	2.9%	7.4%	5.2%	3.0%	EN	Quality	>15%		<=15%
Safe	1.12	Infant health - % women initiating breastfeeding	85.1%	84.5%	90.2%	83.8%	84.4%	85.4%	89.9%	84.6%	87.1%	88.7%	91.5%	86.5%	83.6%	82.6%	84.8%	83.8%	79.2%	EN	Quality	<75%		>=75%
Safe	1.13	VTE risk assessment - inpatients	95.0%	93.9%	92.3%	93.6%	95.0%	92.6%	95.1%	95.4%	94.2%	96.9%	96.8%	96.7%	96.7%	97.1%	96.9%	96.3%	96.6%	EN	Quality	<95%		>=95%
Safe	1.14.1	Sepsis screening - inpatient wards	92.8%	88.9%	95.0%	94.7%	91.4%	94.0%	94.8%	94.6%	94.8%	95.3%	94.2%	94.2%	91.8%	96.1%	93.2%	93.5%	92.5%	EN	Quality	<90%		>=90%
Safe	1.14.2	Sepsis screening - Emergency department	89.2%	88.9%	92.8%	93.1%	93.1%	88.6%	88.8%	91.7%	91.3%	91.3%	88.0%	89.4%	85.9%	89.2%	88.9%	86.6%	88.0%	EN	Quality	<90%		>=90%
Caring	2.1.1	Friends & Family Test (FFT) - Patients	96.6%	95.6%	95.8%	95.6%	95.8%	94.9%	94.2%	95.0%	95.0%	94.5%	95.2%	93.9%	94.2%	92.7%	93.7%	93.7%	92.8%	EN	Quality	<national average		>=national average
Caring	2.1.2	Friends & Family Test (FFT) - Adult Community Services	94.2%	98.2%	92.1%	95.3%	95.0%	93.9%	93.1%	98.1%	93.2%	93.4%	95.1%	87.5%	94.7%	95.5%	96.5%	96.1%	95.3%	EN	Quality	<national average		>=national average
Caring	2.2.1	Complaints - numbers received	5	10	9	18	11	21	12	16	19	17	16	38	14	24	18	20	32	EN	Quality	above HDFT average for 2020/21		On or below HDFT average for 2020/21
Caring	2.2.2	Complaints - % responded to within time														50%	35%	56%	56%	EN	Quality	<95%		>=95%
Effective	3.1	Mortality - HSMR	107.42	106.86	108.69	109.26	107.36	106.73	106.02	102.2	97.21	97.22	98.00	96.60	94.93	95.13	91.94			JA	Quality	Higher than expected		Within expected range or below expected
Effective	3.2	Mortality - SHMI	0.957	0.947	0.955	0.946	0.942	0.937	0.940	0.941	0.929	0.932	0.942	0.935	0.918	0.962				JA	Quality	Higher than expected		Within expected range or below expected
Effective	3.3.1	Readmissions to the same specialty within 30 days - following elective admission	13	16	22	29	31	30	39	43	29	27	23	32	43	42	44	44		RN	Resources	>60	50-60	<=50
Effective	3.3.2	Readmissions to the same specialty within 30 days - following non-elective admission	92	109	106	128	120	129	144	141	134	119	120	132	166	159	144	171		RN	Resources	>170	160-170	<=160
Effective	3.4	Returns to theatre																		RN	Resources	tbc		
Effective	3.5	Delayed Transfer of Care																		RN	Resources	tbc		
Workforce	4.1	Staff appraisal rate	74.6%	69.3%	64.1%	57.0%	49.3%	47.0%	48.7%	50.2%	50.4%	53.1%	54.8%	54.9%	56.3%	58.3%	58.9%	55.9%	55.2%	AW	People and Cult	<70%	70% - 90%	>=90%
Workforce	4.2	Mandatory training rate	90.0%	85.0%	87.0%	89.0%	91.2%	91.4%	91.6%	91.8%	92.1%	91.9%	91.3%	91.2%	91.7%	92.1%	92.0%	92.0%	87.0%	AW	People and Cult	<50%	50% - 75%	>=75%
Workforce	4.3	Staff sickness rate	4.54%	4.15%	4.36%	4.10%	4.10%	4.27%	4.67%	5.11%	4.67%	5.36%	4.93%	4.33%	3.74%	3.94%	4.04%	4.77%	5.02%	AW	People and Cult	>3.9%		<=3.9%
Workforce	4.4	Staff turnover rate	12.7%	13.0%	12.3%	12.3%	12.2%	12.4%	12.2%	13.0%	13.2%	13.4%	13.0%	12.7%	12.9%	13.0%	13.3%	13.5%	14.2%	AW	People and Cult	>15%		<=15%
Workforce	4.5.1	Children's Services - 0-5 Service - vacancies																		AW	People and Culture			
Workforce	4.5.2	Children's Services - 5-19 Service - vacancies																		AW	People and Culture			
Workforce	4.6.1	Workforce Race Equality Standard (WRES) - Relative likelihood of staff being shortlisted across all posts																		AW	People and Cult	tbc		
Workforce	4.6.2	Workforce Race Equality Standard (WRES) - Relative likelihood of staff being appointed from shortlisting																		AW	People and Cult	tbc		
Responsive	5.1.1	RTT Incomplete pathways performance - median	13	16	15	7	8	9	8	8	9	10	9	7	8	8	8	9	9	RN	Resources	>10	08 - 10	<=8
Responsive	5.1.2	RTT Incomplete pathways performance - 92nd centile	32	35	37	39	41	43	45	45	48	50	51	48	44	43	41	40	40	RN	Resources	>24	18 - 24	<=18
Responsive	5.1.3	RTT Incomplete pathways - total	9754	9593	11659	14039	15345	16379	16730	16733	16197	15397	15878	17323	18156	19476	20631	21785	22168	RN	Resources	>15,000	14,000 - 15,000	<=14,000
Responsive	5.1.4	RTT Incomplete pathways - 52-<104 weeks	18	53	139	293	421	524	639	789	974	1062	1268	1345	1196	1082	993	968	932	RN	Resources	>0		0
Responsive	5.1.5	RTT Incomplete pathways - 104+ weeks													3	5	13	20	23	RN	Resources	>0		0
Responsive	5.2.1	RTT waiting times - by ethnicity																		RN	Resources			

Domain	Indicator number	Indicator name	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Exec Lead	Committee reported to:	Monthly RAG thresholds: Red	Amber	Green
Responsive	5.2.2	RTT waiting times - by level of deprivation																		RN	Resources			
Responsive	5.2.3	RTT waiting times - learning disabilities																		RN	Resources			
Responsive	5.3	Diagnostic waiting times - 6-week standard	44.7%	49.2%	65.7%	77.5%	75.6%	70.6%	79.2%	78.4%	73.7%	73.6%	80.5%	81.7%	79.7%	85.4%	79.2%	75.1%	74.0%	RN	Resources	<99%		>=99%
Responsive	5.4	Outpatients lost to follow-up - number of follow up patients past due date																		RN	Resources			
Responsive	5.5	Data quality on ethnic group - inpatients	96.7%	96.2%	96.7%	96.0%	95.9%	95.9%	95.9%	95.9%	95.3%	95.2%	94.3%	95.2%	94.9%	96.5%	95.8%	95.5%	95.7%	RN	Resources	<97%		>=97%
Responsive	5.6	A&E 4 hour standard	92.6%	93.4%	95.1%	91.3%	87.2%	89.5%	90.9%	90.1%	85.4%	85.8%	80.2%	83.7%	86.3%	82.7%	82.6%	79.4%	80.4%	RN	Resources	<90%	90-95%	>=95%
Responsive	5.7	Ambulance handovers - % within 15 mins	91.2%	96.0%	92.5%	95.0%	86.5%	87.8%	93.5%	96.5%	95.2%	93.8%	94.4%	93.7%	93.7%	93.6%	87.9%	89.2%	90.4%	RN	Resources	<90%	90-95%	>=95%
Responsive	5.8	A&E - number of 12 hour trolley waits	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	RN	Resources	>0		0
Responsive	5.9.1	Cancer - 62 day wait for first treatment from urgent GP referral to treatment	89.8%	79.4%	81.5%	92.6%	89.6%	87.2%	87.0%	88.7%	84.7%	84.8%	77.7%	85.4%	85.5%	87.1%	92.3%	83.9%	91.2%	RN	Resources	<85%		>=85%
Responsive	5.9.2	Cancer - 62 day wait for first treatment from urgent GP referral to treatment - number of 104 days	0	0	2	3	0	2	2	5	3	5	2	5	3	2	2	5	2	RN	Resources	>0		0
Responsive	5.10	Cancer - 14 days maximum wait from urgent GP referral for all urgent suspect cancer referrals	93.0%	97.3%	98.4%	94.9%	97.9%	97.7%	98.4%	83.7%	88.0%	91.8%	90.2%	89.0%	81.7%	85.7%	88.2%	83.3%	86.0%	RN	Resources	<93%		>=93%
Responsive	5.11	Cancer - 28 days faster diagnosis standard (suspected cancer referrals)							74.1%	74.0%	81.3%	71.8%	79.0%	85.2%	80.3%	81.0%	79.5%	80.9%	80.2%	RN	Resources	<70%	70-75%	>= 75%
Responsive	5.12	Cancer - 31 days maximum wait from diagnosis to treatment for all cancers	100.0%	95.2%	92.9%	100.0%	100.0%	98.8%	98.9%	97.1%	100.0%	100.0%	98.8%	97.1%	97.0%	96.6%	100.0%	100.0%	98.8%	RN	Resources	<94%		>=94%
Responsive	5.13.1	Children's Services - 0-12 months caseload																		RN	Resources			
Responsive	5.13.2	Children's Services - 2-3 years caseload																		RN	Resources			
Responsive	5.14.1	Children's Services - Safeguarding caseload - number of strategy meetings																		RN	Resources			
Responsive	5.14.2	Children's Services - Safeguarding caseload - number of initial Child Protection case conferences																		RN	Resources			
Responsive	5.14.3	Children's Services - Safeguarding caseload - number of court reports																		RN	Resources			
Responsive	5.14.4	Children's Services - Safeguarding caseload - number of Looked After Children																		RN	Resources			
Responsive	5.15	Children's Services - Ante-natal visits	92.3%	95.1%	95.5%	94.6%	94.9%	93.7%	93.4%	93.9%	93.0%	88.8%	93.2%	89.1%	85.9%	86.7%	89.8%	88.3%	89.4%	RN	Resources	<75%	75% - 90%	>=90%
Responsive	5.16	Children's Services - 10-14 day new birth visit	95.0%	95.9%	96.6%	95.0%	96.4%	94.7%	94.7%	95.7%	92.1%	89.2%	93.6%	97.0%	95.4%	95.4%	95.4%	96.4%	96.2%	RN	Resources	<75%	75% - 90%	>=90%
Responsive	5.17	Children's Services - 6-8 week visit	94.1%	93.3%	94.3%	94.6%	93.7%	95.8%	95.2%	94.8%	91.2%	88.0%	90.0%	95.1%	91.9%	92.4%	93.3%	93.3%	92.7%	RN	Resources	<75%	75% - 90%	>=90%
Responsive	5.18	Children's Services - 12 month review	98.9%	99.0%	97.7%	97.4%	97.1%	98.4%	97.9%	94.9%	92.9%	92.4%	92.5%	93.8%	93.1%	91.2%	92.6%	94.0%	95.0%	RN	Resources	<75%	75% - 90%	>=90%
Responsive	5.19	Children's Services - 2.5 year review	94.0%	96.4%	95.3%	95.0%	94.8%	95.5%	94.5%	95.3%	93.4%	92.8%	93.2%	91.9%	91.5%	91.7%	93.4%	93.0%	93.4%	RN	Resources	<75%	75% - 90%	>=90%
Responsive	5.20	Children's Services - % children with all 5 mandated contacts																		RN	Resources	<75%	75% - 90%	>=90%
Responsive	5.21	Children's Services - Delivery of Immunisation trajectory																		RN	Resources			
Responsive	5.22	Children's Services - OPEL level																		RN	Resources	tbc		
Responsive	5.23	Community Care Adult Teams - performance against new timeliness standards																		RN	Resources	tbc		
Responsive	5.24	Community Care Adult Teams - Number of virtual beds delivered in Supported Discharge Service																		RN	Resources			
Responsive	5.25	Community Care Adult Teams - Number of cancelled routine visits																		RN	Resources			
Responsive	5.26	Community Care Adult Teams - OPEL level																		RN	Resources			
Responsive	5.27	Out of hours - telephone clinical assessment for URGENT cases within 20 minutes of call prioritisation	40.4%	36.4%	42.2%	46.2%	45.3%	41.2%	43.7%	46.2%	40.0%	42.0%	44.1%	40.1%	36.7%	35.5%	39.9%	38.6%	45.9%	RN	Resources	<95%		>=95%
Responsive	5.28	Home visit: Face to face consultations started for URGENT cases within 2 hrs	100.0%	100.0%	90.9%	100.0%	91.3%	85.7%	78.9%	93.8%	81.3%	100.0%	81.3%	89.3%	78.6%	86.2%	75.9%	79.2%	88.5%	RN	Resources	<95%		>=95%
Efficiency and Finance	6.1	Agency spend	£ 367	£ 402	£ 411	£ 370	£ 288	£ 254	£ 310	£ 387	£ 424	£ 308	£ 336	£ 380	£ 419	£ 307	£ 414	£ 517	£ 453	JC	Resources	>3% of pay bill	1% - 3%	<= 1%
Efficiency and Finance	6.2	Surplus / deficit and variance to plan	£ -	£ -	£ -	£ -	£ -	£ -	-£ 340	-£ 693	-£ 491	-£ 402	£ 3,100	-£ 745	£ -	£ -	£ -	-	-	JC	Resources	>1% behind plan	0 - 1% behind plan	On plan
Efficiency and Finance	6.3	Capital spend	-	£ 2,069	£ 3,154	£ 4,084	£ 4,187	£ 5,100	£ 7,093	£ 8,129	£ 10,223	£ 10,797	£ 11,300	£ 16,356	£ 518	£ 834	£ 1,856	£ 2,330	£ 3,188	JC	Resources	>25% behind plan	10% - 25% behind plan	On plan or <10% behind plan
Efficiency and Finance	6.4	Cash balance													£ 39,900	£ 34,587	£ 32,007	£ 32,386	£ 33,600	JC	Resources	>10% behind plan	0 - 10% behind plan	On plan
Efficiency and Finance	6.5.1	Long stay patients - stranded (>7 days LOS)	64	63	65	75	78	96	80	89	92	111	127	122	119	114	103	119	129	RN	Resources	>90	70-90	<=70
Efficiency and Finance	6.5.2	Long stay patients - superstranded (>21 days LOS)	23	19	22	27	26	40	28	22	27	38	48	48	48	44	40	42	51	RN	Resources	>40	30-40	<=30
Efficiency and Finance	6.6	Occupied bed days per 1,000 population	30.2	33.9	34.5	38.9	41.6	44.5	44.7	45.5	47.8	50.4	47.8	52.9	50.8	53.9	50.7	55.3	56.5	RN	Resources	tbc		
Efficiency and Finance	6.7.1	Length of stay - elective	2.80	1.59	1.53	2.61	2.72	2.46	2.15	2.51	2.53	3.25	3.12	2.37	2.26	2.60	2.57	2.66	2.76	RN	Resources	>2.75	2.5-2.75	<=2.5
Efficiency and Finance	6.7.2	Length of stay - non-elective	4.87	3.90	3.64	3.73	3.66	4.36	4.13	4.00	4.23	4.69	4.98	4.86	4.69	4.27	4.49	3.99	4.81	RN	Resources	>4.5	4-4.5	<=4.0

Domain	Indicator number	Indicator name	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Exec Lead	Committee reported to:	Monthly RAG thresholds: Red	Amber	Green
Efficiency and Finance	6.8	Avoidable admissions	104	138	151	148	166	173	177	202	199	145	162	178	187	208	234	248		RN	Resources	>270		<=270
Efficiency and Finance	6.9	Theatre utilisation (elective sessions)	56.2%	58.7%	53.0%	63.1%	64.3%	71.8%	76.8%	80.3%	78.3%	78.6%	88.7%	80.5%	81.2%	83.9%	83.4%	82.0%	83.7%	RN	Resources	<85%	85%-90%	>=90%
Efficiency and Finance	6.10	Day case conversion rate	0.9%	1.4%	2.4%	2.2%	2.0%	1.7%	2.2%	2.0%	2.5%	1.5%	1.4%	1.4%	2.2%	1.7%	1.9%	1.6%	1.9%	RN	Resources	>2%	1.5%-2%	<=1.5%
Activity	7.1.1	GP Referrals against plan																		RN	Resources			
Activity	7.1.2	GP Referrals against 2019/20 baseline																		RN	Resources			
Activity	7.2.1	Outpatient activity (consultant led) against plan (new and follow up)													113.7%	106.9%	123.2%	84.2%	86.7%	RN	Resources			
Activity	7.2.2	Outpatient activity (consultant led) against 2019/20 baseline (new and follow up)													90.8%	86.5%	98.7%	85.3%	88.3%	RN	Resources	<95% (from Jul-21)		>=95% (from Jul-21)
Activity	7.3.1	Elective activity against plan													102.5%	97.3%	109.3%	77.4%	72.3%	RN	Resources			
Activity	7.3.2	Elective activity against 2019/20 baseline													74.8%	80.6%	90.4%	73.9%	69.1%	RN	Resources	<95% (from Jul-21)		>=95% (from Jul-21)
Activity	7.4.1	Non-elective activity against plan													96.5%	97.4%	105.2%	104.3%	94.5%	RN	Resources			
Activity	7.4.2	Non-elective activity against 2019/20 baseline													89.9%	98.6%	104.8%	98.3%	92.6%	RN	Resources			
Activity	7.5.1	Emergency Department attendances against plan													98.9%	106.6%	111.2%	103.4%	104.0%	RN	Resources			
Activity	7.5.2	Emergency Department attendances against plan, 2019/20 baseline													98.9%	106.6%	110.8%	103.7%	104.1%	RN	Resources			

Integrated Board Report - August 2021

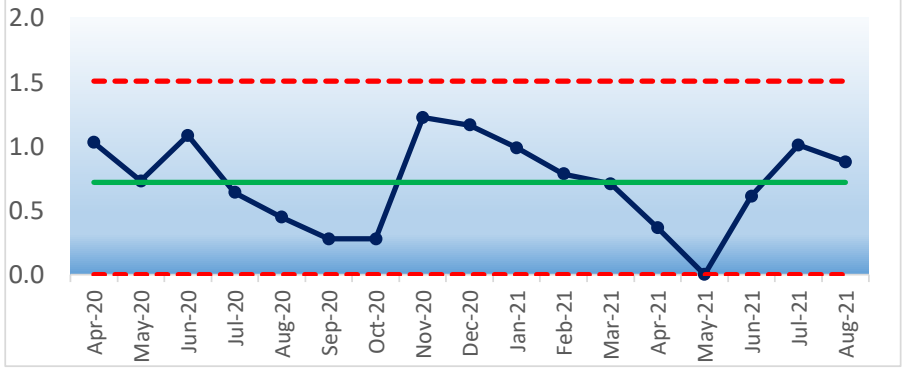
Domain 1 - Safe

Indicator	**1.1 - Pressure ulcers - hospital acquired - cat 3 or above - per 1,000 bed days**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Aug-21
Value / RAG rating	0.88

Indicator description

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

SPC chart



Narrative

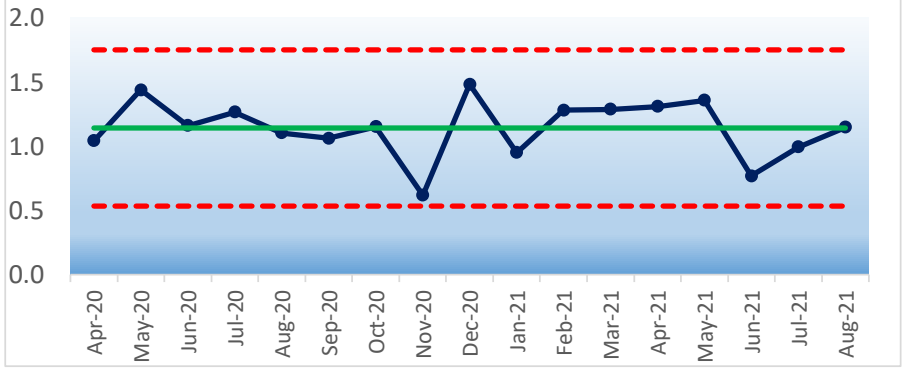
There is an improved position downward trend for the month of August; the TVN (Tissue Viability Nursing) Team has increased so more ward based learning and joint work ongoing with podiatry colleagues. However acuity and admissions are currently high and frail elderly patients are having longer lengths of stays. PULT panels continue to identify themes and instigate immediate actions from learning.

Indicator	**1.2 - Pressure ulcers - community acquired - cat 3 or above - per 1,000 patient contacts**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Aug-21
Value / RAG rating	1.15

Indicator description

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

SPC chart



Narrative

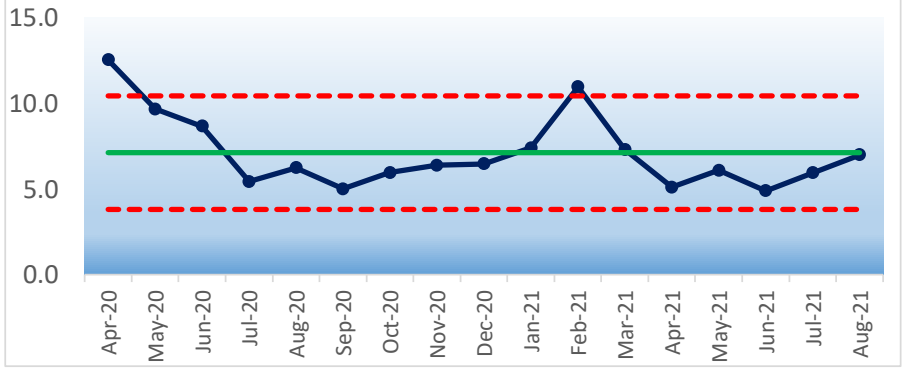
There has been an increase in these pressure ulcers; the acuity of caseloads remains high in Adult Community Services including within the care homes. CCG colleagues are aware of particular homes in which additional learning may be required. The TVN Team are working alongside the District Nursing Teams to support homes.

Indicator	**1.3 - Inpatient falls per 1,000 bed days**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Aug-21
Value / RAG rating	7.00

Indicator description

The number of inpatient falls expressed as a rate per 1,000 bed days. The data includes falls causing harm and those not causing harm.

SPC chart



Narrative

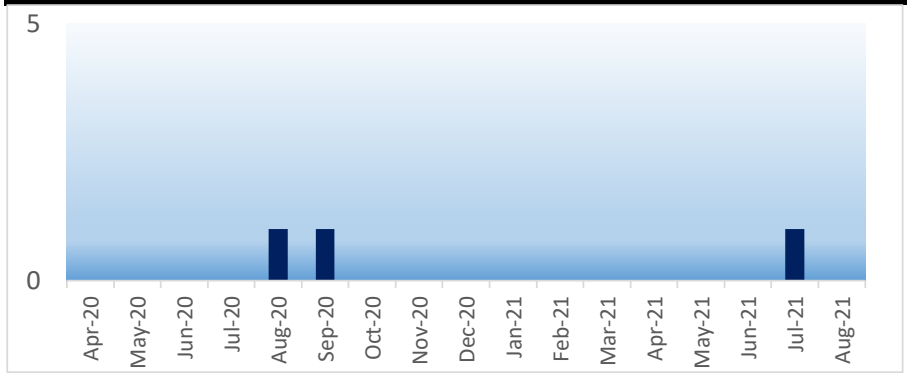
Continuing to see increase in falls since June 2021 which correlates with increase in dependancy of a number of older, frail patients. Work commencing to standardise the enhanced care process to ensure the risk stratification of enhanced needs is correct. The falls with harm Root Cause Analysis (RCA) process has been reviewed to ensure immediate learning from incidents is in place following review at the Quality Panel Review (QPR - formally PULT). RCA documentation has been reviewed and now in line with the National Audit for Inpatient Falls (NAIF). A Falls week will commence 20/09/21 which will create Trustwide awareness of falls prevention and there are several pieces of work ongoing throughout that week to support this.

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

Indicator description

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

Trend chart



Narrative

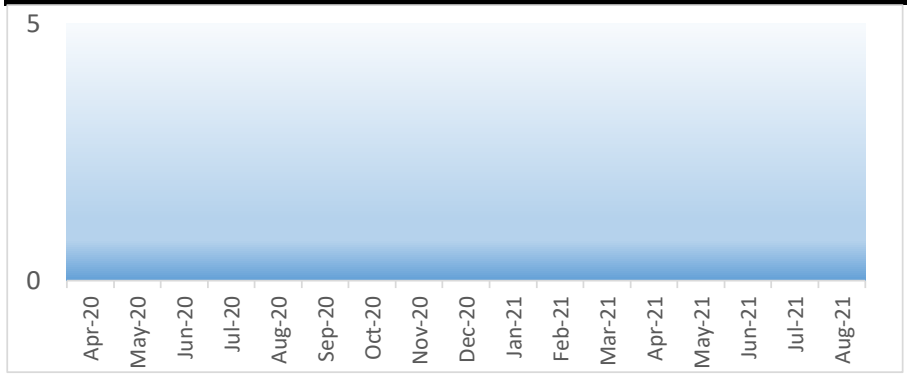
No C.Diff reported where lapses in care as root cause were identified for this reporting period. One case has been identified in July 2021. This case identified issues with antimicrobial stewardship.

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

Indicator description

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

Trend chart



Narrative

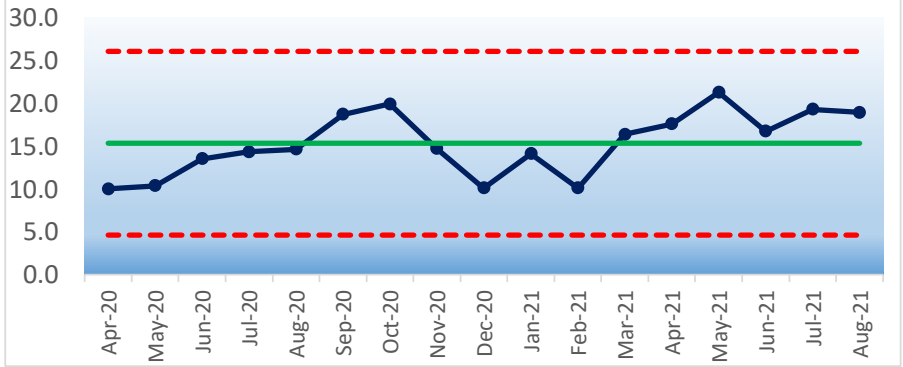
No cases identified.

Indicator	**1.6 - Incidents - ratio of low harm incidents**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Aug-21
Value / RAG rating	19.0

Indicator description

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

SPC chart



Narrative

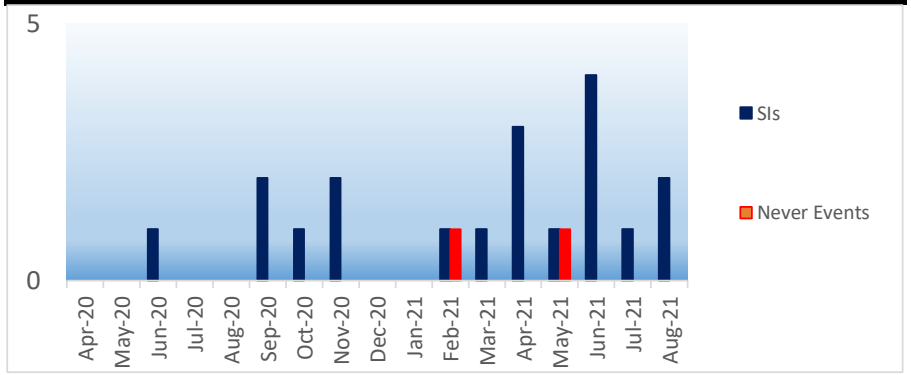
Focused work ongoing in relation to incident reporting and robust management of incidents to ensure feedback and learning is captured and communicated is ongoing. This links to work on quality assurance and improvement.

Indicator	**1.7 - Incidents - comprehensive serious incidents (SI) and Never Events**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Aug-21
Value / RAG rating	2 (SI), 0 (Never Events)

Indicator description

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

Trend chart



Narrative

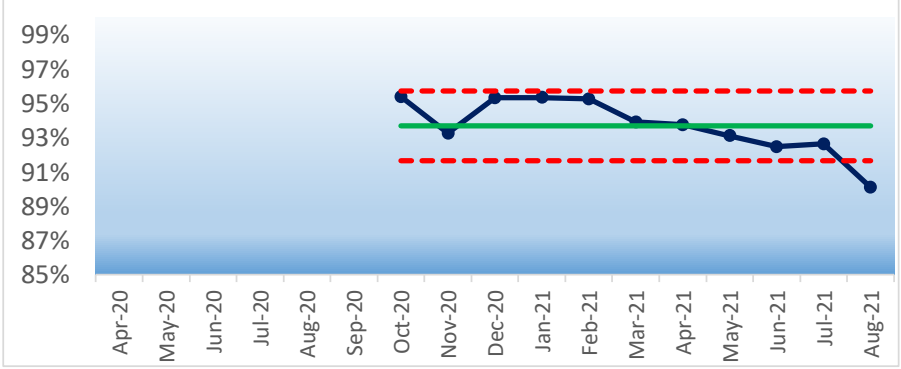
There were 2 comprehensive serious incidents for August. Investigations are underway and immediate actions put in place as required.

Indicator	**1.8.1 - Safer staffing - fill rate**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Aug-21
Value / RAG rating	90.1%

Indicator description

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

SPC chart



Narrative

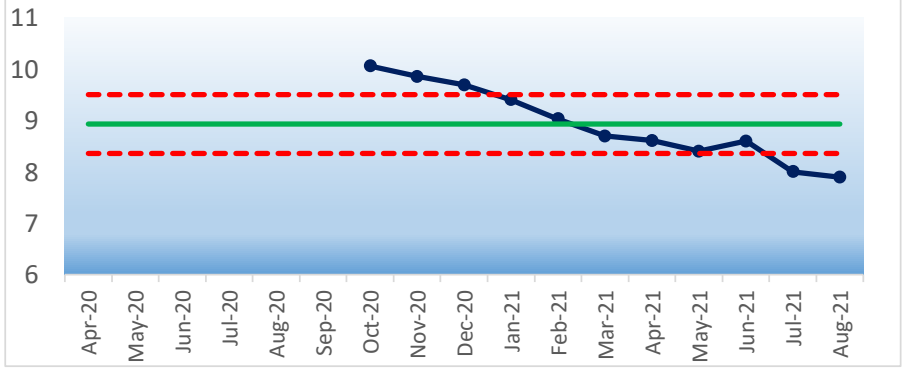
The fill rate for registered and unregistered nursing staff fell for the month of August which reflects an overall increase in sickness absence seen amongst Clinical Teams as well as isolation as a result of Covid, in particular household contact isolation. Annual leave over school holidays has also been a causative factor. Nurse staffing is reviewed at the daily bed meetings where mitigation is put in place by matrons and the site management team. Each mornings the Matrons carry out an assurance walkaround that includes validation of enhanced care requests and this helps inform where mitigation support is needed most. A new bi-weekly meeting attended by the Heads of Nursing, Clinical Site Operations Manager and the Deputy Director of Nursing is now in place that reviews nurse staffing for the current week and projected rostering for the following week. Fill rate has also proved more challenging as the flexible workforce pool has reduced for similar reasons. The Corporate Nursing Team continue to explore ways to help attract flexible workers including an increased bank rate and engagement with new nursing agencies.

Indicator	**1.8.2 - Safer staffing - care hours per patient per day (CHPPPD)**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Aug-21
Value / RAG rating	7.9

Indicator description

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

SPC chart



Narrative

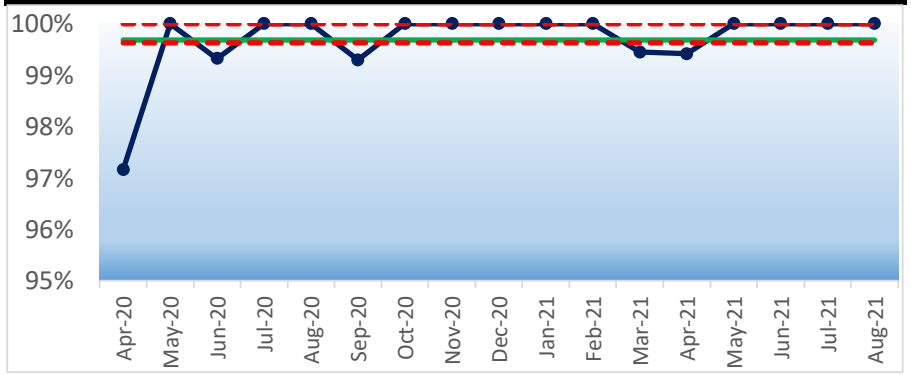
CHPPPD has fallen for the month of August in part due to a reduction in the number of registered and unregistered nursing staff available to deliver care due to various absence reasons. Acuity of patients has remained high and this has been reflected in the rise of enhanced care requests made, particularly across our elderly and complex care wards. Bed occupancy has fluctuated between 95%-107% during August.

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

Indicator description

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

SPC chart



Narrative

100% compliance with this standard.

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

Indicator description
This indicator is under development.

SPC chart

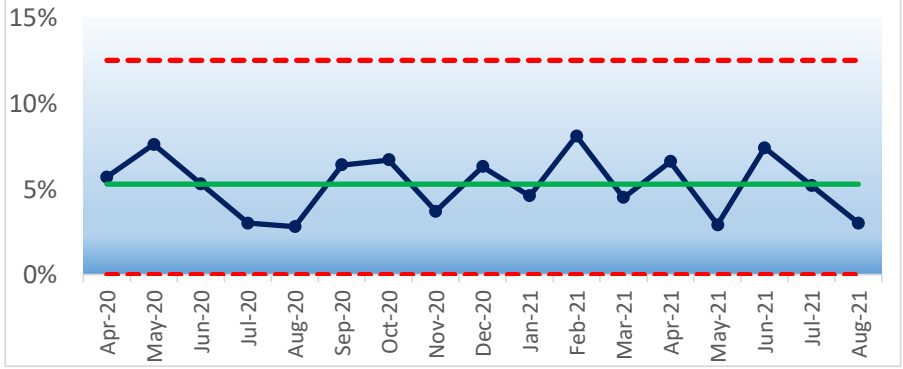
Narrative

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

Indicator description

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

SPC chart



Narrative

Women smoking at the time of delivery remains a low % for HDFT population and we continue to see a reduction. Public health is a key role of the Midwife and smoking is a key area of focus during all midwifery contacts.

Indicator	**1.12 - Maternity - % women initiating breastfeeding**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Aug-21
Value / RAG rating	79.2%

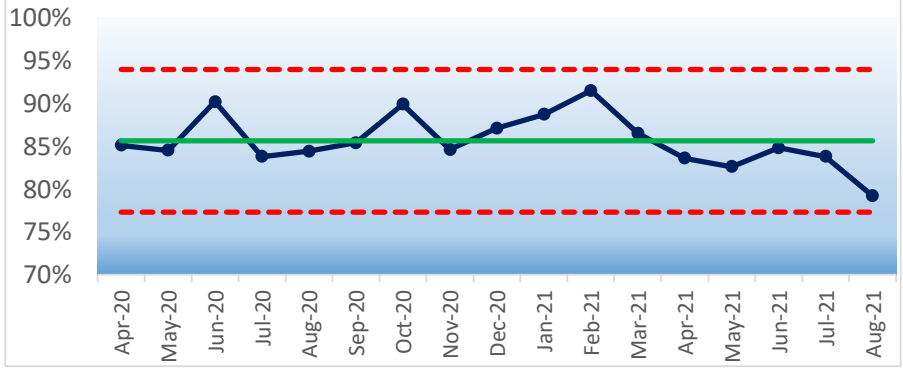
Indicator description

The % of women initiating breastfeeding

Narrative

Reduction in breastfeeding initiation has been impacted during Covid. Women are chosing to go home from hospital earlier which can impact on support available in initiating breastfeeding. Work ongoing with breastfeeding coordinator to ensure more visibility on Pannal Ward and Delivery Suite to support women earlier.

SPC chart

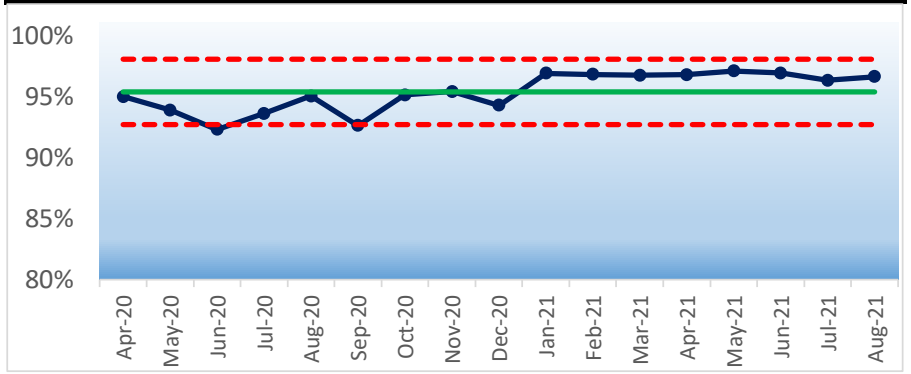


Indicator	**1.13 - VTE risk assessment - inpatients**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Aug-21
Value / RAG rating	96.6%

Indicator description

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

SPC chart



Narrative

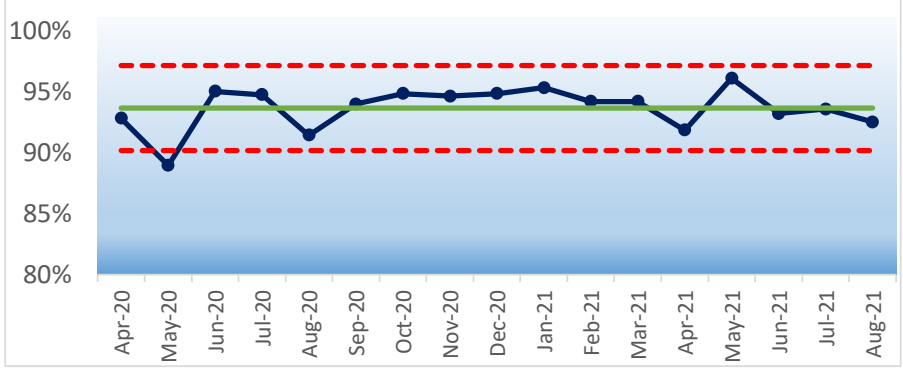
VTE risk assessment compliance audit to commence in October, VTE work to commence regarding root cause analysis and reporting process

Indicator	**1.14 - Sepsis screening - inpatient wards**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Aug-21
Value / RAG rating	92.5%

Indicator description

The percentage of eligible inpatients who were screened for sepsis.

SPC chart



Narrative

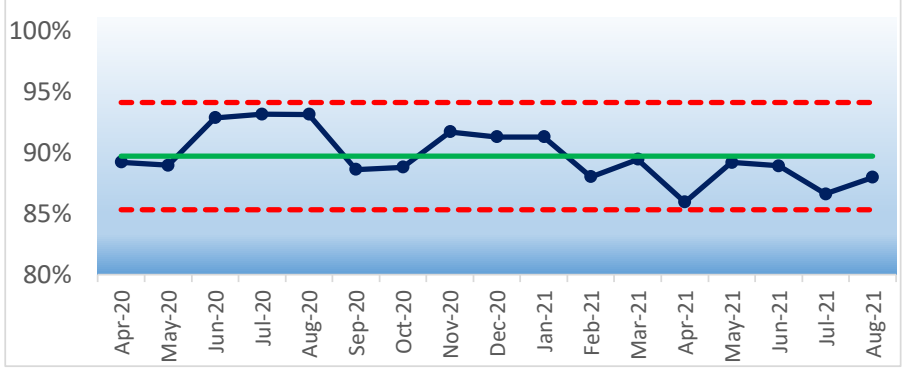
There is a plan to work with clinical matrons from each directorate to ensure the correct sepsis pathway is being followed with a particular focus on admission areas.

Indicator	**1.15 - Sepsis screening - Emergency department**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Aug-21
Value / RAG rating	88.0%

Indicator description

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

SPC chart



Narrative

Work with ED has commenced to identify and strenghten the sepsis screening process. The ED matron is working with the Quality Matron and informatics colleagues to look at ways in which the sepsis screen is more robust. There is a slight improvement from last month following some immediate and quick interventions.

Integrated Board Report - August 2021

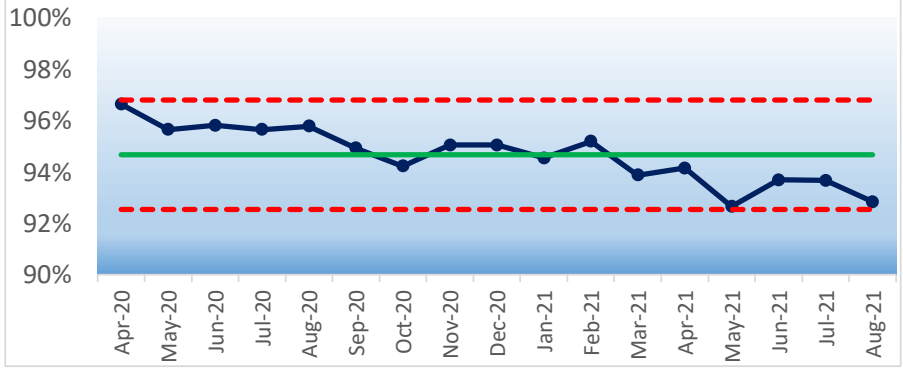
Domain 2 - Caring

Indicator	**2.1.1 - Friends & Family Test (FFT) - Patients**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Aug-21
Value / RAG rating	92.8%

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

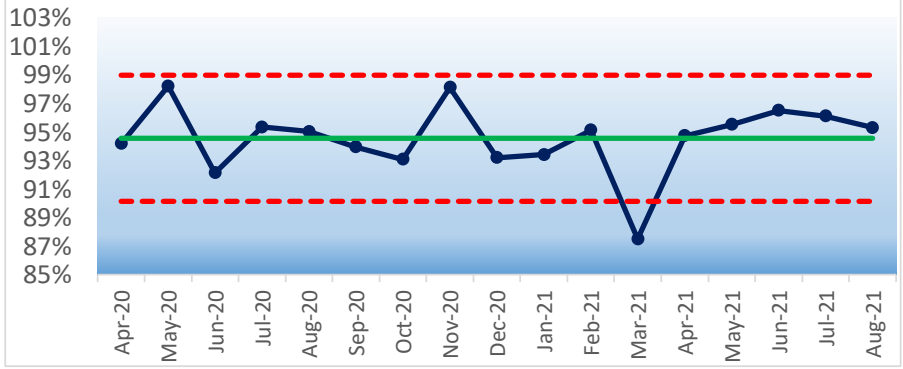
The Trust performs generally well with the Friends and Family Test. This links to the Trust priorities of Caring at Our Best and Making Experience Count and further plans are in development on these areas.

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	Aug-21
Value / RAG rating	95.3%

Indicator description

The Patient Friends and Family Test (FFT) gives patients and service users the opportunity to give feedback. They are asked whether they would recommend the service to friends and family if they required similar care or treatment.

SPC chart



Narrative

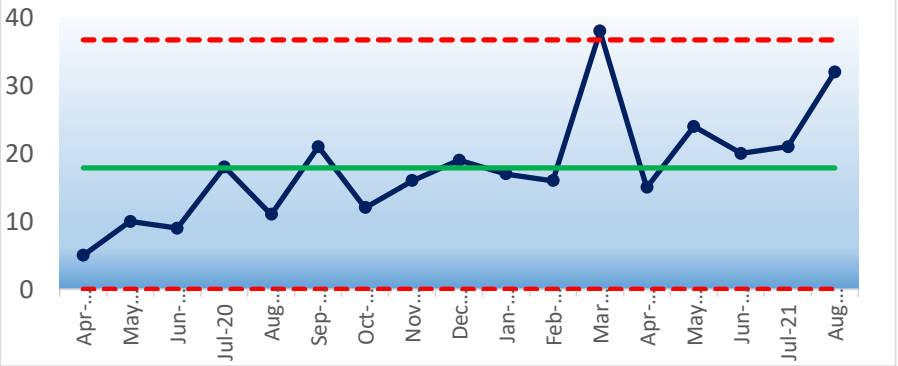
The Trust performs generally well with the Friends and Family Test for Adult Community Services. This links to the Trust priorities of Caring at Our Best and Making Experience Count and further plans are in development on these areas. The Trust saw a deterioration in March 2021 compliance falling below the control limits. However, an increase to mean levels was since from April 2021 onwards, with August 2021 data indicating 95% compliance.

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	Aug-21
Value / RAG rating	32

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

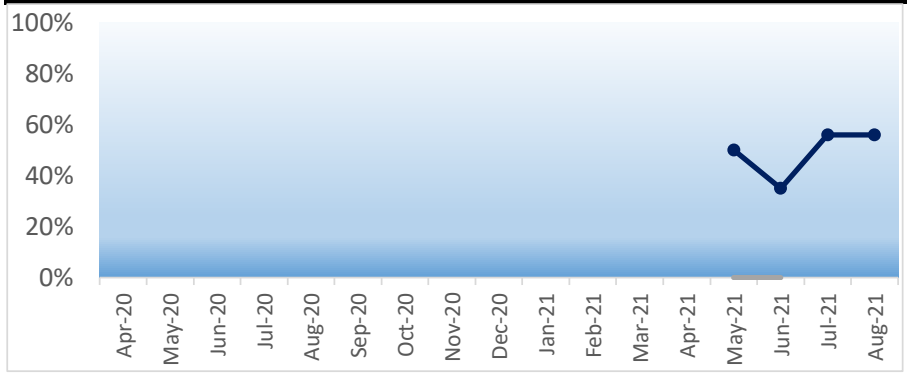
Key work in relation to complaints continues however we have seen an increase in the number of new complaints received by the Trust for the month of August.

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	Aug-21
Value / RAG rating	56%

Indicator description

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

Trend chart



Narrative

The starting position for the trajectory w/c 17th May is 44%. The position as the end of July 2021 was 57%. The next delivery point along the trajectory was 75% by the end of August. Whilst this was achieved and exceeded during the month of August (78% w/c 16th August), the month end position has reduced to 62%. A combination of operational pressures, staff absences and annual leave has contributed to this reduction in performance.

Integrated Board Report - August 2021

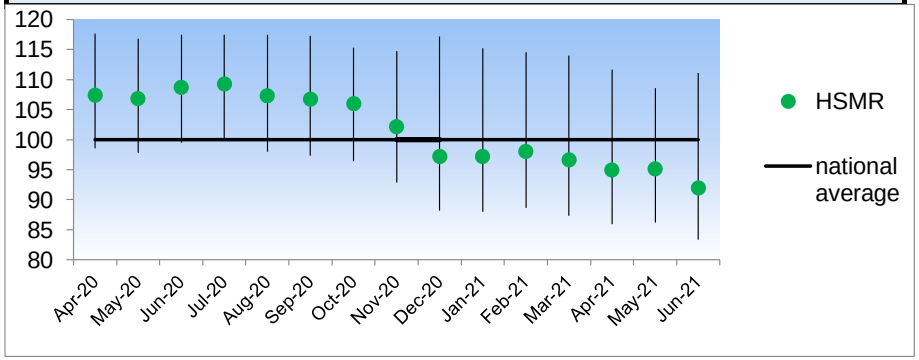
Domain 3 - Effective

Indicator	**3.1 - Hospital Standardised Mortality Ratio (HSMR)**
Executive lead	Jacqueline Andrews, Medical Director
Board Committee	Quality Committee
Reporting month	Jun-21
Value / RAG rating	92.00

Indicator description

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

Trend chart



Narrative

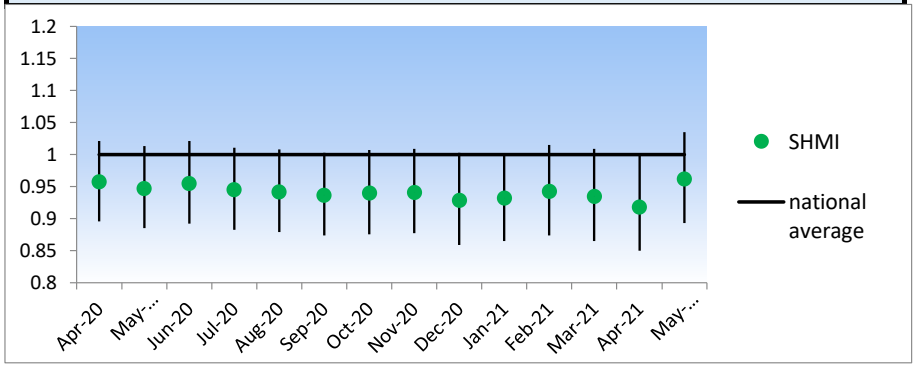
National average is 100. HDFT remains below average and within the expected range. The funnel plot below shows HDFT as the diamond compared to similar Trusts (shown as a cross) and all other Trusts.

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

Indicator description

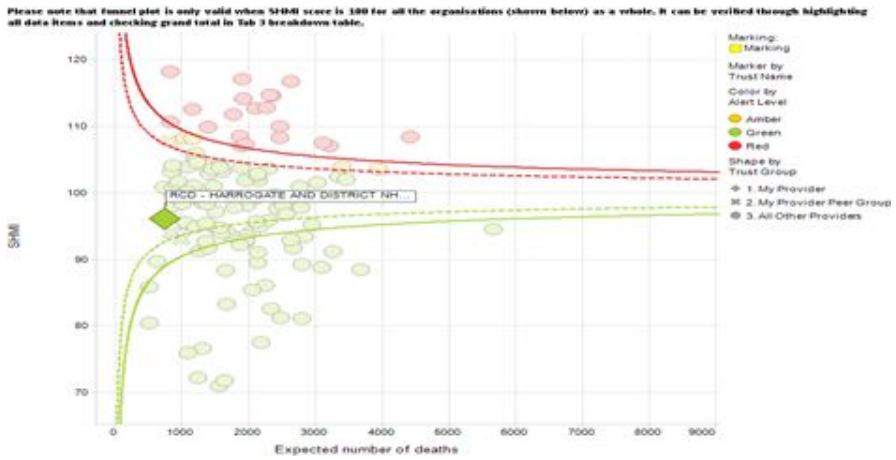
The SHMI looks at the mortality rates for all diagnoses and standardises against various criteria including age, sex and comorbidities. The measure does not make an adjustment for palliative care.

Trend chart



Narrative

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

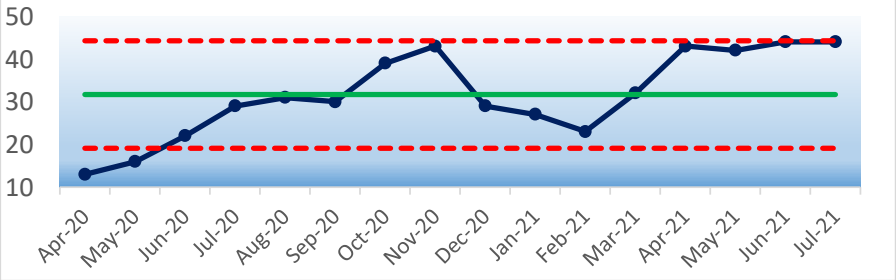


Indicator	**3.3.1 - Readmissions to the same specialty within 30 days - following elective admission**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Jul-21
Value / RAG rating	44

Indicator description

The number 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

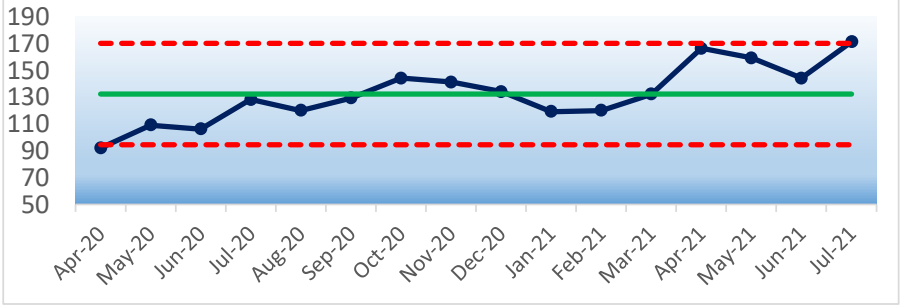
Emergency readmissions (to the same specialty) following an elective admission have increased in recent months. However this is reflective of an increase in elective admissions overall in the same period. In percentage terms, the number of elective admissions readmitted within 30 days is remaining static at around 1.5%.

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	Jul-21
Value / RAG rating	171

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

Emergency readmissions (to the same specialty following an initial emergency admission) have increased this month. In percentage terms, the number of emergency admissions readmitted within 30 days is in line with the historical average level (around 8%).

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	
Value / RAG rating	

Indicator description
This indicator is under development.

SPC chart

Narrative

Board of Directors (Public)
29th September 2021

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

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

Board of Directors (Public) 29th September 2021
Report: Executive Director of Nursing, Midwifery and AHPs
Author: Emma Nunez

Harrogate and District NHS Foundation Trust

Matters of concern & risks to escalate	Major actions commissioned & work underway
• x1 new SI relating to Theatres (medication admin error). Investigation underway. Cognisant of x2 never event and previous SI similar themes. Quality Matron working with theatre team to identify immediate actions. • Patient fall resulting in subdural haematoma – SI declared. Combined falls action plan for this case and previous now combined so actions are trust wide (and link to piece around reviewing falls policy, bed rails and enhanced care policies). • Nurse staffing gaps across hospital and community and increased enhanced care requests. • Theatre staffing gaps remain across ODPs and Scrub teams impacted by annual leave, sick leave. Utilising agencies and internal incentives. • 12-15 years COVID vaccination programme - likely to have significant impact on our school nursing teams and 0-19 services due to likely delivery timelines.	Perfect Ward procurement process underway. Quality boards – finalising wording for non ward areas. Directorate risk registers being transitioned and updated onto datix. Complaints: Work ongoing regarding complaints backlog and timeliness to response. Q4 complaints = 191 (236 previous year). Current themes = ED / outpatients / diagnosis / waiting times /cancelled procedures Flu / Covid booster campaign: Agreed joint start date 4th October. 12-15 vaccine administration. PLACE inspection recommencing (internal only) Quality Matron matrons with Dean H. Revised cleaning standards audit & assurances developed. Ockenden – awaiting dates for peer review. MIS4 – significant changes to training expectations.

Board of Directors (Public) 29th September 2021
Report: Executive Director of Nursing, Midwifery and AHPs
Author: Emma Nunez

Harrogate and District NHS Foundation Trust

Positive news & assurance	Decisions made & decisions required of SMT
• Development of Quality Team, this includes: • All TVN posts now recruited to and in place (4.6 wte). • Falls Band 6 (fixed term) agreed to support and enhance work around falls pathway. • Continence Specialist Nurse (Band 6) for hospital as currently no provision than in community setting. • Enhanced Care Lead – (Band 6) agreed. • CAOB programme Lead commenced. • Change from PULT panel to new 'Quality Panel Review' – to now include falls and PU's combined. • VTE practitioner post agreed (LTUC) and quality matron supporting with incident reporting and investigation. • Autoplanner rollout within Ripon CCT. • Workforce Matron post advertised.	

3

Board of Directors (Public)
29th September 2021

Title:	Freedom to Speak Up Guardian update
Responsible Director:	Emma Nunez – Director of Nursing
Author:	Quality Matron

Purpose of the report and summary of key issues:	To provide The Board with an update on Freedom to Speak Up at HDFT Assurance regarding Fairness Champion recruitment and training and relaunch Trustwide Gaps in assurance: NGO e-learning to be considered by board	
BAF Risk:	AIM 1: To be an outstanding place to work	
	BAF1.1 to be an outstanding place to work	X
	BAF1.2 To be an inclusive employer where diversity is celebrated and valued	X
	AIM 2: To work with partners to deliver integrated care	
	BAF2.1 To improve population health and wellbeing, provide integrated care and to support primary care	
	BAF2.2 To be an active partner in population health and the transformation of health inequalities	
	AIM 3: To deliver high quality care	
	BAF3.1 and 3.4 To provide outstanding care and outstanding patient experience	X
	BAF3.2 To provide a high quality service	X
	BAF3.3 To provide high quality care to children and young people in adults community services	X
	BAF3.5 To provide high quality public health 0-19 services	X
	AIM 4: To ensure clinical and financial sustainability	
	BAF4.1 To continually improve services we provide to our population in a way that are more efficient	
	BAF4.2 and 4.3 To provide high quality care and to be a financially sustainable organisation	
	BAF4.4 To be financially stable to provide outstanding quality of care	
Corporate Risks		
Report History:	Update provided to People & Culture Committee 13/09/21	
Recommendation:	The Board is recommended to review the content of this report and consider the NGO e-learning for all Trust staff	

Board of Directors Meeting

Freedom to Speak Up Guardian update

1.0 Executive Summary

1.1 Freedom to Speak Up Guardians provide regular, comprehensive reports to their Board so that barriers to speaking up are identified and addressed. This report outlines current work nationally, data and themes relating to local contacts to the Guardians and Fairness Champions, progress with local work and further work to be undertaken.

2.0 Background

2.1 This Board Report follows previous Board Reports, presented bi-annually, which have outlined barriers to speaking up, how they are identified and addressed. This report is presented for information outlining current work being undertaken data and themes relating to local Guardians progress with local work and further work to be undertaken.

3.0 Introduction

3.1 HDFT is required to have a robust Freedom to Speak Up Guardian arrangement in place.

3.2 There is a risk that poor standards of care can proliferate unless patients and staff are listened to, and their concerns welcomed and acted upon.

3.3 All NHS trusts are required to appoint a Freedom to Speak Up Guardian and an assessment of speaking up is at the heart of the well led domain of CQC inspections of NHS trusts. See also Freedom to Speak Up: guidance for NHS trust and NHS foundation trust boards | NHS Improvement

4.0 Proposal – this report proposes further action on:

4.1 The implementation of FTSU training for all staff

5.0 Quality Implications and Clinical Input

5.1 There is a risk that poor standards of care can proliferate unless patients and staff are listened to and their concerns welcomed and acted upon.

6.0 Equality Analysis

6.1 This work aims to impact positively on all staff but particularly on staff who might be more vulnerable to speaking up.

7.0 Financial Implications

7.1 This Board report does not have any direct financial implications.

8.0 Risks and Mitigating Actions

8.1 The impact of the Covid-19 pandemic during 2020/2021
8.2 Substantive FTSUG on maternity leave, interim FTSUG in place

9.0 Consultation with Partner Organisations

9.1 This Board Report was created without consulting with partner organisations.

10.0 Monitoring Performance

10.1 HDFT is keen to ensure it has robust FTSU arrangements in place and will continue to report on national and local actions, at least bi-annually to the Board, in relation to developing a culture of speaking up about concerns.

11.0 Recommendation

11.1 The Board is asked to review and comment on the content of this of this Board Report to evaluate the work in relation to embedding a culture of speaking up about concerns.

12.0 Supporting Information

11.1 The following paper appended makes up this report:

Report: Freedom to Speak Up Guardian update report to Board of Directors

Date: September 2021

Introduction

The National Guardian's Office and the role of the Freedom to Speak Up Guardian were created in response to recommendations made in Sir Robert Francis' report "The Freedom to Speak Up" (2015). These recommendations were made as Sir Robert found that NHS culture did not always encourage or support workers to speak up, and that patients and workers suffered as a result.

The ambition across the NHS is to affect the cultural change that ensures speaking up becomes business as usual.

Workplace culture is the character and personality of an organisation. It is made up of the organisation's leadership, values, traditions, beliefs, and the behaviours and attitudes of the people working within it. We know that:

"If leaders and managers create positive, supportive environments for staff, they in turn create caring, supportive environments and deliver high-quality care for patients. Such leadership cultures encourage staff engagement".

(The King's Fund: Improving NHS culture)

National publications

The Strategic Framework (July 2022) outlines the priorities of the National Guardian's Office for Freedom to Speak Up in the healthcare sector.

In the five years since the Freedom to Speak Up Review, much has been achieved.

The strategic direction of the National Guardian's Office is to build on those improvements and to ensure that speaking up arrangements work consistently well. There is now a network of over 700 Freedom to Speak Up Guardians supporting nearly 500 organisations. The ambition is that the freedom to speak up should be available to everyone in the healthcare system, irrespective of where they work.

Over the past five years, the work of the National Guardian's Office has shown that the promoters and barriers of speaking up are universal. Universal principles for creating a speak up, listen up, follow up culture – and implementing the Freedom to Speak Up Guardian role – will promote consistency and support the development of a more integrated healthcare system.

This Strategic Framework also sets out the intention of the National Guardian's Office to obtain greater assurance about speaking up cultures and the quality and consistency of how the Freedom to Speak Up Guardian role is implemented.

Russell Parkinson, Head of Office and Strategy at the National Guardian's Office, said: *"This framework enables the National Guardian's Office to build on the achievements of Freedom to Speak Up to date and to respond to wider changes in the healthcare landscape. The 50,000+ cases that have been brought to Freedom to Speak Up Guardians have offered 50,000+ opportunities for learning and improvement. But despite this, the pandemic has highlighted how much more needs to be done.*

"The most immediate concern of the National Guardian's Office is ensuring that speaking up works well now so that our healthcare workforce feels empowered and listened to. Making

speaking up business as usual will enhance the working life of the healthcare workforce and improve the quality and safety of care.

"This Strategic Framework will give the new National Guardian a framework to build upon, shape and lead."

National Guardians office annual report 2020

There is evidence that a strong Freedom to Speak Up culture at all levels in healthcare has significant benefits. The speaking up culture of the health sector in England has changed due to a network of 600 guardians in over 400 organisations.

https://www.nationalguardian.org.uk/wp-content/uploads/2021/03/ngo_ar_2020_digital.pdf

Freedom to Speak Up Guardian survey report 2020 (published mid-March 2021)

The report outlines FTSU Guardian's views on a number of key areas relating to their experience, to gather insight into the role and how it can be improved.

Findings

- A Speaking up culture was found to have improved from 2019 to 2020.
- The results show that the vast majority of boards are directly accessible to FTSU Guardians
- Over three quarters of those surveyed had presented reports to board meetings or equivalent in person, indicating the level of visibility being placed on the work of the FTSU Guardian role by senior leaders.
- There remain issues around support and detriment at other levels of organisations, which leaders must play an active role in tackling.
- There are still barriers to speaking up in just over half of NHS Trusts.

https://www.nationalguardian.org.uk/wp-content/uploads/2021/03/ftsug_survey_report_2020.pdf

National Guidelines on Speaking Up training in the health Sector in England

Freedom to Speak Up e-learning, has been developed in association with Health Education England and freely available for anyone who works in healthcare. 'Speak Up, Listen Up, Follow Up' is divided into three modules, it helps learners understand the vital role they can play in a healthy speaking up culture which protects patient safety and enhances worker experience.

Speak Up: Core Training for all Workers , covers what speaking up is and why it matters. It will help you understand how you can do this and what to expect. Listen Up – for managers at all levels, focuses on listening and understanding the barriers to speaking up. A final module, Follow Up, for senior leaders – including executive and Non-Executive Directors, lay members and governors – will be launched later this year.

Learning objectives

- Workers will feel encouraged to speak up and understand how to do so.

- Managers will feel confident to respond appropriately when workers speak up, to support individuals when they speak up, and know where to go for support themselves.
- Senior leaders will feel enabled to set the tone for the speaking up culture in their organisation, have a good understanding of the wider drivers for speaking up and understand how speaking up can promote learning and improvement.

file:///H:/Freedom%20to%20speak%20up/2021/Report%20information%20March%202021/20190812-national-guidelines-on-freedom-to-speak-up-training-in-the-health-sector-in-england.pdf

The publications and the work of the National Guardian's office need to be utilised to relaunch the Freedom to Speak Up ethos within our organisation and will be valuable tools for the lead Guardian and associate(s) roles to use

Local work

Freedom to speak up current data Q3

The following table captures the numbers of cases received by the Freedom to speak up guardians between July 2021 – present 2021, common themes identified and a summary of learning points.

Numbers of referrals to the guardians has been small during this period. We have started to relaunch FTSU across the organisation and training is planned for October for more Fairness Champions; this is to raise the profile of FTSU and encourage more contacts.

Numbers of cases brought by professional level	Worker Manager Senior leader Not disclosed	5 1 0 0
Numbers of cases brought by professional group	Allied Health Professionals Medical Registered Nurses and Midwives Nursing Assistants or Healthcare Assistants Administration, Clerical & Maintenance/Ancillary	1 0 3 1
Number of cases raised anonymously		0
Number of cases with an element of bullying or harassment		2

Response to the feedback question; 'Given your experience, would you speak up again?	Total number of responses The number of these that responded 'Yes'	3 3
Common themes identified	Communication – updating staff on progress of actions after a concern has been raised HR processes not explained to staff involved adequately – unaware of progress	
Summary of learning points	Improved communication Employees to follow guidelines and HDFT policies	

The Freedom to Speak Up Guardian role update

The last eighteen months has not been easy or straightforward for any member of staff working in the NHS due to the ongoing challenges of the Covid-19 pandemic.

In June 2020, Kath Banfield and Alison Pedlingham were appointed as interim Freedom to Speak up Guardians and Shona Kerr remained in post as the substantive Guardian. Both Kath and Alison completed the national FTSUG training and attended an initial regional meeting as an introduction to the role and to network with other guardians. The decision to support Shona with two interim guardians was made to allow time for the Trust Executive Board to collectively agree a more permanent arrangement for the Freedom to Speak Up Guardian role and structure within the organisation.

A decision was made to consider having an overarching guardian role supported by associate guardian(s) with a number of fairness champions in place. There is an acknowledgement that the guardian role will support the current work of 'Your vision, your voice and your values' being undertaken by the Trust.

An all user email was sent in August asking for any member of staff working in the organisation interested in becoming either the lead or the associate FTSUG to contact Jill Foster, Chief Nurse.

Shona, Kath and Alison were asked to complete the first phase of the recruitment process. During the month of October, the three FTSUG's interviewed interested parties and candidates were asked;

- Why they were interested in one or both of the roles (lead and/or associate guardian)
- A discussion with the panel on how they would approach the issues raised within a scenario as a FTSUG
- The panel were impressed by the commitment of staff interviewed in promoting high standards of care, respect and fairness within the workplace. Candidates showed a very good understanding of the guardian role during this process

- A shortlist of five candidates for the lead guardian role were identified and names given to the Chief Nurse to arrange the next stage of the process
- A short introduction was arranged for the shortlisted candidates with the Chief Nurse and Chief Executive prior to arranging progression to the next stage
- A FTSUG was appointed however has commenced maternity leave prior to commencing in post.
- Kath Banfield and Alison Pedlingham have stepped down from their roles and Shona Kerr has retired from the Trust.
- Charly Gill – Quality Matron has been appointed on an interim basis to cover the maternity leave
- Two Associate Guardians have been appointed; Lisa Layton and Christine Hines.

Since July 2021 the FTSUG has;

- Met with the Associate Guardians to determine roles and responsibilities
- Attended regional FTSUG meetings
- Followed up emails received to the confidential FTSUG e mail address
- Supported members of staff and escalated individual cases to line managers as appropriate
- Established an accurate database of Fairness Champions
- Arranged Fairness Champion Training (1/10/21)

Next steps for 2021/2022

- To agree a job description for the associate role
- Executive board to confirm a model for the Trust
- Use these important appointments to relaunch the Freedom to Speak Up service across the whole organisation and consider how this service reaches the wider community footprint of the organisation
- To include the FTSUG role in the current work on the organisational culture, values and behaviours.
- Consider new ways to support staff in speaking up – e.g. Trust App
- Launch the Speak up and listen up e - learning package- part 1 for all staff and part 2 for managers delivered through Learning Lab providing a record of staff completion.

Strengthening Maternity and Neonatal Safety Report

Board of Directors (Public)

29th September 2021

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

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

teamHDFT At our best

NHS Harrogate and District NHS Foundation Trust

Board of Directors
Report: Strengthening Maternity & Neonatal Safety Report
Author: A. Pedlingham

NHS Harrogate and District NHS Foundation Trust

Matters of concern & risks to escalate	Major actions commissioned & work underway
• Prompt online training compliance – midwives and medical staff (plan in place)	• Ockenden bid monies received - £273,125 (7/12th midwifery and 75% medical staffing due to time in financial year) • Maternity Incentive Scheme (year 3) – submission 22nd July
Positive news & assurance	**Decisions made & decisions required of Board**
• Full compliance with 10 safety actions from MIS (year 3) – Board sign off 30th June • Submission of evidence required to support the Ockenden report • Monies received from Ockenden bid (5.0WTE midwives and 0.8WTE Consultant Obstetrician) • >90% fetal monitoring compliance training – midwives and medical staff	

STRENGTHENING MATERNITY AND NEONATAL SAFETY REPORT

1.0 Summary

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

1.0 Introduction

1.1 In January 2021 the Trust Board received a maternity report, including the mandated trust actions in response to the first Ockenden Report. One of these actions was to implement the Perinatal Quality Surveillance model including the provider level detailed here.

2.0 Proposal

2.1 The report covers the provider Board level measures required as part of the perinatal surveillance model.

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

3.0 Quality Implications and Clinical Input

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

4.0 Equality Analysis

5.1 An equality analysis has not been undertaken

5.0 Risks and Mitigating Actions

6.1 The middle grade staffing numbers have improved since the new doctors' start in August. However, the three new starters do not have sufficient entrustability to work without on-site supervision from a senior colleague. Although the new appointments have improved the in-week daytime staffing, out of hours cover remains a challenge. A staffing review is required and preliminary discussions have taken place. Current mitigations include consultants remaining resident until 20:00h in week and the use fo internal and external locums to cover some of the night shifts.

6.2 The low compliance levels for medical staff for obstetric emergency training (Prompt) previously presented a risk to the delivery of high quality care. The Trust Board agreed a plan identify in reaching the 90% threshold by 31st August 2021 and this was achieved by 3rd September.

7.0 Recommendation

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

Narrative in support of the Provider Board Level Measures – September 2021

Introduction

NHS England and Improvement published the revised perinatal surveillance model in December 2020, setting out six requirements to strengthen and optimise board oversight for maternity and neonatal safety.

This report for SMT follows the overview on quality and safety and the response to the Ockenden Report last presented at the board meeting in July 2021.

The maternity department made the decision to incorporate the Perinatal Quality Surveillance model into the existing Maternity Services Forum that meets bi-monthly; the last meeting was August 20th 2021 and terms of reference for the group have been updated and agreed to include this model within the existing structure of the group.

Review of WY&H LMS dashboard

As part of implementing a revised perinatal quality surveillance model (December 2020; LMS action) the LMS are "leading on the production of a local quality dashboard which brings together a range of sources of intelligence relevant to both maternity and neonatal services from provider trusts within the LMS".

Discussions continue within the WY&H LMS about the content of maternity dashboards and the current variation between all six maternity units within the LMS. This work stream is being led by the LMS Programme analyst.

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

In August, there was 1 new qualifying case for PMRT review.

This was a delivery of twins at 22+6 weeks gestation, born with signs of life and then sadly died shortly afterwards. This PMRT is in progress – the cause of death being 'extreme prematurity'. The MBRACCE notification and surveillance data was reported within the given timescale.

Findings of review all cases eligible for referral to HSIB

In August 2021:

No new cases notified in this period

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

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

There is an agreed list of maternity specific clinical incidents for completion of a datix form as part of the trust clinical incident reporting process. Once a week, a multi-disciplinary panel (the Professional Advisory Panel – PAP) meet to discuss the clinical incidents from the previous week and actions are agreed. If, after discussion further escalation is required, a 48

hour/SBAR report is completed and referred to the newly implemented weekly Quality summit. A decision is then made to investigate further as an SE/SI, local investigation or not.

At PAP, if any concerns about individual staff clinical practice are identified, further investigation by a senior member of staff is undertaken via the capability policy.

In August there was one incident logged as moderate harm in August 2021. This was for a 4th degree perineal tear. Following multidisciplinary review at PAP (Professional Advisory Panel) it was felt that actions were appropriate with correct technique used during delivery. The patient has been followed up and appears to be recovering well. Duty of Candour letter has been sent.

Additional incidents of note but unclear level of harm:

- Unexpected delivery of a baby at 26^{+5} weeks gestation on Pannal Ward. The baby is progressing satisfactorily despite lack of steroid/magnesium sulphate administration. SE investigation commenced.

- Baby born at 41^{+2} following transfer from Leeds homebirth team. Progressing well following birth but developed seizure activity at 16hours of age and transferred to tertiary unit. Initially suspected herpes infection but subsequently diagnosed with arterial stroke. Management appropriate so level of harm unclear. Does not fit HSIB criteria.

Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training

The revised standards for the Maternity Incentive Scheme Safety Standard 8 allow Trusts to be compliant provided there is a plan and a date in place to achieve > 90% staff completion.

Prompt emergency skills training

	Medical staff (including anaesthetists)	Midwives
March 2020	85% (face to face)	88% (face to face)
End March 2021	25%	11%
Early May 21	51%	45%
31st May 21	47%	49%
Early - June 2021	47%	56%
1st July 2021	47% (16/34)	64% (44/69)
Mid-July	49% (19/39)	69% (48/69)
Early August	67% (26/39)	94% (61/65)
3rd September	97.3% (35/37)	96.9% (63/65)

Fetal monitoring training (K2 online training package)

	Medical staff	Midwives
March 2020	93%	94%
End March 2021	15%	40%
Early May	61%	69%
31st May 21	78%	76%
Early June 21	98%	80%
1st July 2021	98%	91%

Mid-July	98%	91%
Early August	98%	95%
3rd September	100% (14/14)	98% (64/65)

Prompt emergency skills training
One member of anaesthetic staff that we do not know if they have completed their Prompt and two midwives have not completed. Both midwives are community midwives and both have completed their face-to-face emergency drills training specifically for the community environment.

It is anticipated that face to face Prompt training will resume this month with the first date planned for 21st September.

Minimum safe staffing in maternity services

The rosters in August and September have continued to be a challenge with midwifery numbers below the minimum staffing levels on a number of shifts due to:

- Increased numbers of staff leaving/left
- Holiday season
- Band 6 midwifery posts regularly advertised with a steady stream of good applications received.
- Staff recruited and start dates in October or awaiting confirmation of start dates.

After allocation of £274,125 from the Ockenden bid monies for uplift to midwifery staffing establishment, obstetric staffing and backfill for multi-disciplinary training.

- 5.0WTE midwives above funded establishment – advert closes, interviews planned for 22/09/21
- 0.8WTE Obstetric Consultant – business case to be written

Obstetric cover on the delivery suite, gaps in rotas

The maternity unit has been staffed to minimum safe staffing standards at all times despite the gaps in the establishment and risks detailed below.

Staffing Gaps and Contingencies			
Grade of doctor	**Staffing gaps**	**Contingency**	**Risks**
First on call rota FY2/ GPVTS/ ST1/2	None	Internal cover for short term sickness as required	None identified
Second on call rota ST3-7/ specialty doctor	All posts filled Issue with entrustibility in three members of staff means they must have on site supervision at all times. Gap in on call cover due to change in training meaning ST3	Internal cover prioritising labour ward cover Internal cover for short term sickness as required	Risk of fatigue in doctors on second on call tier Risk of cancelling elective activity to protect Delivery Suite cover

	cannot work on call without a resident senior Gap in on call cover due to ST4 current entrustibility level Gap in on call cover due to specialty doctor entrustibility level	Consultants remaining resident until 20:00h weekday evenings to supervise non-entrustible doctors	Risk of consultant fatigue Added to risk register March 2021
Consultant	Full consultant complement for current job planned work but not to cover extended cover required for Ockenden	All new consultant appointments now in post Funding from Ockenden for 0.8WTE consultant-consultant case to be written	Risk of fatigue in consultants due to covering non-entrustible juniors

Midwife minimum safe staffing planned cover versus actual prospectively

August data gives an average shift fill rate of 94.1% for midwives and 82.8% for maternity support workers on Delivery suite and for 86.3 % midwives and 87.1% maternity support workers on Pannal Ward.

Specialist midwives and ward managers have continued to support the service by working clinically. Staff have worked NHSP shifts and a small number of agency

Midwives left – 1.5WTE

Staff given notice – 2.0 WTE

Staff recruited

No new starters in August

Recruited a further 5.42 WTE band 6 midwives – start dates to be agreed

Recruited 3.0 WTE new Band 5 midwives – to start October, they are able to work as band 4's until they have their NMC PINS

Recruited 2.5 WTE band 3 MSW's to support the Maternity Assessment Centre – start date to be confirmed.

The digital midwife will start in post end of September.

Current midwifery/maternity support worker vacancies:

Band 6 midwives – 1.5 WTE

Band 2 MSW's – 2.00 WTE (both going on maternity leave)

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

There is a recognition of the number of times the maternity unit closes to further admissions and women diverted to other units in the region as a consequence. This decision is currently

made by the Delivery Suite coordinator and the Consultant on call/on duty if out of office hours supported by the clinical site coordinator team. During office hours the HOM and Matron are involved in discussions and decision. As a department, we feel this decision needs to be discussed with the Manager and Executive Director on call and this will be reflected in the revised maternity escalation guideline which will be available for comments by 30/09/2021

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

Date/time **Length of time closed**	**Reason**	**Women diverted**	**Action taken**
12/8/21 (Thursday) 03.45 – 08.00 (4 hrs 15 mins)	Increased activity and staff sickness – 1 midwife off sick	No	Midwife moved from Pannal ward to Delivery Suite, On call midwife worked 20.00-03.15
14/8/21 (Saturday) 14.50 – 18.50 (4 hrs)	Increased activity (staffing levels normal)	1 woman to James Cook	2 additional CofC midwives worked on DS and staff stayed on at end of shift. Support provided by weekend Matron
15/8/21 (Sunday) 13.30 – 04.30 (15 hrs)	Increased activity – 6 midwives on DS and 2 on Pannal ward	Attempt to divert twins 22+6/40 by ambulance but brought in by YAS and delivered	CofC midwife to support on L shift, midwife worked additional hours
19/8/21 03.00 – 08.00 (5 hrs)	Increased activity	No	No midwife on call – worked night shift
21/8/21 02.15 - 07.30 (5 hrs 15 mins)	Increased activity (both DS and Pannal ward)	No	Midwife on call attended at 01.30

Service User Voice feedback

There were two formal complaints received in August

- Complaint about care in pregnancy/birth for baby diagnosed with hemiparesis
- 4th degree tear claim

Five other concerns were received in this period

- relating to issues with multiple attempts to site a spinal (followed up by Consultant Anaesthetist),
- Concern regarding lack of communication
- Concern regarding breastfeeding/tongue tie
- Patient care in the ED
- Issue re: traumatic birth and physiotherapy follow up

FFT – 93 responses have been received for Friends and Family (FFT) in August 2021. Of the 63 responses inputted for August 2021, 100% of the responses were reported as good or very good.

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

HSIB/NHS Resolution/CQC or other organisation with a concern or request for action made directly with the Trust

No concerns or requests for action from HSIB/NHSR/CQC have been made directly to the Trust.

Coroner Reg 28 made directly to Trust

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

No Regulation 28 notifications have been received in August 2021.

Maternity incentive scheme – year 3

The maternity unit declared compliance with all of the ten maternity safety actions.

The previous risk mentioned in the August report of not achieving >90% of each maternity unit staff group having completed in-house multi-professional emergency training session (online Prompt) – achieved by 3rd September

Recent figures for early September above.

Update on continuity of carer (CofC)

The community and continuity of carer team midwives have continued to aim to provide continuity of carer during the antenatal and postnatal periods with a small number of midwives providing intrapartum care but not necessarily to women on their caseloads.

Beth Fisher, CofC project lead will be leaving the Trust in October to be a midwifery lecturer in Bradford. Mary McCaul, Community & CofC Team leader goes on maternity leave at the end September. Cory Taylor-Wheeler has been recruited on a fixed term contract for 12 months to cover Mary and we have recruited Rachel Askey to Beth's role until March 2022. The monies from the WY&H LMS to support the continuity of carer model (supporting Beth's role) are in place until the end March. Rachel currently works in Bradford in a CofC team; she has previously worked at Harrogate in the Ivy CofC team when the model was first introduced at Harrogate. As we have a plan in place with the aim of achieving the trajectory, set by the national team by March 2023, both these roles will support the community/CofC teams with some additional project work streams.

Clinical Indicators – Yorkshire and Humber Regional Dashboard and Local Dashboard

There is no new regional data since last report

In summary:

- Bookings less than 10 weeks are 77.9%. No Y&H Trust has met the 90% target, and HDFT compares favourably with other Trusts.
- 1:1 care in labour was 96.8%. Again, this compares very well against other Trusts.

- Normal delivery rate is lower (51.6%), with high rates of instrumental and elective Caesarean sections (up from 14.9% in Q4 to 16.0% in Q1)
- Induction rate (30.1%) was lower than the Y&H average
- Significant PPH rate was higher in this quarter (5.3%), and marginally raised compared with the regional average (3.8%). This will reflect the higher Caesarean section rates.
- Rolling annual antenatal stillbirth rate is significantly lower (1.1 per 1000 births compared with the Y&H average of 3.4 per 1000)

- Breastfeeding initiation rates remain very high at 84.6% compared with the regional average of 67.8%, and are the highest in the region.
- Smoking rates at booking and time of delivery are amongst the lowest in the region
- Carbon monoxide testing at booking and 36 weeks recently reintroduced due to Covid restrictions, with additional issues with Smoking Cessation support services. Current rates of referral (for CO≥4ppm) are 22.8% and 20% at booking and 36weeks respectively. Although low, these are in line with regional figures.

Local HDFT dashboard information (August)

For month of August (from Dashboard and electronic birth register):

- Anticipated 159 deliveries based on bookings, but actually 165 mothers delivered (168 babies born)
- Elective Caesarean section rate 18.5% (high, 31 patients). Harrogate has historically had a higher than average elective caesarean section rate however, this rate was discussed at Maternity Risk management Group (10th September). The outcome of discussions was to request a comparison with other maternity units (whether they have noticed an increase), the impact of the Ockenden report and checking that all the risk assessments and discussions have been undertaken.

- 16.1% emergency Caesarean section rate
- 48.2% normal delivery rate
- 32.7% induction rate
- 7.7% significant PPH ≥1500ml rate (10 patients, with 7 of these being delivered by Caesarean section)
- 5 3rd/4th degree tears (8 listed on Dashboard ?data quality issue)
- 79.2% breastfeeding rate at delivery
- 3% smoking rate at time of delivery

Board of Directors (Public)
29th September 2021

Title:	Medical Director Update
Responsible Director:	Medical Director
Author:	Medical Director

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

Medical Director Report
Date: September 2021 Public Board

Harrogate and District NHS Foundation Trust

Matters of concern & risks to escalate	Major actions commissioned & work underway
• National shortage of BD blood bottles alert - HDFT have reduced usage by 25% since alert published and have sourced compatible alternatives should they be required	• Digital Aspirant Programme – commissioned review of HDFT digital services complete, recommendations report out to the Executive Team • NHS X recent publications to support providers to improve, sustain, develop the use of digital technologies: 1. What Good Looks like 2. Who Pays for What 3. Unified Tech Fund. HDFT gap analysis/identification of opportunities/bids being submitted through ICS • Caring at our Best programme (includes all active Quality Priorities): PM now in place, scoping workshop complete and monthly report to QC and SMT commenced • GIRFT – information gathering underway to understand how peer Trusts are integrating GIRFT into CE structures/leadership model • VCHA working group being set up to oversee HDFT's application to be a "Veteran Aware" accredited organisation • Clinical Strategy engagement work to commence now DoS in place • Annual quality improvement schedule and future operating model for QI in development
Positive news & assurance	**Decisions made & decisions required of Public Board**
• Learning bursts signed off for each QGMG and now being disseminated across HDFT (to bring in staff app) • Clinical Audit Awards – Inaugural Q1 awards presented to dental services team. Plans to publicise award programme further and support future submissions for regional/national award events. • Clinical Standards form being trialled to ensure standard and compliance reviewed at service level before sign off at CEF • Clinical Standards – 15 reviews underway. 9 received in last month– good progress against backlog due to pandemic • Medical appraisal system- new oversight process now launched and assurance achieved from recent internal audit • Chief Registrar and DMD undertaking a review of medical trainee rotas in response to concerns raised and rise in exception reports • Stroke services RPIW completed • Quality Charter revised and rebranded as Quality Improvement At Our Best, in line with values framework.	• Digital working group commissioned by QGMG to report on options for an integrated digital solution for HDFT data relating to clinical standards and compliance to maximise efficiencies, thematic reviews and clinical engagement

Board of Directors (Public)
29th September 2021

Title:	**Guardian of Safe Working Quarterly Report**
Responsible Director:	Executive Medical Director
Author:	Guardian of Safe Working

Purpose of the report and summary of key issues:	This is the Fifteenth quarterly report of the Guardian of Safe Working Hours. Its purpose is to report to the Board of Directors the state of safe working of doctors in training ('junior doctors') in relation to their working hours, gaps in rotas and their educational experience. This report covers the period 1st April 2021 to 15th September 2021, which covers two quarters [Q1 & the majority of Q2 2021/22].	
BAF Risk:	AIM 1: To be an outstanding place to work	
	BAF1.1 to be an outstanding place to work	X
	BAF1.2 To be an inclusive employer where diversity is celebrated and valued	X
	AIM 2: To work with partners to deliver integrated care	
	BAF2.1 To improve population health and wellbeing, provide integrated care and to support primary care	
	BAF2.2 To be an active partner in population health and the transformation of health inequalities	
	AIM 3: To deliver high quality care	
	BAF3.1 and 3.4 To provide outstanding care and outstanding patient experience	X
	BAF3.2 To provide a high quality service	X
	BAF3.3 To provide high quality care to children and young people in adults community services	X
	BAF3.5 To provide high quality public health 0-19 services	X
	AIM 4: To ensure clinical and financial sustainability	
	BAF4.1 To continually improve services we provide to our population in a way that are more efficient	
	BAF4.2 and 4.3 To provide high quality care and to be a financially sustainable organisation	
	BAF4.4 To be financially stable to provide outstanding quality of care	
Corporate Risks	All	
Report History:	Previous updates submitted to Public Board meetings.	
Recommendation:	The Board is asked to note this report, and identify any areas in which further assurance is required, which is not covered in the Board papers.	

Board of Directors (Public)
29th September 2021

Guardian of Safe Working Hours Report (Q1 and Q2 2021/22)

1.0 Executive Summary

This is the Fifteenth quarterly report of the Guardian of Safe Working Hours. Its purpose is to report to the Board of Directors the state of safe working of doctors in training ('junior doctors') in relation to their working hours, gaps in rotas and their educational experience. This report covers the period 1st April 2021 to 15th September 2021, which covers two quarters [Q1 & the majority of Q2 2021/22].

The trusts GOSWH reports continue to run out of synchronization with the regional quarterly reporting pattern. The Trust's reports are alternately in and out of phase with the quarters. The effect of this is that there is always an incomplete quarter encompassed within the reports timeframe.

The report provides the Board with up-dated quarterly evidence to support its assurance that the issues of safety within the Guardian's remit are in a satisfactory state. The Trust now has all trainee doctors employed on the 2016 Terms and Conditions of Service (TCS) contract. These have moved to Version 5 of the contract.

70 exception reports have been received from trainees in Q1 (63 in Q4) and 58 so far in Q2. This is a continuation of the higher-than-normal numbers seen in the last report. These have mainly concerned over-runs of working hours ('hours and rest') owing to the busy state of the wards and to individual patient matters in General Medicine. Most concerning is the increase in exception reports concerning missed or compromised educational opportunities – there were 5 reports submitted in Q1 and 7 so far in Q2, compared to a total of 3 for the whole of 2020/21 and 8 for the whole of 2019/20. Exception reporting remains comparable to other Trusts across the region although it is unclear whether the other trusts are seeing the same increase in educational exception reports.

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

There has been one regional meeting for Guardians since the last report. Trainee doctors' fora have been held jointly with the Director of Medical Education. These continue in both a face-to-face and virtual capacity but have been reduced to quarterly.

The experience of trainee doctors – as for the whole NHS – has changed profoundly from March 2020 with the onset of the viral pandemic. The pandemic has had a significant impact on the training delivered and the subsequent progress through the respective training programs of the junior doctors. In turn this is likely to have resulted in a shift of priorities for those junior doctors affected and potentially increasing the likelihood of an exception report being submitted.

This is the key quality assurance statement for the Board:
'*The Board is advised that overall working hours across the organisation are satisfactory, however there are some concerns that have been brought to the attention of the guardian and these are currently being investigated.*'

The Trust Board has requested that the Guardian enlarges his role: in addition to the existing role to doctors in training grades, the Guardian will embrace the remaining non-training, non-career grade doctors in his system and responsibility. The Guardian has agreed to this change. The Guardian has discussed implementation of this process with the medical workforce department and unfortunately there are some challenges to overcome before it can take place. The system used by the junior doctors cannot be used for the non-training grades and an alternative system will be necessary. There has been no further progress with this implementation. The Guardian remains committed to bringing this ambition to fruition.

2.0 Introduction

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

Its purpose is to report to the Board of Directors the state of safe working of doctors in training ('junior doctors') in relation to their working hours, gaps in rotas and their educational experience. The quarterly report is a contractual duty upon the employer under the 2016 TCS. The report provides the Board with up-dated quarterly evidence to support its assurance that the issues of safety within the Guardian's remit are in a satisfactory state.

3.0 High level data
September 2021

Trainee posts: the position is similar to previous reports. At any time there are rota gaps around 5% in established NHS training posts. These from time to time include maternity and other leave, resigners and vacant posts not filled. The Medical Workforce Department continuously seeks recruitment to vacant posts.

The current position is 11 Whole time equivalent (WTE) gaps. There should be 137 junior doctors in the trust. This increases to 166 when GP trainees are included.

The following table explains the breakdown of gaps by directorate.

	Dept	Rotates	Grade	Deanery or Trust	WTE	Recruitment
LTUC	Acute Medicine	12 months	ST3+	Deanery	2	2 full time gaps. 1 applicant appointed but subsequently withdrew. Interviews held 07/09/21
LTUC	Acute Medicine	6 months	ACCS – CT1	Deanery	1	1 trainee on maternity leave (returns Jan '22). Dept covering with short term locums until then.
LTUC	Cardiology	6 months	ST3+	Deanery	1	Plans to recruit 1 WTE LAS ST1/2 in cardiology/ general medicine currently going through vacancy control.
LTUC	Elderly Medicine	12 months	ST3+	Deanery	2	Advertised twice without success. Awaiting instruction from Dept.
LTUC	Elderly Medicine	12 Months	LAS FY2	Trust	1	Successfully appointed and then candidate withdrew days before starting. Readvertised – interviews 06/09/21
LTUC	Psychiatry	12 months	FY1	Deanery	1	Student failed to pass exams & didn't graduate. No plans to recruit to this gap.
LTUC	Respiratory	6 months	ST3+	Deanery	1	Trainee received their CCT. Dept discussing advertising for LAS post.
PSC	Anaesthetics	12 months	Fellow (ST3+)	Trust	1	2 of 3 fellow posts recruited to. Unsuccessful despite re-advertising
PSC	Dermatology	12 months	ST3+	Deanery	1	Dormant post – no plans to fill

4.0 Exception reports

Exception reports are individual notifications to the DRS system by trainee doctors who have had a problem occasion causing them to vary their working hours from the contracted rota. Exception reports have a time-limited process for response by the Trust. At any one time there may be a few reports awaiting attention by individual clinical supervisors.

Clinical supervisors are in most cases poor at responding to exception reports although there is ongoing work to improve engagement in the process. This task was added to the

supervisors without their agreement by the 2018 Trainees new contract and has never had an enthusiastic response. The Guardian has to review and agree outstanding reports. This role change has been agreed in the V5 Terms and Conditions.

This report presents Quarter 1 & 2 – 2021/22

Q1: 1.4.2021-30.6.2021 Exception reports by department: hours/rest				
Specialty[five top]	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
General Medicine	0	62	62	0
General Surgery	0	6	6	0
Emergency Medicine	0	1	1	0
Obstetrics & Gynaecology	0	1	1	0
TOTAL	0	70	70	0
Q2: 1.7.2021- to date Exception reports by department: hours/rest				
Specialty[five top]	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
General Medicine	0	41	39	2
General Surgery	0	7	7	0
Emergency Medicine	0	2	2	0
Paediatrics		5	3	2
Obstetrics & Gynaecology		2	2	0
TOTAL	0	57	53	4

There were 5 Education exception reports in Q1 and 7 so far in Q2. This represents a significant and worrying increase when compared to the 3 reports for the entire 2020/21 year. The overall trend is an increase in the number of clinical exception reports (46/52/63/70) for the last 4 completed quarters.

Nearly all reports are of over-working at the end of the day when clinical workload, acutely ill patients and too few colleagues demand working beyond normal hours. This is especially true in general medicine. [Exception reports are known generally to under-report over-working]. If a doctor has overworked their contracted hours on an occasion, then they are entitled under the TCS to over-time pay or time off in lieu. If the over-work is caused by rota gaps, then time off is not appropriate if it will compound the shortage situation. The doctor is entitled to overtime pay even if their overtime commitment followed from their own inefficiency or misjudgement. Clinical supervisors are expected to guide their trainees in efficient working, prioritising clinical activities and making timely handovers to over-night teams. The Trust will incur a small cost each month in some hours' over-time pay; but this is offset somewhat by vacant posts owing to rota gaps. But overall, the Trust is usually over-spent on medical locum costs for consultants and trainees.

The job of filling posts, balancing rotas and workloads properly belongs to clinical directorates with professional support from the HR function. Individual trainees' employment experiences are managed by their individual clinical supervisor - a clinical consultant usually in the same or a related specialty. Clinical supervisors are intended to respond to each exception report.

Despite repeated advice some never do, and the report must be managed by the Guardian. The Guardian has no actual managerial power over individuals in directorates.
Of course, ideal conditions of employment for trainee doctors are one obligation amongst many in the Trust, particularly in periods of winter pressures.

5.0 Work schedule reviews and interventions

5.0a Work schedule review

A work schedule review would be undertaken to investigate any case of systematic or repeated over-working of contracted hours where the planned schedule itself is questioned. No work schedule review has been necessary to date. However, concerns have recently been raised by the trainee doctors in Obstetrics & Gynaecology about the management of their rota, specifically lack of surgical operating time, last minute rota changes and working patterns that do not correlate with their planned work schedule. The guardian has asked that a review of the rotas be undertaken by medical staffing – this is ongoing.

5.0b Interventions

Since the last report, the Guardian has been asked to co-lead an investigation into a bullying and harassment complaint made by 2 junior doctors. Although this is still in the fact-finding stage the complaints are cause for significant concern. The outcome of this process with be shared with the board in due course.

The Guardian has asked for medical staffing to undertake a review of the Obstetrics & Gynaecology rotas to ensure that the rota worked matches the proposed individual work schedules agreed by medical staffing.

The previous Guardian raised the issue of over-working in General Medical wards for FY1 and FY2 trainees with the Director of Postgraduate Medical Education. The Director of Postgraduate Medical Education raised the issue with consultants in the medical specialties and robust discussions took place. The consultants rightly stated that everyone on medical wards was under an increased pressure of work and anxiety arising from the pandemic. Unfortunately, these discussions have yet to find a solution and the level of exception reporting is increasing. Unlike consultants and nurses, trainee doctors have specific contractual protection against over-working and remedies available to put this right.

The Guardian suggests that isolated cases of over-working are to be expected in emergency conditions. The Trust is grateful for trainees' flexibility on occasion and in ensuring patient safety. However, repeated instances raise the question of whether the rotas and workload are appropriate for the trainees in this specialty. Trainee doctors have responded magnificently to the challenge of COVID – as have all health-care staff – but the Trust is contractually obliged to ensure that the trainees balance their service work with educational opportunity and rest.

A significant number of exception reports (18.5% in Q1), specifically mention staffing levels being below minimum levels. It is unclear as to the specific reasons why this was the case, but it is possible that COVID isolation played a part. A survey of Junior Doctors (mentioned in a previous report) commented that 80% felt staffing levels had worsened since August 2020, whilst this does not represent a formal review the Guardian will be monitoring the situation and in conjunction with the feedback from the Junior Doctors Forum a future assessment may be necessary.

6.0 Vacancies

The vacancies have increased and sit at 11 (whole time equivalent) (8%) of established training posts. Of these vacancies, 2 are in recruitment, 1 is awaiting approval for vacancy control, and one is a 'dormant' post which the Trust has decided not to fill currently.
There is one vacant Foundation Year 1 post that is unlikely to be filled.

The continual successful filling of rota gaps is of course a measure of the diligence and ingenuity of the Medical Workforce and Recruitment team but is challenged by the availability and willingness of suitable doctors to apply.

Of course, any rota gaps will add to the strain on the trainees in post and add to the Trust's workforce costs by necessitating locum and other temporary employees and working down of senior grades of staff.

The percentage of vacancies is known to be worse in other Trusts: we are doing relatively well.

The Guardian usually has access to the HR database of trainee doctors which is up-dated monthly.

There are also 12 Trust posts for doctors not in training schemes who participate in the same rotas as trainees. There are about 60 SAS grade doctors in the Trust.

7.0 Fines

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

No fine has been necessary to date. There have been no identified breaches of the Working Time Directive caused by the Trust. Fines have been levied in other trusts in the thousands of pounds.

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

8.0 Meetings

The Guardian has attended one regional meeting of Guardians in the previous quarter, conducted via MS Teams. Whilst previously it was reported that there had been a reduction in the number of exception reports filed by junior doctors across the region during the pandemic, there has now been a significant and increasing trends in reports after normal working patterns have been resumed.

9.0 Trainees' Forum

Trainees' fora increased to monthly during the viral pandemic but have now been stepped back to the usual quarterly meetings. The importance of exception reporting has been canvassed to the trainees.

It is clear that the COVID-19 emergency has greatly affected post-graduate medical training. Educational opportunities, assessments, courses, and examinations have been discontinued and the amount of clinical experience in their home specialties has been curtailed. On the other hand, trainees understand that they have participated in front-line service in the national emergency, greatly appreciated by the public at large and educational in its own way. They will each have something impressive to put on application forms and to discuss in future interviews. Some trainees will have delayed completion of examinations and completion of training programmes.

The full impact of the pandemic on the training and successful progression through training programmes only became apparent when the round of ARCPs was completed. Two new ARCP outcomes were created (10.1 & 10.2) to denote trainees whose training has been adversely affected by COVID-19. There are likely to be some trainees that will require additional training time before they can progress (Outcome 10.2) – this may be playing a part in the increasing number of educational exception reports being submitted as the priorities of the Junior Doctors shift and they feel they need to become more vocal to achieve their training requirements.

10.0 Disclosure

These regular Guardian reports are submitted to Health Education England at their request and by standing consent of the Trust Board of Directors. A regional summary is assembled and discussed at each regional meeting. Guardians assume that their quarterly reports to their boards of directors are open to the public domain. The change in periodicity of reporting to the Board has disrupted the flow of reports to Health Education England.
Health Education England will receive periodical download of the entire database of exception reports for the purpose of research by the mining of big data. The Board has agreed to this. They are sent this whenever they ask.

11.0 Confidentiality

Given that Guardians' reports may be in the public domain, the identities of any individual doctors and supervisors are concealed in the Guardian's quarterly report. Full data are available to the Board of Directors in private session on request.

12.0 Care Quality Commission

The Guardian has had no contact with CQC inspectors in these quarters.

13.0 Inclusion of SAS doctors within the scope of the Guardian

The Trust Board has requested that the Guardian enlarges his role: in addition to the existing responsibility to doctors in training grades, the Guardian will embrace the remaining SAS (non-training, non-consultant grade) doctors within his system and responsibility. Strictly, this has no contractual or statutory basis, but the Trust has agreed – in an exchange of letters with the Medical Director - that it will honour agreements and determinations made by the Guardian as if these doctors were training grade doctors covered by the 2016 TCS V5. The Guardian has agreed to this change. The Guardian has discussed implementation of this process with the medical workforce department and unfortunately there are some challenges to overcome before it can occur. The system used by the junior doctors cannot be used for the non-training grades due to the complexity of individual job plans and work schedules and an alternative system will be necessary. There has been no further progress with this implementation. The workload and IT implications of this change are still to be fully determined. Currently, there exists an inequality between training and non-training doctors on the same rota, where one group can exception report and subsequently be paid for their additional hours and the other cannot. A satisfactory method to correct this should be seen as a priority.

14.0 Issues arising

a. The Trust continues in comparatively good standing. Exception reports have continued along the increasing trend seen after the return to normal working patterns.
b. There is an on-going problem of over-working and late finishes for trainee doctors owing to colleagues off sick, rota gaps and pressure of clinical work. This is especially true in General Medicine. The Guardian has raised this formally with the Director of Medical Education who is currently continuing to discuss this issue with consultants and managers.
c. Reluctance in trainees to report exceptions exists regionally and nationally.

d. Exception reports are being received and processed. There remains some reluctance from educational supervisors to assist with this task.
e. There are gaps in rotas, but recruitment is ongoing.
f. No national Guardian meeting has yet been announced for 2021.
g. The Trust Board has requested that the Guardian enlarges his role in relation to SAS doctors. This is agreed in principle: the Guardian will discuss implementation of this process with the medical workforce department as becomes possible.

15.0 Actions taken to resolve issues

a. No fine has been necessary this quarter.
b. Two interventions have been necessary this quarter.
c. At the date of reporting, the Board of Directors is assured from the evidence available that:
   i. The exception reporting system is operational for all trainees; they are now all to be converted to 2016 TCS Version 5.
   ii. Over-working owing to pressure of work and rota gaps is a chronic problem in General Medicine. This is under active management by the DME and consultants in Medicine.
   iii. The Guardian can only intervene on notified problems.

16.0 Questions for consideration by the Board of Directors

a. The Board is asked to receive the quarterly report of two quarters and to consider the assurances provided by the Guardian.
b. There are presently no issues outlined in the report which are not being (or cannot be) tackled. The situation in General Medicine continues to be concerning, with the risk of systematic over-working in FY trainees.
c. The Guardian makes no additional request for escalation, internally, externally, or both, which might be recommended in order to ensure that safe working hours would not be compromised in the future.
d. Issues of medical [and indeed all healthcare professional] workforce planning are an urgent strategic challenge to the Trust and to the entire NHS. The Trust always has vacancies gaps in trainee doctor posts; these currently run at 8 per cent.

Dr Matthew Milsom
Guardian of Safe Working Hours

15th Sept 2021

3

Board of Directors (Public)
29th September 2021

Title:	Learning from Deaths Quarterly Report 1: April-June 2021
Responsible Director:	Executive Medical Director
Author:	Deputy Medical Director for Quality and Safety

Purpose of the report and summary of key issues:	The board is asked to note the surveillance of mortality indices across the trust. Trust mortality is in line with expected values. Details are provided in the report for areas where any concerns have been identified.	
BAF Risk:	AIM 1: To be an outstanding place to work	
	BAF1.1 to be an outstanding place to work	
	BAF1.2 To be an inclusive employer where diversity is celebrated and valued	
	AIM 2: To work with partners to deliver integrated care	
	BAF2.1 To improve population health and wellbeing, provide integrated care and to support primary care	X
	BAF2.2 To be an active partner in population health and the transformation of health inequalities	
	AIM 3: To deliver high quality care	
	BAF3.1 and 3.4 To provide outstanding care and outstanding patient experience	X
	BAF3.2 To provide a high quality service	X
	BAF3.3 To provide high quality care to children and young people in adults community services	
	BAF3.5 To provide high quality public health 0-19 services	
	AIM 4: To ensure clinical and financial sustainability	
	BAF4.1 To continually improve services we provide to our population in a way that are more efficient	
	BAF4.2 and 4.3 To provide high quality care and to be a financially sustainable organisation	
	BAF4.4 To be financially stable to provide outstanding quality of care	
Corporate Risks	N/A	
Report History:	Patient Safety Forum	
Recommendation:	The board is asked to note the contents of the report, including the metrics and methodology used.	

Board of Directors (Public)
29th September 2021

Learning from Deaths Quarterly Report 1

Executive Medical Director

1.0 Executive Summary

Crude mortality rates for HDFT continue to track the national trends.

Standardised mortality rates continue to be within the expected range.

13 Structured judgement reviews have been undertaken since the last report. 10 cases had overall care described as good or excellent. No cases had overall care described as "poor".

There have been 2 Covid-19 deaths in this quarter.

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

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

2.0 Introduction

Quarter 1 in 2021 was marked by a reduction in Covid admissions and the linked return to many pre-pandemic working arrangements.

3.0 Findings

3.1 Crude Mortality Data

The crude mortality rate for admissions gives a longer-term view of trust mortality rates. In total, 144 deaths were recorded in Q1. This data is not risk-adjusted so takes no account of the unique characteristics of the admissions. Comparison with the national mortality rate is also shown where data is available (shown in the darker blue line in Figures 1 and 2). This demonstrates that the peaks and troughs we see in HDFT are often mirrored at the national level. Figure 2 gives a "zoomed in" view of data from the last 2 years, confirming the impression in the last report that our crude mortality rate in the second Covid wave period was below the national average.

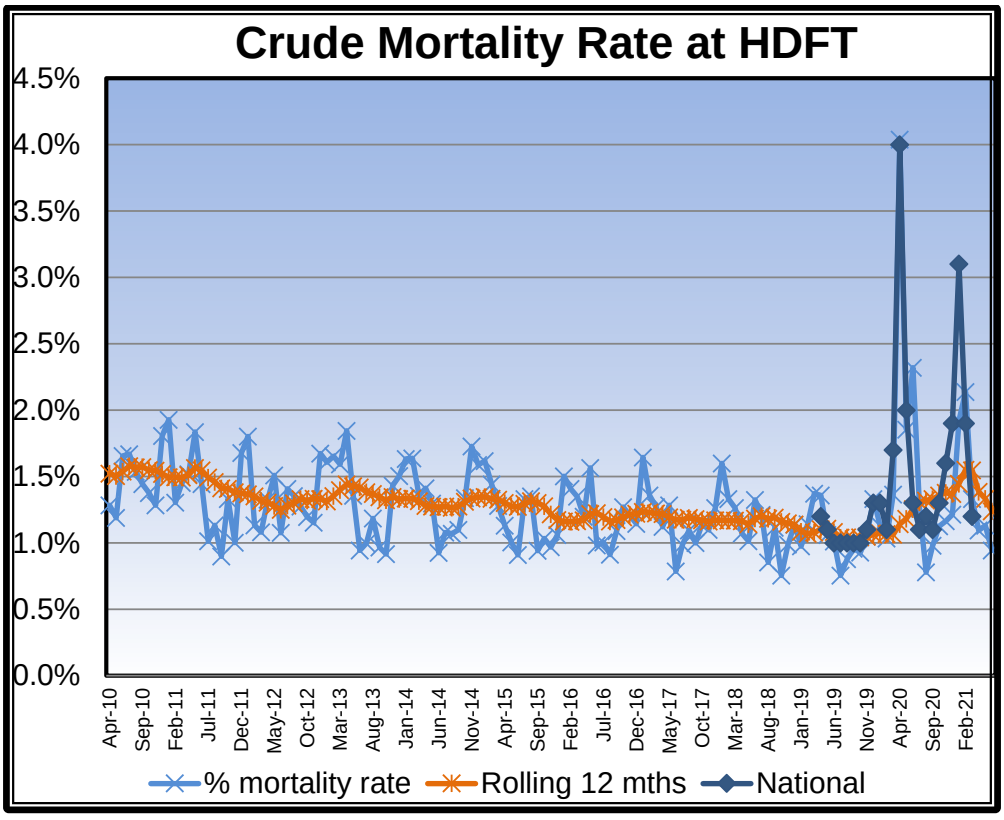


Figure 1: Crude mortality rates over the last 11 years (%deaths per qualifying admission activity)

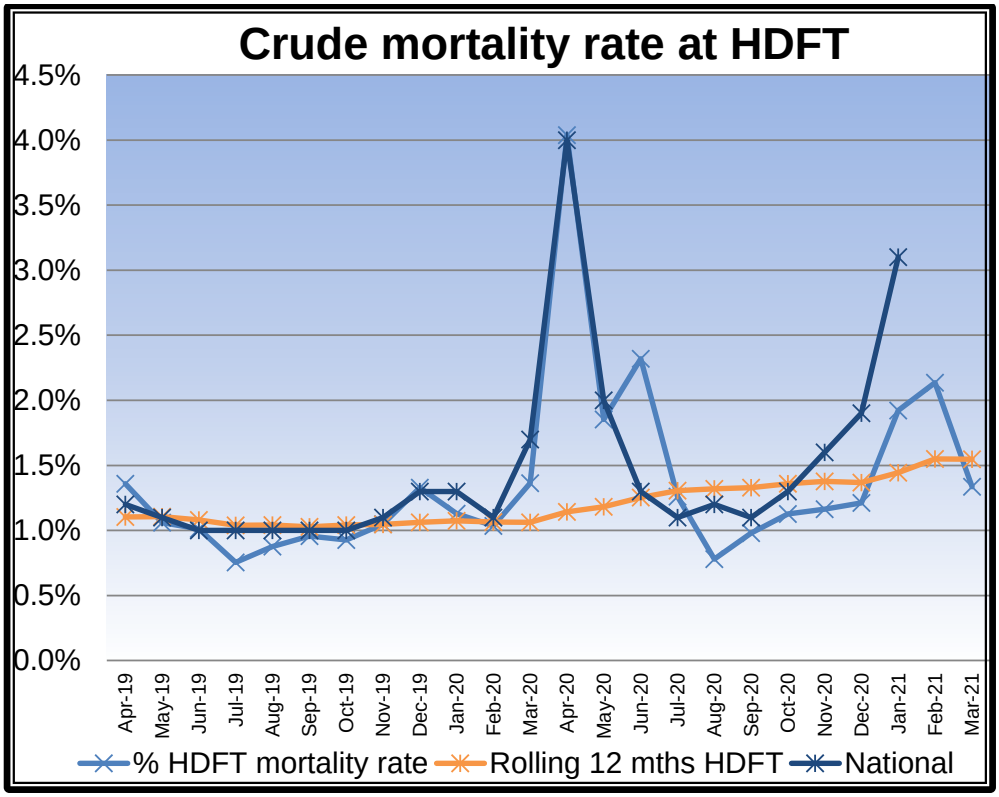


Figure 2: Expanded crude mortality rates over the last 2 years (%deaths per hospital admission)

3.2 Standardised Mortality Rates (HSMR and SHMI)

The HSMR has fallen since October 2020, as demonstrated in Figure 3 (taken from the IBR). The most likely explanation is the reduction in cases used in the HMSR methodology as a percentage of our total mortality. For example, in September 2020, 87% of our deaths were used to calculate HMSR. By November, only 49% were included. This is likely explained by the exclusion of Covid-19 deaths from the dataset.

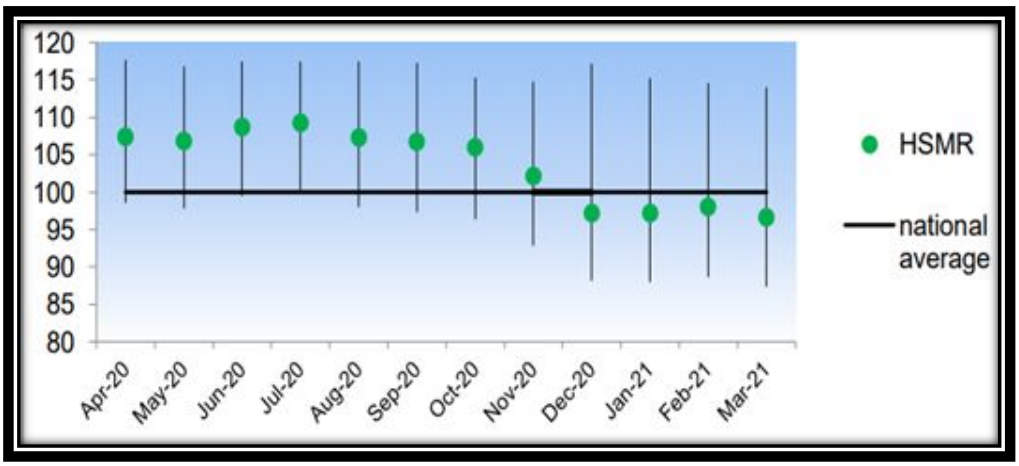


Figure 3: HSMR. Dots show the recorded values with error bars showing possible range of true values.

To give further context to our HMSR data, our results are shown alongside peer NHS organisations for comparison. Figure 4 demonstrates trusts of a similar casemix to HDFT, whereas Figure 5 demonstrates how we compare to other Trusts in the region.

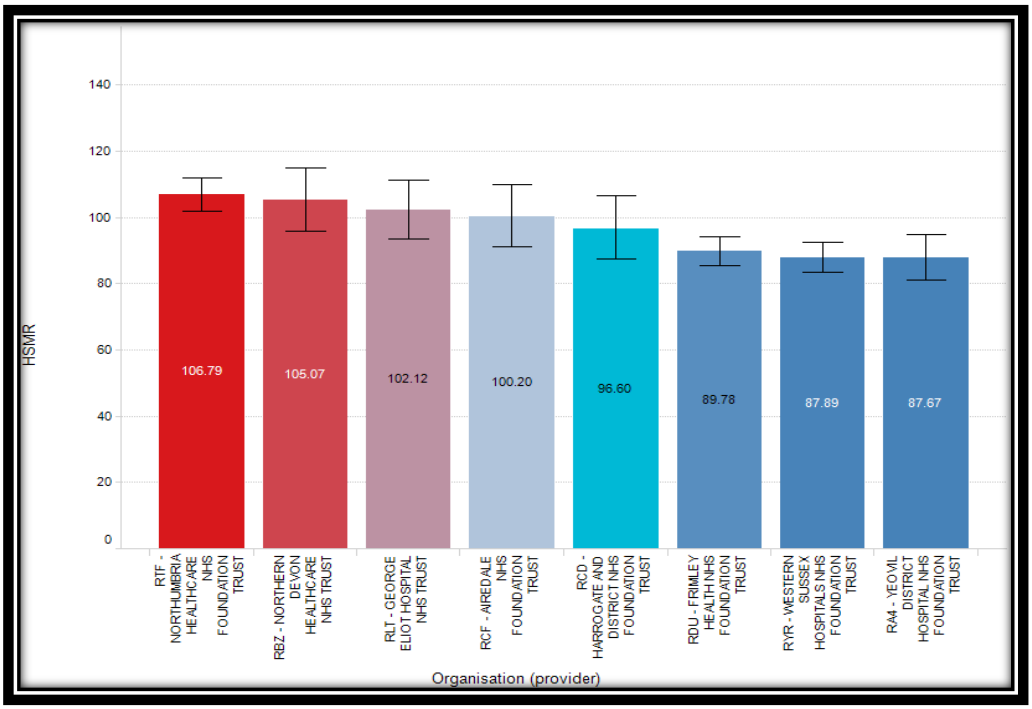


Figure 4: HMSR data for peer organisations

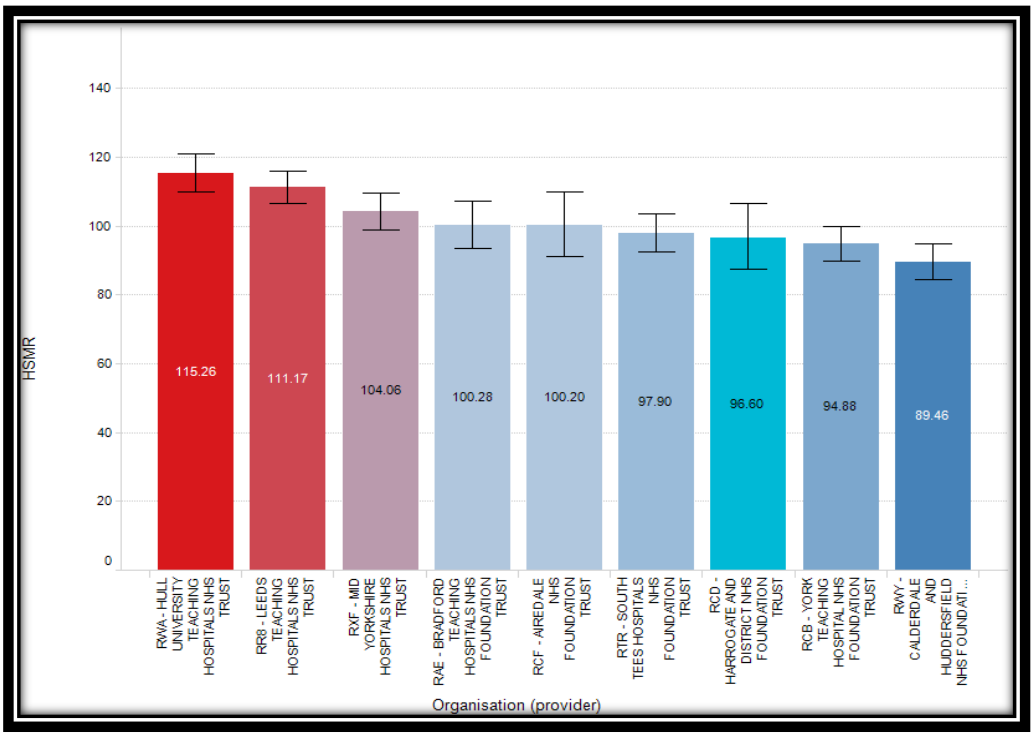


Figure 5: HMSR data for regional organisations

SHMI rates (Figure 6) are consistently below 1 on a rolling 12-monthly basis, and statistically are within the expected range. Please note that due to modelling difficulties, all Covid-19 related deaths are excluded in the SHMI reporting by NHS Digital.

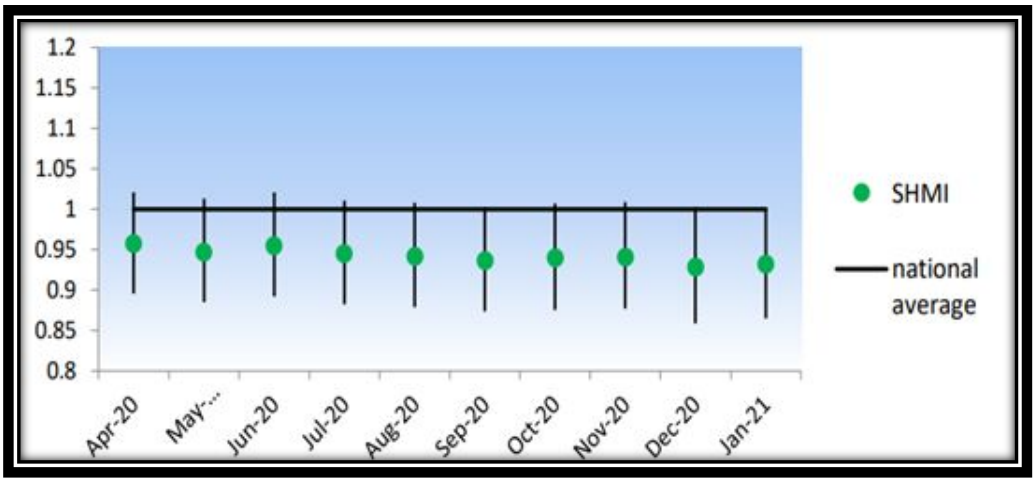


Figure 6: SHMI Dots show the recorded values with error bars showing possible range of true values.

Figures 7 -8 demonstrate our SHMI against that of peer and regional trusts:

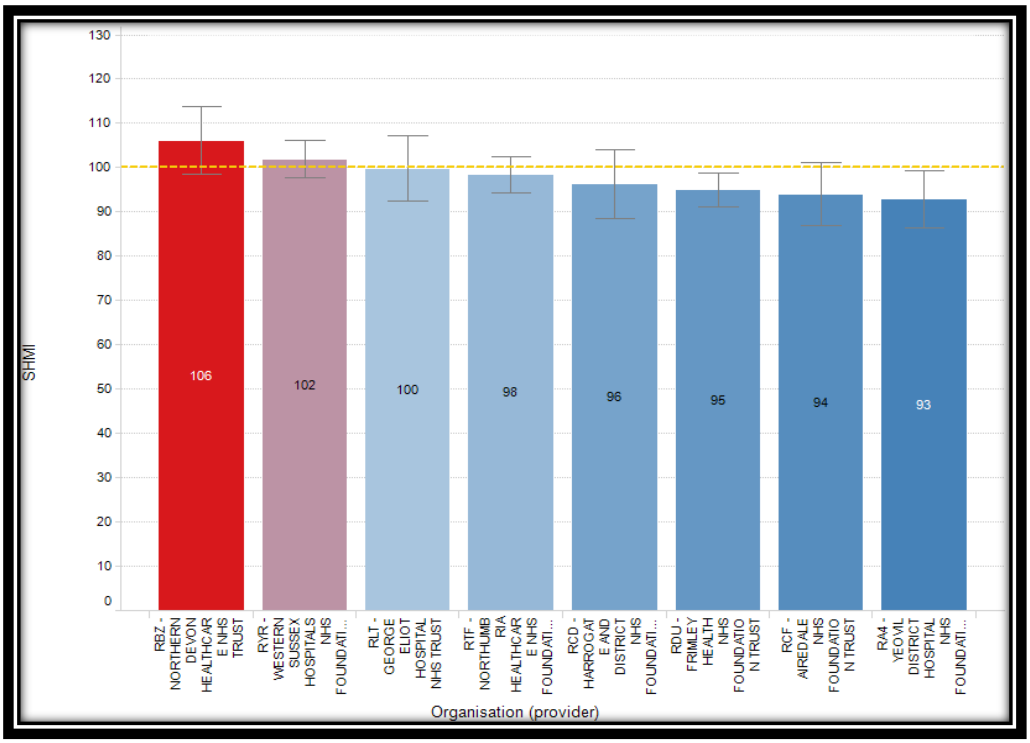


Figure 7: SHMI data for peer organisations

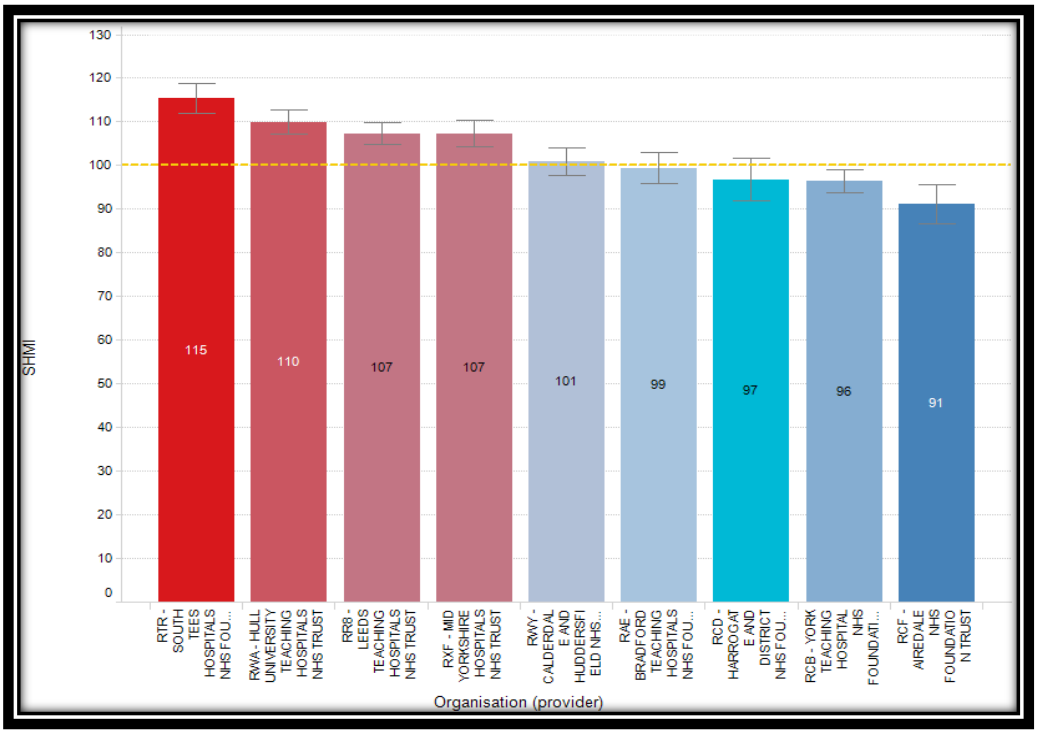


Figure 8: SHMI data for regional organisations

3.3 Structured judgement reviews

13 cases have been reviewed in this quarter, with 6 relating to deaths in this quarter, 6 from earlier in 2020-2021 and 5 from Q4 in 2019-2020 (reflecting reviews highlighted by previous HSMR/SHMI alerts). These include 7 in-hospital deaths with a diagnosis of "acute cerebrovascular disease" which were highlighted in a previous SHMI alert and are discussed later in this report.

The overall assessment of standard of care of all cases is shown in Table 1:

Case ID		Learning Disability ?	Serious Mental Health Issue?	Quality of Care in first 24hr (1-5)	Quality of Ongoing Care if applicable (1-5)	Quality of End of Life care (1-5)	Quality of Overall Care (1-5)	Quality of Note-keeping (1-5)
1	Nov-20	N	N	5	5	5	**5**	5
2	May-21	N	N	4	3		**4**	4
3	Nov-20	N	N	4	4	4	**4**	4
4	Apr-21	N	N	4	4	4	**4**	4
5	Jan-21	N	N	4	3	3	**3**	3
6	Jun-21	N	N	2	4	4	**3**	3
7	Feb-21	N	N	4	4	4	**4**	4
8	Mar-21	N	N	5	3	4	**4**	4
9	Feb-21	N	N	4	4		**4**	5
10	Jan-21	N	N	4	3	4	**3**	3
11	Oct-20	N	N	4	4	4	**4**	4
12	May-21	N	N	4	4	3	**4**	3
13	Mar-21	N	N	4	4	4	**4**	5
Median Score		-	-	4	4	4	**4**	4

Table 1: Structured Judgemental Reviews (SJR) conducted in Q4 2020-2021

No recurrent themes have been identified in these reviews. One case scored 2 for care in the first 24 hours, which equates to "poor care". The issue was identified shortly after admission and although the patient sadly died, this was not influenced by the diagnostic error. This case has been discussed with the clinical lead and is due to be discussed in depth at their Quality of Care meeting.

3.4 Covid-19 Deaths

Table 2 show the hospital's Covid-19 mortality for Q4 2020/21 and Q1 2021/22. Please note that this data uses the current NHS definition of a positive Covid-19 diagnosis and does not include data where Covid-19 is included on a death certificate based on clinical suspicion. The data in the 1st column titled "Total" represents all inpatients with a positive PCR test. The 2nd column "Death within 28 days" refers to deaths that occurred after hospital discharge and is therefore in addition to the in-hospital deaths shown in column 3. This data confirms the significant decline on both the number of Covid cases admitted and their mortality.

Confirmed Covid-19 inpatient discharges (Jan-Mar 2021)				% (of patients)	
Age category	Total	Death within 28 days	Death in hospital	% Death within 28 days	% Death in hospital
0-5	2	0	0	0.0%	0.0%
6-17	2	0	0	0.0%	0.0%
18-24	2	0	0	0.0%	0.0%
25-34	7	0	0	0.0%	0.0%
35-44	26	0	1	0.0%	3.8%
45-54	47	0	2	0.0%	4.3%
55-64	53	0	6	0.0%	11.3%
65-74	56	0	11	0.0%	19.6%
75-84	93	0	27	0.0%	29.0%
85+	80	4	29	5.0%	36.3%
Total	**368**	**4**	**76**	**1.1%**	**20.7%**

Confirmed Covid-19 inpatient discharges (Apr-Jun 2021)				% (of patients)	
Age category	Total	Death within 28 days	Death in hospital	% Death within 28 days	% Death in hospital
6-17	0	0	0	0	
18-24	0	0	0	0	
25-34	4	0	0	0	0.0%
35-44	3	0	0	0	0.0%
45-54	7	0	1	0	14.3%
55-64	1	0	0	0	0.0%
65-74	5	0	0	0	0.0%
75-84	11	0	0	0	0.0%
85+	8	0	1	0	12.5%
Total	**39**	**0**	**2**	**0**	**5.1%**

Table 2: Covid19 deaths for admissions by Quarter, either whilst still an inpatient or after discharge but within 28 days of positive test. Note that "Confirmed Covid-19" relates to patients with a positive PCR test and excludes any patient with negative PCR results whose imaging and clinical impression was of suspected Covid-19.

3.5 Mortality after Critical Care Admission

Figure 9 shows the changing mortality rates for Critical Care admissions over the last year. When each admission is added to the chart along the X-axis, the dark-blue line in the middle will rise or fall depending on that individual patient's predicted mortality. The orange line should follow the dark blue line but will deviate away if our mortality is above or below expected. This demonstrates that from January to March 2021, our Critical Care mortality increased significantly from expected levels, almost reaching the 3-standard deviations level. The likeliest explanation is that this represents patients with Covid-19 requiring CPAP as a ceiling on care (based on their pre-existing health status). In many institutions these patients are managed in ward areas rather than HDU/ITU and are therefore not counted in ICNARC data. By including them in our critical care cohort, it may impact our adjusted mortality. The clinical lead, Dr Martin Huntley, is undertaking a deep-dive to investigate further the reasons behind this, and his report will be included in the Q2 report.

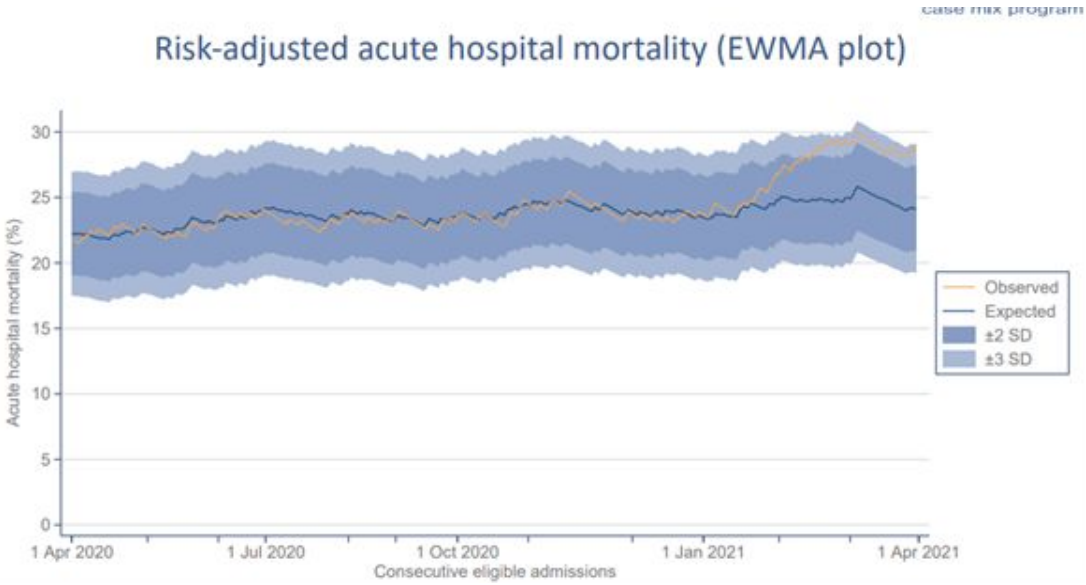


Figure 9: Observed versus expected Critical Care mortality over time.

3.6 Excess Death in Patients with a Diagnosis of Stroke

A previous HSMR-based alert related to excess deaths in patients with a coding of "Acute cerebrovascular disease". 10 cases with the lowest predicted mortality have been highlighted for review using the SJR process. Of the 7 completed, no lapses in care were apparent and the alerts has ceased in the most recent reporting period. There were some observations of good practice:

- "Most patients were repatriated from the regional Hyperacute stroke service, with a clear, detailed summary of care delivered and recommendations for ongoing care
- Multi-disciplinary team involvement including Speech and Language Therapists, Physiotherapists and Dieticians
- Detailed documentation of family discussions, including discussion regarding poor prognosis where appropriate

4.0 Medical Examiner Service

The Medical Examiner Service has been fully staffed since March 2021, with a full time Medical Examiner Officer and 4 Medical Examiners providing scrutiny of deaths 5 days per week.

In Q1, 100% of all inpatients and Emergency Department deaths were scrutinised by either a Medical Examiner or were accepted for investigation by the Coroner. Only 6 cases did not have a Medical Certificate Cause of Death issued within the target of 72 hours from death. 5 of these related to deaths at the start of a bank holiday weekend, and one was due to medical notes going missing. No certificates were rejected by the local Registrar. Detailed feedback was collected from 45 bereaved families and fed back to ward teams. The overwhelming majority of feedback was positive during this quarter, and adds an additional layer of assurance that we are actively sourcing real time patient and family feedback.

5.0 Future Plans and Learning

An HSMR CUSUM amber alert has been raised for deaths from “Pneumonia [except that caused by tuberculosis or sexually transmitted disease” for both February and March 2021. Case notes review using SJR methodology are underway to ensure no lapses of care in this diagnostic group.

Work is ongoing to optimise how learning from this report and other mortality and morbidity data is best communicated and shared across the organisation. A workshop for senior leaders in the quality and safety structure at HDFT was held in August, facilitated by our Improvement and Transformation team.

6.0 Recommendation

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

Board of Directors (Public)
29th September 2021

Title:	**IPC Service Annual Plan and Progress 2020-21**
Responsible Director:	Executive Medical Director
Author:	Matron, Infection Prevention & Control

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

Infection Prevention and Control and TB Teams Annual Work Plan

April 2020 – March 2021

Monitored by: Infection Prevention and Control and TB Team meetings

Reports to: Infection Prevention and Control Committee

Report author: Sonya Ashworth, Matron Infection Prevention and Control and TB Services

Operational and Responsible Leads:

SA	Sonya Ashworth		LH	Lauren Heath
AG	Amanda Gooch		RH	Richard Hobson
SO	Sharon Oyston		SC	Sarah Chadwick
IG	Iona Goodwin		AP	Anna Padget
GJ	Gillian Johnson		CR	Christopher Richardson
AM	Alison Mawson		SN	Sam Nganga
GM	Gillian Mitchell		KC	Karina Coxhead
CM	Consultant Microbiologist		WH	Ward Hygienist

H = Hospital Team
C = Community Team
TB = TB Team

Plan produced by S Ashworth Oct 2020, progress details completed June 2021

Infection Prevention and Control and TB Service Annual Work Plan and Progress April 2020 – March 2021

NB: Progress comments against the plan

ID No	Issue	Indicator (if relevant)	Action/s	Op. Lead	Resp Lead	Target Date	Progress 04/21
1 H C	Maximise collaborative working opportunities to impact infection prevention and control practices across HDFT hospital and also North Yorkshire community settings	Evidence of integrated working systems between the Community and Hospital Teams	CIPCN's to provide support to the hospital in relation to swabbing and increase demand due to Covid *This was undertaken during the first wave of Covid until a more robust system was implemented by the swabbing team*	SA	SA	June -20	Achieved
			Provide IPCN weekend On-Call Service to the hospital *On call undertaken by the team providing a weekend and BH service from 10:00- 16:00. No issues identified with this system and remains in place*	SA	SA	June -20	Achieved
			Continually review and revise IPC working systems and staffing establishment to ensure effective use of resources and achieve cost improvement target *Business case for additional trained member of staff for the hospital team was not successful. The team had support from an additional band 3 HCA. Additional temporary post funded for the Community IPC Team to assist with the demand of Covid in care homes and the increased pressures from the CCG and LA*	SA	SA	Mar-20	Partial
			Work collaboratively with the CCG to review CDI and MRSA Bacteraemia cases *This was put on hold by the CCG due to the demands of Covid. Review meetings re-commenced in April 2021with NYCCG*	AG / SA / SO	SA	Mar-20	Suspended
2 H	Revise Trust IPC Policies	All Policies are up to date on the intranet	Produce 'Guidance on a page' to accompany policies *Put on hold due to the pressures of Covid. Recommenced work on Policies on a page in April 2021*	SA / AG	SA	Mar-21	Suspended
			Review policies in line with the policy review dates *Put on hold due to the pressures of Covid. Recommenced work on Policies in April 2021*	AG / LH	SA	Mar -21	Suspended
			Simplify content and format of policies	SA	SA	Mar-21	
			Produce Trust IPC guidance in line with national guidance related to Covid	SA/AG	SA	Ongoing	

ID No	Issue	Indicator (if relevant)	Action/s	Op. Lead	Resp Lead	Target Date	Progress 04/21
3 C	Amend Community Provider Policies in line with PHE Standard Precautions	Policies available on the website	Review and amend all policies and guidance in relation to standard precautions and make available on the CIPC website *All Community IPC Policies updated with an addendum detailing national changes in standard precautions*	AP/GJ	SA	Jun-20	Achieved
4 H C	Deliver education to reduce HCAI specifically Covid		Deliver IPC PPE and Covid 'tool box' training to wards and departments *Wards and departments received ongoing educational support for Covid focusing on PPE in line with national guidance.*	AG	SA	Ongoing	Achieved
			Deliver CIPC education sessions via MSTeams / Zoom to care homes in North Yorkshire in collaboration with the CCG's and LA's *The Team delivered training to the care homes in North Yorkshire and York working collaboratively with the CCG and LA to help deliver this.*	SO	SO	Jun -20	Achieved
			Develop new PPE resources, e.g. posters to support HCAI knowledge, skills and practice *Resources were developed working with the QIT Team and key staff and included posters designating the PPE required for red, yellow and Green areas and posters on the back of all the toilet doors to get key messages across.*	AG / CK	SA	Nov–20	Achieved
			Deliver PPE Quip to raise awareness of the correct PPE prevent the spread of Covid *A number of resources were developed by the Team these were renewed every 2 weeks to get key messages across.*	AG /SO	SA	Nov -20	Achieved
			Participate in Global Hand Hygiene Awareness initiatives and Antimicrobial Stewardship campaign *Not undertaken in October due to the demands on the service with Covid.*	AG / SO	SA	Nov 20	Not achieved
			Deliver targeted training sessions to underachieving hospital wards /departments, GP Practices, Care Homes, Dom Care establishments *Training sessions delivered Achieved on PPE and Covid*	AG / SO	SA	Mar-21	Achieved
5 H	Audit practices to ensure policies are adhered to	Completed audits	**Hospital:**				
			Isolation – Audit of Equipment - *undertaken June 2020*	WH	AG	Mar-21	Achieved
			Cleanliness of patient fans – wards only (annual) - *undertaken February 2021*	WH	AG	Mar-21	Achieved

ID No	Issue	Indicator (if relevant)	Action/s	Op. Lead	Resp Lead	Target Date	Progress 04/21
			CDI – Monthly audit of commodes and raised toilet seats *Undertaken monthly by the Ward Hygienists, results notified to Ward Managers, Matrons*	WH	AG	Mar-21	Achieved
			Correct use of water filters - results discussed at *Water Safety Group Meetings*	WH	AG	Mar-10	Achieved
			IPQAT verification audit – *suspended until February*	AG	AG	Mar-21	Partial
			Decontamination – Audit of disinfectant availability	WH	AG	Mar-21	Achieved
			Decontamination – Blood glucose testing equipment how often – removed as not required	WH	AG	Mar-21	Removed
			Monthly Saving Lives audits for departments - *suspended*	AG	AG	Mar-21	Suspended
			IV- Monthly cannula audits - *some months not undertaken due to demands of Covid*	CK / AG	AG	Mar-21	Partial
			Community: Annual hand hygiene assessments for lone working community staff (Podiatrists, Dental, Community Nurses, GP OOHs, Imm and Vac) *Not undertaken due to the restrictions associated with Covid*	SO	SA	Mar-21	Suspended
			Annual IPC environmental audits of Ripon and Selby MIU Units, GP OOH Service, Ripon Hospital including Trinity Ward, Outpatients, Physiotherapy, Maternity, Radiology *Not undertaken due to the demands on the service due to Covid*	SO	SA	Mar-20	Suspended
			Submission of mandatory reports to Public Health England via DCS – MRSA / MSSA bacteraemia; *Clostridium difficile* infection; glycopeptide-resistant enterococcal bacteraemia; bacteraemia Gram-negative *Results were submitted onto the national database*	CR / AG	LH	Mar-21	Achieved
			Undertake orthopaedic surgical site infection surveillance (Hemiarthroplasty July-September 2020) *SSI surveillance undertaken and submitted to PHE*	IG / AG	JC	Mar-21	Achieved
6 H	Monitor HCAI through implementation of surveillance programme	Achievement of DH objectives for MRSA Bacteraemia (0) and Clostridium difficile infection	Continue Alert Organism/Condition surveillance (Hospital-acquired MRSA; *Clostridium difficile* infection and colonisation; MRGNB; norovirus; MSSA in SCBU; Pseudomonas in ITU, SCBU / Haematology Ward; CPE; Urinary catheter prevalence *National Targets not released by NHSE. Surveillance continued to be undertaken by the team reported to DIPC*	AG / CR	AG	Mar-21	Achieved

ID No	Issue	Indicator (if relevant)	Action/s	Op. Lead	Resp Lead	Target Date	Progress 04/21
		(17); Reports of year-on-year reduction of hospital attributed HCAI					
H C	Ensure resources are easy to locate on the Trust internet And On the CIPC teams website	Accessible information on the website	Review access to IPC resources on the Trust Intranet, Review access to the NYIPC website *Unable to review access due the Communication Team being responsible for the Covid intranet pages and requiring all issues related to Covid to be in one place.* *CIPC website updated with MIXD and easy to navigate*	CR / AP	SA	Mar-21	Achieved
7 H	Improve cleanliness of equipment and the environment within inpatient settings	Reduction in HDFT-acquired CDI cases	Monthly IPQAT audits *Audits were suspended for several months by the Chief Nurse due to the pressures of Covid. They were re-commenced with the IPC Team undertaking the audits in February and March to get a non-biased bench mark, with wards recommencing them in April 2021*	AG	SA	Mar-21	Partial
			Support implementation of Ward Hygienist's audits	AG	AG	Mar-21	Achieved
			Ward Hygienists to provide drop in workshops for decontamination of commodes *Not undertaken due to Covid and staff pressures on the wards*	WH / AG	AG	Mar -21	Suspended
8 H C	Contribute to reduction of HCAI across community settings	Achievement of DH objectives for *Clostridium difficile* infection for the NY CCGs	Support PIR process for all NY community cases of MRSA bacteraemia *Undertaken for all cases*	SO	SA	Mar-21	Achieved
			Contribute to CCG RCA review meetings for CDI and MRSA Bacteraemia cases *This was put on hold by the CCG due to the demands of Covid. Review meetings re-commenced in April 2021 for HRW, and Harrogate localities, no date arranged by the CCG to review cases in York and SR*	SO	SA	Mar-21	Suspended
			Provide monthly CDI reports and quarterly HCAI assurance reports to the CCG This was suspended due to the focus and workload associated with Covid	SO	SA	Mar-21	Suspended
9 C	Contribute to reduction of HCAI in Trust		IPC Audit programme for HDFT community bases, annual environmental audit for: • MIU's at Selby and Ripon	SO	SA	Mar-21	

ID No	Issue	Indicator (if relevant)	Action/s	Op. Lead	Resp Lead	Target Date	Progress 04/21
	Community Services		• Podiatry across North Yorkshire • Dental across North Yorkshire • Ripon Hospital – Trinity, OPD, Physiotherapy, Radiology, Maternity *Not completed due to the demands on the service due to Covid*				Suspended
10 C	Prevention of HCAI in NY Care Homes	Provide IPC Resources	• Active marketing of IPC resources • Regular communication messages and use of social media • Raise awareness via newsletters • Work collaboratively with CCG's and LA's in relation to Covid • Use surveillance to identify and prioritise care homes requiring additional support • Provide IPC education and support for homes requiring additional support • Produce regular educational newsletters • Provide up to date IPC resources on the website *Due to providers receiving Covid funding the sales of all the educational resources we produce substantially increased with a large number of CCG's and LA's purchasing the resources for care homes and domiciliary care. Newsletters were produced monthly to keep providers up to date with national guidance and care homes received education either face to face or via MSTeams and support during outbreaks.*	AP	SO / SA	Mar-21	Achieved
11 C	Continued development of Community IPC website, raise awareness and maximise Marketing of resources	Increased number of hits to the website and achievement of cost improvement target (£90K)	Work collaboratively with MIXD Ensure resources up to date on website Achieve income generation target *Continued to work with MIXD on improvements and alterations to the website, Income generation target of £90k achieved.*	AP / SO	SO / SA	Mar-21	Achieved
12 C	Reduction of Gram-negative bacteraemia	Achievement of reduction target	• Work collaboratively with the CCG, promoting Care Homes and GP Practice UTI pathways • Quarterly reports and Annual report for the CCGs and LA	SO	SO/SA	Mar-21	Suspended

ID No	Issue	Indicator (if relevant)	Action/s	Op. Lead	Resp Lead	Target Date	Progress 04/21
	cases in the community		*Community cases were investigated if from a care home, however, the focus switched to Covid with collaborative working taking place*				
13 TB	Set up a service for BCG immunisation	Operational Service for BCG	• PGD to be developed and agreed by the Trust • Attend training course • Undertake 10 observations *PGD developed and agreed by the Trust. Due to Covid restrictions observations of practice have not been possible, will commence when restrictions allow*.	KC	SA	Mar-21	Partial
14 TB	Raise awareness of TB		• Produce regular Newsletters • Produce packs for Homeless organisations • Website to be user friendly and able to be translated into other languages *Website updated to ensure it is user friendly. Packs for homeless organisations produced. Newsletters not produced due to staffing issues in the team.*	SN /KC	KC	Mar-21	Partial
15 C	Provide assurance to the CCGs and LA	Quarterly and Annual Reports provided	• Quarterly and Annual Report to be produced and discussed with the CCGs / LA's *Suspended due to Covid. Recommence April 2021*	SN/KC	SA	Mar-21 0	Suspended

Board Committee Report to the Board of Directors

Committee Name:	People and Culture Committee
Committee Chair:	Andy Papworth
Date of meeting:	13th September 2021
Date of Board meeting this report is to be presented	29th September 2021

Summary of key issues

1 The committee received a presentation from Emily Reid and Elaine Burata on the working experiences of OSCE nurses at HDFT. This presentation covered the excellent support given to help nurses already in the UK to gain their qualifications. 11 nurses have been recruited this year to the Trust and this is separate, and in addition to, the 42 "Global Learners" that the Trust has also supported. The committee applauded the work here, with good feedback from nurses who used the programme, and a valuable source of recruitment for the Trust.

2. The Chief Executive updated on the Culture Plan, where we continue to embed the values and supporting tools.

- Inpulse, the new staff feedback mechanism, has been launched and the first output is with line managers, providing valuable insight. A summary will be presented to Senior Management Team and then People &Committee at our next meeting. 668 colleagues participated in the first survey, which appears low, but benchmarks reasonably well. The committee discussed the value of line managers using the resulting information locally to make improvements. Radiology remains an area of focus.
- The teamHDFT app has been downloaded and used by 1292 colleagues.
- Feedback received by the Chief Executive for the recent letter, poem and badge issued to colleagues has been mostly positive.
- We will receive updates at the next meeting on proposals to take forward leadership development; the pilot with 'blunt' measures to improve the recruitment shortlisting of BAME colleagues; and utilisation of colleague wellbeing tools and services including the EAP (Employee Assistance Programme).
- The committee felt assured that progress is being made, recognising that it will take time but that the ambition and momentum is right.

3. The committee was updated on the work to become an anti-racist organisation. A useful workshop with 21 colleagues was held on 2nd September, covering actions to move forward on three key items for BAME colleagues, namely refreshing mandatory training, equality of access to learning and

development, and bespoke leadership development. The Allyship programme by Leeds Community Heathcare Trust has also started (13 colleagues in cohort one) with really positive feedback - the committee welcomed the offer of a presentation on this programme for our next meeting. It continues to prove difficult to recruit an EDI lead - alternative options are being explored given the importance of this work.

4. The Director of Workforce and OD presented a deep dive into sickness absence. The depth of information was welcomed and the committee were assured by the breakdown of data. Members were able to discuss high absence areas and reasons for this. A good discussion was then held around 'long Covid' and we agreed there is a need to find a way to monitor for this. Non Execs also raised about display equipment, given the higher level of ongoing homeworking - this is being considered as part of a refresh of the Agile, Health and Wellbeing policy.

5. Staff Network chairs updated on activities. We welcomed Mel Aubin as co-chair for the Disability and Long Term Conditions network. Lisa McCabe updated on plans for Black History month and other important activities. Chunda Sri-Chandana is standing down as chair of the BAME network but will remain a member. The LGBT+ update was unable to be presented but will be circulated to committee members.

6. The FTSU guardian provided her first update to the committee. 30 fairness champions have been identified and a further 10 champions are in training. Plans are in place to heavily promote the various speak up routes in October, which is speak up month. Non Execs emphasised the importance of this activity and opportunity for promotion.

7. The Director of Workforce and OD updated on the People Plan. Some Executive drop in sessions have commenced, providing useful feedback. The rollouts of Manager Self-Service and HealthRoster are progressing well, as are a range of actions to address aggressive patient behaviour towards staff, which the committee are monitoring.

8. On the back of an action from the last meeting, the Director of Workforce and OD also presented some useful benchmarking information, comparing HDFT versus the region on sickness, turnover, vacancy and EAP utilisation. Sickness is running lower (3.9% vs 4.55%), turnover is higher (12.37% vs 9.69%), vacancies are slightly higher (6.4% vs 6.0%) and EAP utilisation is better (0.13% vs 0.06%). The committee agreed to continue monitoring these benchmarks over time through future meetings.

9. The committee received the draft reports for the Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES), Gender pay and Ethnicity pay. Members were asked to provide early feedback on these but they will go through Senior Management Team (SMT) and then come to board for approval.

10. Finally, we discussed the criticality of HR support for TUPE activity. It was assured that if HR capacity became constrained, work would be prioritised accordingly so that any TUPE responsibilities would be fulfilled.

There are no new risks to escalate to the Board.

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

There are no escalations to the Board, but we would like the board to be sighted on Black History month and the promotion of FTSU arrangements during October. There has also been previous discussion at both People & Culture Committee and Board on Exit interviews, and we will be discussing this topic again in our next meeting in November.

Integrated Board Report - August 2021

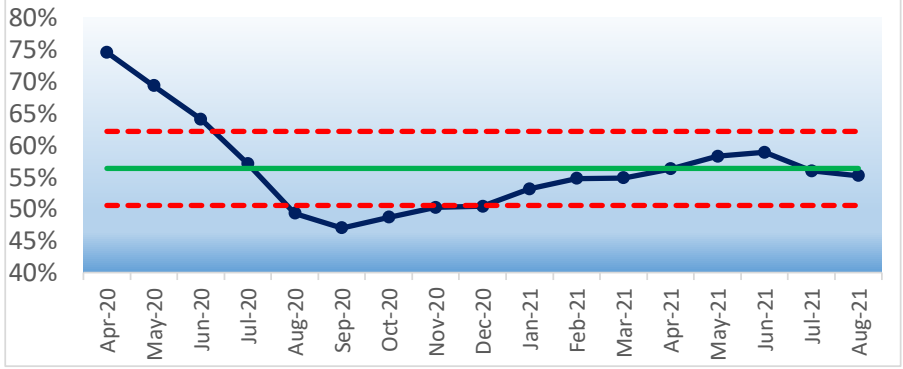
Domain 4 - Workforce

Indicator	**4.1 - Staff appraisal rate**
Executive lead	Angela Wilkinson
Board Committee	People and Culture Committee
Reporting month	Aug-21
Value / RAG rating	55.2%

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

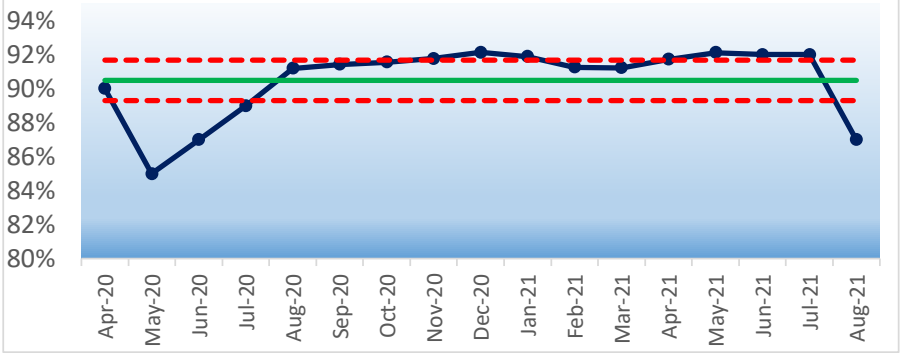
The appraisal rate in August is 55.2%, which is a small decrease from July. Non-Medical appraisal is at 52.4% (previous month 52.6%) and Medical appraisal at 62.5% (previous month 62.5%)

Indicator	**4.2 - Mandatory training rate**
Executive lead	Angela Wilkinson
Board Committee	People and Culture Committee
Reporting month	Aug-21
Value / RAG rating	87.0%

Indicator description

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

SPC chart



Narrative

The overall training rate for mandatory elements for substantive staff is 87%, a decrease of 5%. We are now reporting training compliance from our new Virtual Learning Environment Learning Lab. When we transferred across to Learning Lab, we took the opportunity to action some changes, as approved through our Governance processes, which has impacted our performance this month.

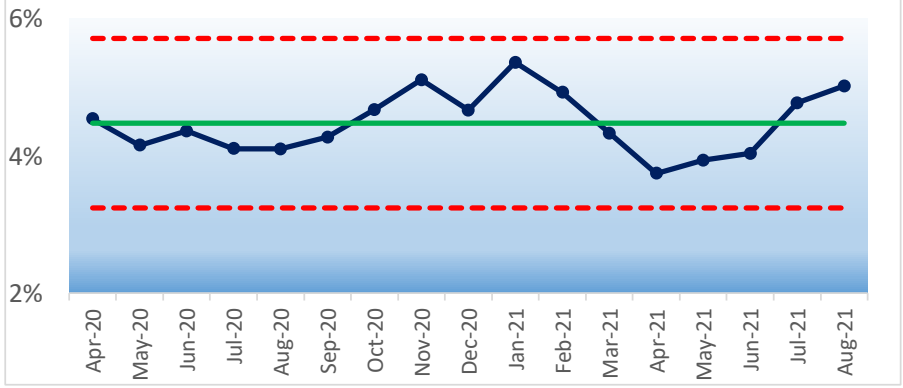
However with the increased accessibility of training data and reports to managers via Learning Lab, an ability for staff and managers to book themselves directly onto training and a move to 'live' attendance data, we are confident training access and compliance will increase.

Indicator	**4.3 - Staff sickness rate**
Executive lead	Angela Wilkinson
Board Committee	People and Culture Committee
Reporting month	Aug-21
Value / RAG rating	5.0%

Indicator description

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

SPC chart



Narrative

The Trust has seen an increasing trend since the beginning of the financial year, with August seeing a further increase to 5.02%. Excluding Covid sickness, the Trust sickness rate for August is 4.70%. An increase in both short term and long term sickness rates in August has contributed to the overall rise in sickness rate this month. All Directorates have seen an increase in sickness rates in August, with notable increase to sickness rates within Adult Community Services, Maternity Services and the inpatient wards.

"S10 Anxiety/stress/depression/other psychiatric illnesses" remains the top reason for sickness this month, which accounts for 23.7% of the overall sickness in August. "S25 Gastrointestinal problems" is the top reason for short term sickness in August and this reason equates to 8% of the overall sickness in the month.

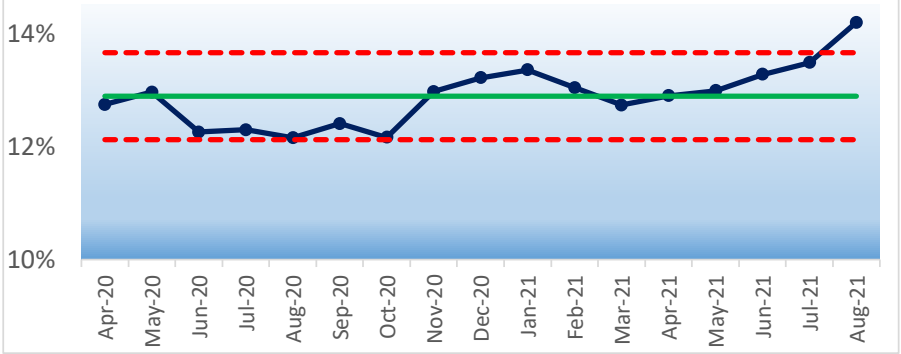
Analysis of the data shows that the Additional Clinical Services staff group has the highest sickness rate this month.

Indicator	**4.4 Staff turnover rate**
Executive lead	Angela Wilkinson
Board Committee	People and Culture Committee
Reporting month	Aug-21
Value / RAG rating	14.2%

Indicator description

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

SPC chart



Narrative

Turnover has seen a further increase this month, however this remains below the Trust threshold of 15%. The breakdown of turnover in August is 4.1% due to involuntary terminations and 10.1% due to voluntary terminations. Turnover has seen an increase this month in all Directorates, with Planned and Surgical Care seeing the greatest increase.

Based on areas with a headcount of over 20 employees, the areas with high levels of turnover are Theatres (27.2%), Children's Services – North Yorkshire (24.7%) and Therapy Services (22.0%).

Turnover continues to increase in the Nursing and Midwifery staff group, with the level of turnover in August being 17.0%. This equates to 261 leavers. 66% of leavers are voluntary resignations and the top reason for voluntary resignation is 'Work Life Balance'. 18% of the leavers are due to retirements, which equates to 46 leavers.

Indicator	**4.5 - Children's Services - 0-5 Service - vacancies**
Executive lead	Angela Wilkinson
Board Committee	People and Culture Committee
Reporting month	
Value / RAG rating	

Indicator description
This indicator is under development.

SPC chart

Narrative

Indicator	**4.6 - Workforce Race Equality Standard (WRES) - Relative likelihood of staff being shortlisted across all posts**
Executive lead	Angela Wilkinson
Board Committee	People and Culture Committee
Reporting month	
Value / RAG rating	

Indicator description
This indicator is under development.

SPC chart

Narrative

Indicator	**4.7 - Workforce Race Equality Standard (WRES) - Relative likelihood of staff being appointed across all posts**
Executive lead	Angela Wilkinson
Board Committee	People and Culture Committee
Reporting month	
Value / RAG rating	

Indicator description
This indicator is under development.

SPC chart

Narrative

Board of Directors Meeting
29th September 2021

4

Title:	**Director of Workforce & OD Report**
Responsible Director:	Director of Workforce & OD
Author:	Deputy Director of Workforce & OD

Purpose of the report and summary of key issues:	This report details Workforce priorities in terms of:- • Major Actions Commissioned and Actions underway • Positive News and Assurance • Any Matters of Concerns and Risks to Escalate	
BAF Risk:	AIM 1: To be an outstanding place to work	
	BAF1.1 to be an outstanding place to work	x
	BAF1.2 To be an inclusive employer where diversity is celebrated and valued	x
	AIM 2: To work with partners to deliver integrated care	
	BAF2.1 To improve population health and wellbeing, provide integrated care and to support primary care	
	BAF2.2 To be an active partner in population health and the transformation of health inequalities	
	AIM 3: To deliver high quality care	
	BAF3.1 and 3.4 To provide outstanding care and outstanding patient experience	
	BAF3.2 To provide a high quality service	
	BAF3.3 To provide high quality care to children and young people in adults community services	
	BAF3.5 To provide high quality public health 0-19 services	
	AIM 4: To ensure clinical and financial sustainability	
	BAF4.1 To continually improve services we provide to our population in a way that are more efficient	
	BAF4.2 and 4.3 To provide high quality care and to be a financially sustainable organisation	
	BAF4.4 To be financially stable to provide outstanding quality of care	
Corporate Risks	As detailed within the report.	
Report History:	N/A	
Recommendation:	The Board of Directors are requested to receive and accept this report.	

teamHDFT
At our best

NHS
Harrogate and District
NHS Foundation Trust

Board of Directors
Public Board Report
Director of Workforce & Organisational Development

September 2021

1

10.1 Director of Workforce and OD Report

Harrogate and District NHS Foundation Trust

Matters of concern & risks to escalate	Major actions commissioned & work underway
Sickness Absence • The Trust has seen an increasing trend since the beginning of the financial year, with August seeing a further increase to 5.02%. Excluding Covid sickness the Trust sickness rate for August is 4.70%. • Covid related sickness has seen a small decrease in August from 0.36% last month to 0.32%. The majority of Covid sickness cases are within the community Children's Services. • An increase in both short term and long term sickness rates in August has contributed to the overall rise in sickness rate this month. Short term sickness has increased from 1.44% last month to 1.59% and long term sickness has increased from 3.34% to 3.42%. • Deep dive discussed as people and culture committee attached Appendix 1 Turnover • Turnover has seen a further increase this month from 13.48% in July to 14.19%, however this remains below the Trust threshold of 15%. • The appraisal rate in August is 55.23%, which is a small decrease from July which saw an appraisal rate of 55.95%. • Non-Medical appraisal % = 52.37% (previous month 52.57%) • Medical appraisal % = 62.50% (previous month 62.46%) • Demand and capacity imbalance continuing to impact upon service delivery across occupational health, EDI and HR operations in particular as hortage of applicants and skills in the marketplace also impacting • Larger departments transferring over to **HealthRoste**r has been more complex than expected and may need further support. This may impact further roll-out, the E-Rostering Manager and the Project Manager are monitoring the project plan closely. • Recruitment Activity within the Trust is incredibly high. 259 candidates are currently going through the recruitment process. • Staff who go into care homes are required to be fully vaccinated by the 14th November, the workforce information team and the resourcing teams are working closely with Mike Forster to identify who these staff are and what actions are required.	• HR support, guidance and data provided to support programme of mandatory vaccination for care home staff • Theatres Investigation – Project Plan and TORS being agreed • Northumberland, Hull and other TUPE arrangements underway • Additional Allowances non medical staff review completed.

10.1 Director of Workforce and OD Report

NHS
Harrogate and District
NHS Foundation Trust

Positive news & assurance	Decisions made & decisions required of the Board
• Two Employment Tribunal proceedings dismissed following withdrawal of claims by claimants • Flowers Case - Staff to be notified of back pay for annual leave, in writing. All payments to be made with September salaries. • Declaration of Interests - 1200 responses received as at 9th September. Data to be updated prior to regular reminders being sent to managers and staff. Plans underway to generate reports, analyse data and share updates with Managers on a regular basis. • E-Rostering successful migrated 32 wards / departments across to Health Roster • The E-Rostering Team will be awarded the Team of the month award for August.	

Board of Directors(Public)
29th September 2021

Title:	**Board Assurance Framework**
Responsible Director:	Chief Executive
Author:	Company Secretary

Purpose of the report and summary of key issues:	The report provides the Trust Board with key updates and actions since the previous meeting held on 28th July 2021. Each Board Assurance Framework risk has been reviewed and assessed with the designated responsible Executive Director. The changes to the BAF made since the last meeting are detailed within the report	
BAF Risk:	AIM 1: To be an outstanding place to work	
	BAF1.1 to be an outstanding place to work	X
	BAF1.2 To be an inclusive employer where diversity is celebrated and valued	X
	AIM 2: To work with partners to deliver integrated care	
	BAF2.1 To improve population health and wellbeing, provide integrated care and to support primary care	X
	BAF2.2 To be an active partner in population health and the transformation of health inequalities	X
	AIM 3: To deliver high quality care	
	BAF3.1 and 3.4 To provide outstanding care and outstanding patient experience	X
	BAF3.2 To provide a high quality service	X
	BAF3.3 To provide high quality care to children and young people in adults community services	X
	BAF3.5 To provide high quality public health 0-19 services	X
	AIM 4: To ensure clinical and financial sustainability	
	BAF4.1 To continually improve services we provide to our population in a way that are more efficient	X
	BAF4.2 and 4.3 To provide high quality care and to be a financially sustainable organisation	X
	BAF4.4 To be financially stable to provide outstanding quality of care	X
Corporate Risks	All	
Report History:	Previous updates submitted to Public Board meetings.	
Recommendation:	The Board is asked to note this report, and identify any areas in which further assurance is required, which is not covered in the Board papers.	

Board Assurance Framework

1. STRATEGIC OBJECTIVE: TO BE AN OUTSTANDING PLACE TO WORK

Risk ID	Principle Objective	Principle Risk to the Delivery of Objective	Inherent Risk Rating			Residual (Current) Risk Rating			Target Risk Score	Target Date Risk Score will be met/closed	Corporate Risks Linked to BAF	Positive Assurance			Gaps in Assurances/Controls	Responsible Committee	Lead Executive Director	September 2021 Updates
			Likelihood	Conseq	Rating	Likelihood	Conseq	Rating				Existing Key Controls	Internal	External				
BAF#1.1	To be an outstanding place to work	There is a risk HDFT's culture will be compromised due to an insufficient focus on the culture of the Trust and the health and wellbeing of staff.	3	4	12	3	4	12	2x4=8	Apr-22	CRR6 – Wellbeing of Staff	Your Voice Vision and Values Programme which incorporates multiple improvement projects/programmes of work First Line Leaders Programme and other development programmes Shadow SMT Reverse mentoring programme EDI work programme Inpulse Survey and Analysis	Board of Directors Senior Management Team People and Culture Committee	Staff Survey Action Plan	Cultural programmes in place and are being embedded. Data awaited from Inpulse Surveys and Analysis to assess the impacted on these and to determine how well embedded the cultural programmes are in HDFT and HIF	People and Culture Committee	A Wilkinson, Director of Workforce and OD	Target risk score amended from 2x2=4 to 2x4=8. The consequence rating has been amended inline with the inherent and current risk. Additional mitigation included – inpulse survey Risk reworded to better reflect the potential risk Reassessment of gaps in control to reflect the current conditions.
BAF#1.2	To be an inclusive employer where diversity is celebrated and valued.	There is a risk that HDFT's culture may be compromised due to a lack of diversity.	4	5	20	3	4	12	2x4=8	Apr-22	CRR6 – Wellbeing of staff	Your Voice Vision and Values Programme which incorporates multiple improvement projects/programmes of work First Line Leaders Programme and other development programmes Shadow SMT Reverse mentoring programme EDI work programme Inpulse Survey and Analysis	Board of Directors SMT People and Culture Committee	Staff Survey	EDI programme governance paused, a need to re-establish	People and Culture Committee	A Wilkinson, Director of Workforce and OD	Target risk score amended from 2x2=4 to 2x4=8. The consequence rating has been amended inline with the inherent and current risk. Additional mitigation included – inpulse survey Risk reworded to better reflect the potential risk

2. STRATEGIC OBJECTIVE: TO WORK WITH PARTNERS TO DELIVER INTEGRATED CARE																	
Risk ID	Principle Objective	Principle Risk to the Delivery of Objective	Inherent Risk Rating			Residual (Current) Risk Rating			Target Risk Score	Target Date Risk Score will be met/closed	Corporate Risk Register	Assurances in Controls			Gaps in Assurances/Controls	Responsible Committee	Lead Executive Director	September 2021 Update
			Likelihood	Conseq	Rating	Likelihood	Conseq	Rating				Existing Key Controls	Internal	External				
BAF#2.1	To improve population health and wellbeing, provide integrated care and to support primary care	There is a risk that the Trust does not maximise its contribution to improving population health and reducing health inequalities because of a lack of strategic relationships with primary care and local authorities and an internal focus which will impact on our strategic ambition to improve population health and wellbeing, provide integrated care and to support primary care.	3	3	9	3	3	9	2x3=6	Apr-23		Medical Director attendance at LMC and HARA with focus on development of an aligned focus on health inequalities as a strategic priority Appointment of Director of Strategy	MD Board Report SMT Medical Directorate Team meeting	HARA Yorkshire Health Network LMC	This risk could exasperate due to the potential local government and NHS (integrating care) reorganisation	SMT	S Russell, Chief Executive J Andrews, Executive Medical Director	Target risk score amended from 2x2=4 to 2x3=6. The consequence rating has been amended in line with the inherent and current risk. Updated existing controls and reducing in gaps in assurance with the commencement of Director of Strategy in September 2021
BAF#2.2	To be an active partner in population health and the transformation of health inequalities	Risk that the population is not able to fully benefit from being part of an integrated care system because our acute services face towards West Yorkshire ICS and our place based population health activities sit within HCV ICS and there is insufficient executive capacity to participate in 2 ICSs.	3	3	9	3	3	9	2x3=6	Apr-23		West Yorkshire ICS and Humber Coast and Vale ICS meetings by Executive Team members Appointment of Director of Strategy				SMT	J Andrews, Executive Medical Director	Target risk score amended from 2x2=4 to 2x3=6. The consequence rating has been amended in line with the inherent and current risk. Risk reworded to better reflect the true risk. Updated existing controls and reducing in gaps in assurance with the commencement of Director of Strategy in September 2021

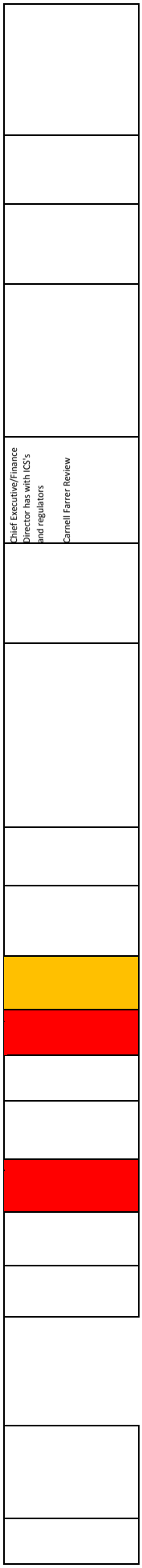
3. STRATEGIC OBJECTIVE: TO DELIVER HIGH QUALITY CARE

Risk ID	Principle Objective	Principle Risk to the Delivery of Objective	Inherent Risk Rating			Residual (Current) Risk Rating			Target Risk Score	Target Date Risk Score will be met/closed	Corporate Risk Register	Assurances in Controls			Gaps in Assurances/ Controls	Responsible Committee	Lead Executive Director	September 2021 Update
			Likelihood	Conseq	Rating	Likelihood	Conseq	Rating				Existing Key Controls	Internal	External				
BAF#3.1	To provide outstanding care and outstanding patient experience	There is a risk to achieving outstanding quality of care and patient experience due to insufficient focus on a culture of quality improvement.	4	4	16	3	4	12	2 x 4 = 8	Apr-22	None	A number of key quality governance changes have taken place over the last few months to strengthen the line of sight of quality of care and experience in our services. These include establishment of Quality Governance Management Group (QGMG) which includes 3 main fora – Patient Safety Forum, Clinical Effectiveness Forum and Making Experiences Count Forum. These groups will provide Executive level oversight of quality, identify risk and mitigations and triangulate learning and improvement.	CQC Action Plan Quality Account Caring at Our Best programme Appointment of Quality Matron to support rollout of ward/team accreditation	CQC Inspections Bi-monthly Assurance meetings with CCG	Do not have consistent quality control in place	Quality Committee	Emma Nunez, Director of Nursing	Target risk score amended from 3x3=9 to 2x4=8. The consequence rating has been amended in line with the inherent and current risk. Risk reworded to better reflect the true risk. Existing controls update to reflect developments in recent months
BAF#3.2	To provide a high quality service	Risk that a number of our clinical services are not operationally and financially sustainable because of the size of population we serve and associated financial income, the changing shape of the clinical workforce and preferences for ways of working and also our ability to deliver sub-specialty programmes of work	4	4	16	4	4	16	2x4 = 8	Apr-23	None	**External:** Carnell Farrer report Ongoing Clinical Services review to develop Clinical Strategy Ongoing conversations with WYATT	SMT Directorate Oversight on Annual Clinical Plans Quality Committee Board of Directors	WYATT Committee in Common	No Project Management Support for clinical review and support to draft strategy	Quality Committee	J Andrews, Executive Medical Director	Target risk score amended from 3x3=9 to 2x4=8. The consequence rating has been amended in line with the inherent and current risk. Risk reworded to better reflect the true risk.
BAF#3.3	To provide high quality care to children and young people in adults community services	There is a risk that there is not sufficient visability of the child in adult pathways which will impact on the individualised care for patients.	4	4	16	3	4	12	2 x 4 = 8	Apr-22	None	This remains an organisational priority (links to CQC recommendations from 2018). Focus on areas that are main hospital sites: Radiology, ED, Outpatients and Theatres. 'Hopes for Healthcare' sets out our organisational actions following engagement with children and young people on what they want from our services and each Directorate is working towards implementing these. Each Directorate is nominating a children's champion who will provide the Directorate link from the quarterly Children's Champions meeting back to the Directorate. This will be monitored via QGMG.	Adult and Young People Safeguarding Reports	CQC Outstanding Report OFSTED Reports JTAI Reports	Lack of tangible metrics	Quality Committee	Emma Nunez, Director of Nursing	Target risk score amended from 3x3=9 to 2x4=8. The consequence rating has been amended in line with the inherent and current risk. Current risk reduced likelihood from 4 to 3. Therefore current risk rating is 3 x 4 = 12 Risk reworded to better reflect the true risk. Current controls updated.
BAF#3.4	To provide outstanding care and outstanding patient experience	There is a risk that the Trust is unable to deliver treatment and care to the required national standards which may cause patient satisfaction to drop and harm to arise	3	4	12	4	3	12	2 x 3 = 6	Apr 22	CRR41 - RTT	Planned Care Recovery Programme in Place Weekly access meetings to track weekly progress against activity targets Clinical prioritisation of all patients on admitted waiting list to assign (P1-6) priority and regularly review Use of independent sector to increase inpatient, daycase and diagnostic capacity Collaboration initiatives with other Acute Trusts Theatres utilisation workstream Elective Recovery progressing, ,Endoscopy Unit now fully operational	SMT/ Resource Committee/ Trust Board reporting Performance Reporting - Resources Review	NHSE/I Reporting		Quality Committee	Russell Nightingale, Chief Operating Officer	Target risk score amended from 3x3=9 to 2x4=8. The consequence rating has been amended in line with the inherent and current risk. Risk reworded to better reflect the true risk. Current risk – consequence amended to 4 from 3 and likelihood amended from 3 to4. Risk remains 12. Current controls updated

BAF#3.5	To provide a high quality public health 0-19 service	There is a risk to providing a preventative 0-19 service because there is a significant rise in safeguarding and there is an inability to recruit and retain sufficient school nurses and health visitors.	5	4	20	4	4	16	2x4=8	Apr-22	CRR5 – Nursing Shortage CRR57 – Safeguarding Demand	Recruitment & Retention Group set up & action plan in place and being progressed (includes skill mix work, setting up services on NHSP, rolling monthly recruitment in line with ward based nursing) Business case submitted to enhance Safeguarding resource which would support the specialist team and 0 -19 service pressures. Would support 'breaking the cycle' by freeing up 0 -19 capacity to undertake preventative work. Request made for support from wider Trust (needs to be nurses with experience of working with children and families) Modelling of demand & capacity (review of current demand & capacity model / demand & capacity review) Development of OPEL to increase visibility of pressure & actions taken Agile / Base & Home working - Developing offers with teams to support alternative ways of working • Work commenced on 0 -19 'Safer staffing' tool Services recommencing face to face contacts, however recognising that many community services have not returned to pre-pandemic arrangements.	SMT/ Quality Committee/ Resource Committee		The national mandate for roll out of Covid vaccinations for healthy 12-15 year olds is likely to impact on ongoing pressures		Emma Nunez, Director of Nursing	Current mitigation and gaps in control updated.

4. STRATEGIC OBJECTIVE: TO ENSURE CLINICAL AND FINANCIAL SUSTAINABILITY

Risk ID	Principle Objective	Principle Risk to the Delivery of Objective	Inherent Risk Rating			Residual (Current) Risk Rating			Target Risk Score	Target Date Risk Score will be met/closed	Change since last Report	Existing Key Controls	Assurances in Controls		Gaps in Assurances/ Controls	Responsible Committee	Lead Executive Director	September 2021 Update
			Likelihood	Conseq	Rating	Likelihood	Conseq	Rating					Internal	External				
BAF#4.1	To continually improve services we provide to our population in a way that are more efficient	Due to a prolonged recovery from CoVid-19 there is a risk that the focus on the Trust's strategic ambitions is compromised, which will Impact upon service transformation and underlying financial improvement	4	4	16	2	4	8	2x4=8	Mar-22	None	Current financial regime; national framework, ICS discussions; engagement in regional and local service transformation programmes; internal transformation programme; alliances with Leeds; membership and engagement with WYAAT	SMT reports and oversight Resource Committee reports and oversight Board of Directors reports and oversight	WYAAT reports and Committee in Common engagement and oversight NHSE/I regulatory oversight	**Internal:** capacity to deliver internal service transformation **External:** no governance structure or programme of work with Leeds regarding transformation	Resource Committee	J Coulter, Deputy Chief Executive/ Finance Director	Target risk score amended from 2x3=6 to 2x4=8. The consequence rating has been amended in line with the inherent and current risk. Current risk rating amended from 4x3=12 to 2x4=8.
BAF#4.2	To provide high quality care and to be a financially sustainable organisation	Due to the difficulty of generating sufficient internal funds through inward investment or additional cash releasing savings, there is a risk to long term financial sustainability and ability to invest in capital, which will impact upon the quality of care that can be provided.	4	4	16	2	4	8	2x4=8	Mar-23	None	Capital asset register and planning process; financial plan; current financial regime Strength of balance sheet Engaged with ICS	Capital Oversight Group		**Internal:** No efficiency programme	Resource Committee	J Coulter, Deputy Chief Executive/ Finance Director	Target risk score amended from 2x3=6 to 2x4=8. The consequence rating has been amended in line with the inherent and current risk. Current risk rating amended from 4x3=12 to 2x4=8. Mitigation updated
BAF#4.3	To provide high quality care and to be a financially sustainable orgnisation	There is a risk that the digital maturity of the Trust is restricted because of the insufficient leadership capacity and the inability to invest sufficient resource in infrastructure and new technologies which will result in missed opportunities to improve efficiency and safety	4	4	16	3	4	12	2x4=8	Apr-22	None	1. Digital Strategy 2. Digital Board Training provided by NHS Digital/NHS Providers NHSI Digital Maturity Programme	Capital Oversight Group Digital Strategy Group		No Trust or ICS Estate Strategy or plan in place	Resource Committee	J Coulter, Deputy Chief Executive/ Finance Director	Target risk score amended from 3x3=9 to 2x4=8. The consequence rating has been amended in line with the inherent and current risk. Mitigation updated
#4.4	To be financially stable to provide outstanding quality of care	Due to the allocation formula not providing sufficient resources to meet the needs of the unique demography of the local area, there is a risk that standards of care are compromised which will impact on the Trust's ambition to provide outstanding care and its reputation for quality	4	4	16	3	4	12	2x4=8	Apr 22	None	Quality governance arrangements; Contracts with commissioners Annual audit cycle PLACE Assessments 4. ICS and Place based networks Current financial regime	Integrated Board Report Chief Nurse Report Quality Committee minutes Clinical Audit Reports SMT, Resource Committee and Board reports and oversight	CCG Meetings CQC inspection reports Memorandum of Understanding with CCG Memorandum of Understanding with ICS's HARA engagement Relationships with Local Authorities Ongoing dialogue Chief Executive and Deputy	Lack of system wide financial plan	Resource Committee	J Coulter, Deputy Chief Executive/ Finance Director	


Chief Executive/Finance Director has with ICS's and regulators
Carnell Farrer Review

Risk Matrix

	Likelihood				
	1	2	3	4	5
Consequence	Rare	Unlikely	Possible	Likely	Almost Certain
5. Extreme	5	10	15	20	25
4. Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2. Minor	2	4	6	8	10
1. Negligible	1	2	3	4	5

Changes in Ratings

No change in risk rating since from previous Assurance Framework

Risk rating has been downgraded from previous version

Risk rating has increased from previous version

Progress on Actons

1 Fully on plan across all actions
2 Actions defined - most progressing, where delays are occurring interventions are being taken
3 Actions defined - work started but behind plan
4 Actions defined - but largely behind plan
5 Actions not yet fully defined

Board of Directors (Public)
29th September 2021

Title:	Northumberland 0-19 Healthy Families Service
Responsible Director:	Deputy Chief Executive / Finance Director
Author:	Head of Charity and Business Development Project Manager

Purpose of the report and summary of key issues:	For noting and information	
BAF Risk:	AIM 1: To be an outstanding place to work	
	BAF1.1 to be an outstanding place to work	x
	BAF1.2 To be an inclusive employer where diversity is celebrated and valued	x
	AIM 2: To work with partners to deliver integrated care	
	BAF2.1 To improve population health and wellbeing, provide integrated care and to support primary care	x
	BAF2.2 To be an active partner in population health and the transformation of health inequalities	x
	AIM 3: To deliver high quality care	
	BAF3.1 and 3.4 To provide outstanding care and outstanding patient experience	x
	BAF3.2 To provide a high quality service	x
	BAF3.3 To provide high quality care to children and young people in adults community services	x
	BAF3.5 To provide high quality public health 0-19 services	x
	AIM 4: To ensure clinical and financial sustainability	
	BAF4.1 To continually improve services we provide to our population in a way that are more efficient	x
	BAF4.2 and 4.3 To provide high quality care and to be a financially sustainable organisation	x
	BAF4.4 To be financially stable to provide outstanding quality of care	x
Corporate Risks	None	
Report History:	• Board of Directors 26 May 2021 • Resource Committee Business Development update 26 July 2021 • Board of Directors 25 August 2021	
Recommendation:	The Board of Directors is asked to: • Note and record the approval to enter into a Section 75 agreement with Northumberland County Council for 0-19 services, which the Board discussed and agreed in August • Note the work continuing to mobilise and transfer the workforce from Northumbria Healthcare NHS Foundation Trust to HDFT on 1 October 2021.	

Board of Directors Meeting 29th September 2021

Northumberland 0-19 Healthy Families Service

Report from: **Deputy Chief Executive/Finance Director**

Report Purpose: **For Information and Approval**

1. Background

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

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

1.3 This paper outlines the current position, including the ongoing work to mobilise and TUPE transfer the workforce for the partnership commencement on 1 October 2021.

2. Current Position

2.1 Following the public consultation undertaken by NCC and the subsequent agreement by NCC to enter into a formal partnership arrangement with HDFT on 25 August 2021, the Trust, having also concurrently agreed to enter into a partnership with NCC, has been able to engage in a TUPE consultation process with the 0-19 workforce led by Northumbria Healthcare NHS Foundation Trust (NHFT).

3. Workforce TUPE Consultation and Transfer

3.1 The TUPE consultation process commenced on 31 August for a period of 30 days with the following highlights:

- We have shared the Trust's Measures letter with NHCT, detailing what terms and conditions will change or remain the same at their point of transfer.
- We have held five 'welcome to HDFT events' with the staff with over 140 NHFT staff in attendance along with Union representatives across Northumberland in 4 separate locations.
- Individual 1:1 meetings for staff have been held to enable key concerns and queries about the transfer to be raised with HDFT colleagues as part of the TUPE process.

4. Mobilisation

4.1 The initial mobilisation timescales continue to be challenging, particularly with the work required to TUPE the workforce, roll out IT connectivity and ensure IT hardware is set up with HDFT systems for the partnership commencement. However, we have established key workstream meetings with representatives from HDFT, NCC and NHCT to work ensure a safe transfer and continuation of service for 1 October 2021.

4.2 A number of key roles have been identified including the future provision of Safeguarding with interviews recently held for the Named Nurse which was successfully appointed into following competitive interview.

4.3 The mobilisation risks are being managed through the mobilisation risk register which is monitored through the mobilisation board. Key risks relate to TUPE/IT/Estate but plans are in place to manage these risks and no risk is currently scored above an 8 post mitigation.

4.4 A business continuity plan has been developed to ensure that there is no gap in service provision from the partnership commencement date.

5. Next Steps

5.1 Work will continue in order to:-

- Continue to mobilise the service with the key workstreams identified
- Undertake the transfer of the workforce from NHFT to HDFT, including engagement with our new colleagues

6. Recommendation

6.1 The Board of Directors is asked to:

- Note and record the approval to enter into a Section 75 agreement with Northumberland County Council for 0-19 services, which the Board discussed and agreed in August
- Note the work continuing to mobilise the service and transfer the workforce for partnership commencement on 1 October 2021.

Integrated Board Report - August 2021

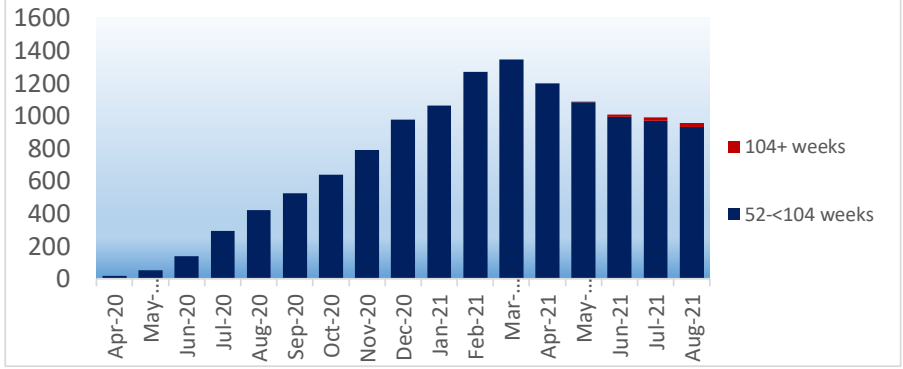
Domain 5 - Responsive

Indicator	**5.1 - RTT Incomplete pathways - 52+ weeks**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Aug-21
Value / RAG rating	955

Indicator description

The number of incomplete pathways waiting over 52 weeks.

Trend chart



Narrative

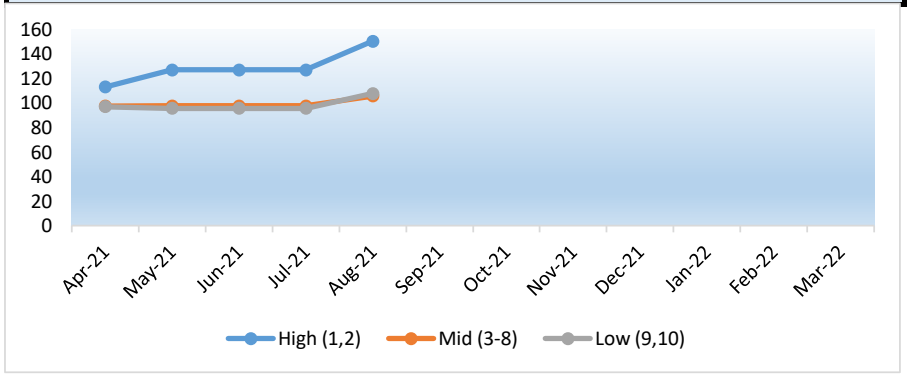
Due to the Covid-19 pandemic and the ceasing of elective work, waiting times have risen significantly. The over 52 weeks waiters peaked in March 2021 at 1,345. There has been a further decline to 955 in August with a combination of grip around the booking process and theatre efficiency, as well as the increase of elective work now underway. Risks remain in two main specialties of T&O and Community Dental (which together account for 78% of the over 52 week waiters). Current end of financial year target is to reduce this figure to below 800 patients.

Indicator	**5.2 - RTT waiting times - by level of deprivation**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Aug-21
Value / RAG rating	

Indicator description

The average RTT waiting time by level of deprivation.

Trend chart



Narrative

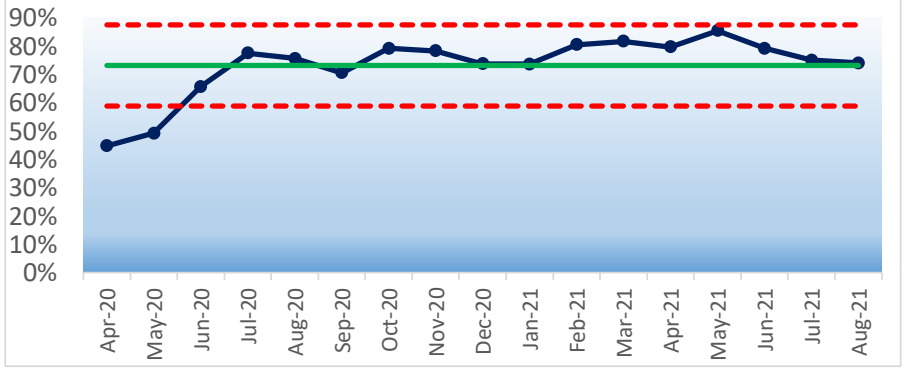
The Trust has carried out an analysis of waiting times by ethnicity, by deprivation and for patients with learning disabilities. There does not appear to be any inequity in waiting times by ethnicity or for patients with learning disabilities but these will continue to be tracked on a monthly basis. There does appear to be a difference in waiting times by deprivation with patients from the most deprived postcodes waiting longer. A further analysis of this is being carried out looking at the data by clinical priority and by specialty.

Indicator	**5.3 - Diagnostic waiting times - 6-week standard**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Aug-21
Value / RAG rating	74.0%

Indicator description

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

SPC chart



Narrative

74% of patients were waiting less than 6 weeks for a diagnostic test at end August against a 99% target. The main areas of concern are DEXA scans, non-obsteric ultrasound and echocardiography.

The demand for new outpatient echocardiography has increased by 37% based on 2019 demand (circa 70 referrals) and for inpatient echocardiography has increased by 43% (circa 25 patients). The Trust is currently booking for new patients at 12 weeks (all clinically reviewed & urgent prioritised). A new echocardiography has been machine ordered and expected in October. There is also planned change to Heart Centre space use and job plans, with the ability to run 4 rooms once the new machine arrives. Recruitment for a locum is also ongoing but there appears to be low availability. Bank staff capacity is being maximised. The anticipated recovery based on 221 on waiting list is 4 months. There will be an ongoing need for follow up echocardiography.

Indicator	**5.4 - Outpatients lost to follow-up - number of follow up patients past due date**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	
Value / RAG rating	

Indicator description
This indicator is under development.

SPC chart

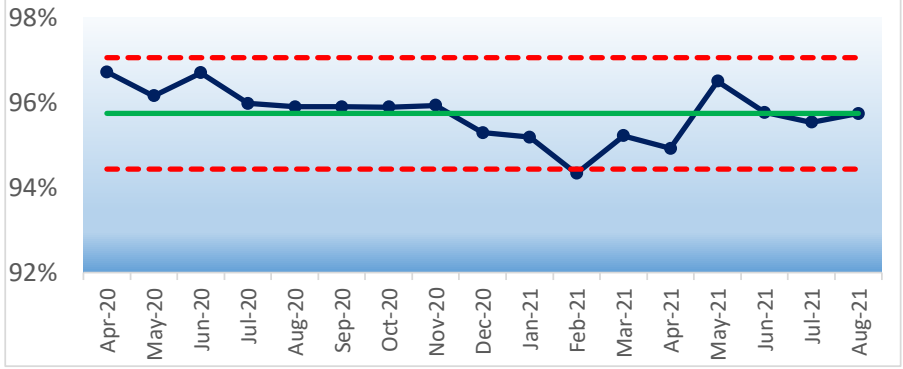
Narrative
A data quality exercise is underway to review the follow up outpatient waiting list data and to understand the full scope of this problem and determine how many patients still require a follow up appointment. It is likely that we will refine the metric for reporting in this report as part of this work.

Indicator	**5.5 - Data quality on ethnic group - inpatients**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Aug-21
Value / RAG rating	95.7%

Indicator description

The number of inpatients with a valid ethnic group recorded on the Trust's PAS system.

SPC chart



Narrative

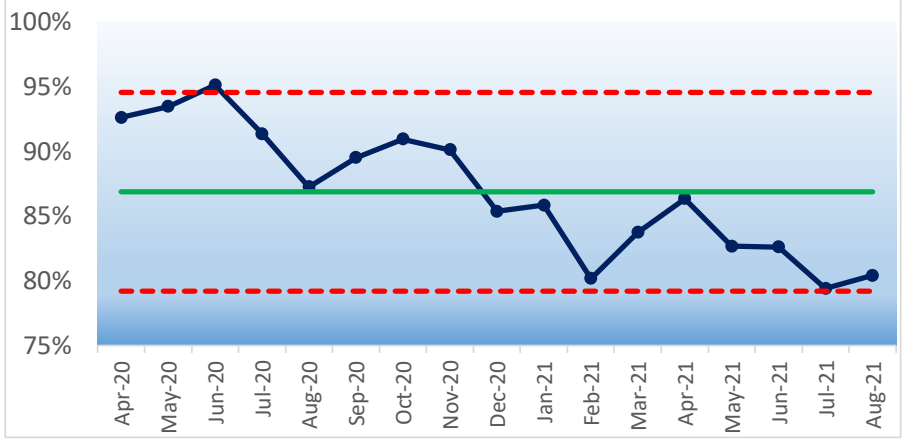
The Trust remains below the required standard of 97%. A revised focus on ethnicity data collection is underway, this measure is monitored at Trust weekly access meeting. Forecast for achievement by October 2021.

Indicator	**5.6 - A&E 4 hour standard**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Aug-21
Value / RAG rating	80.4%

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

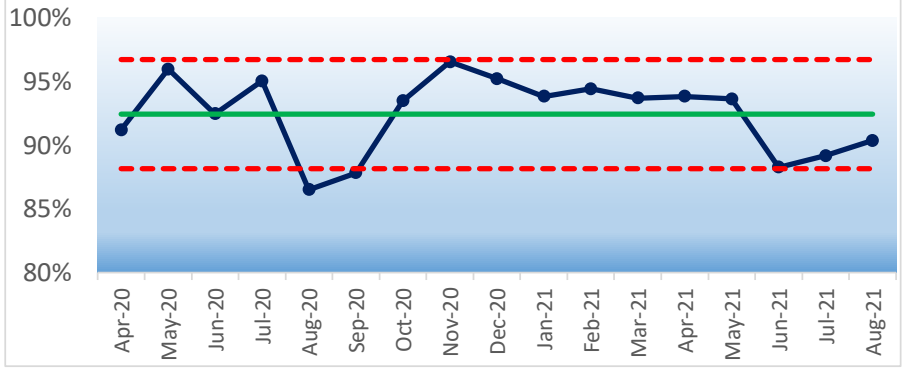
Performance against the A&E 4-hour standard increased to 80.4% in August but remains below the 95% standard.

Indicator	**5.7 - Ambulance handovers - % within 15 mins**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Aug-21
Value / RAG rating	90.4%

Indicator description

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

SPC chart



Narrative

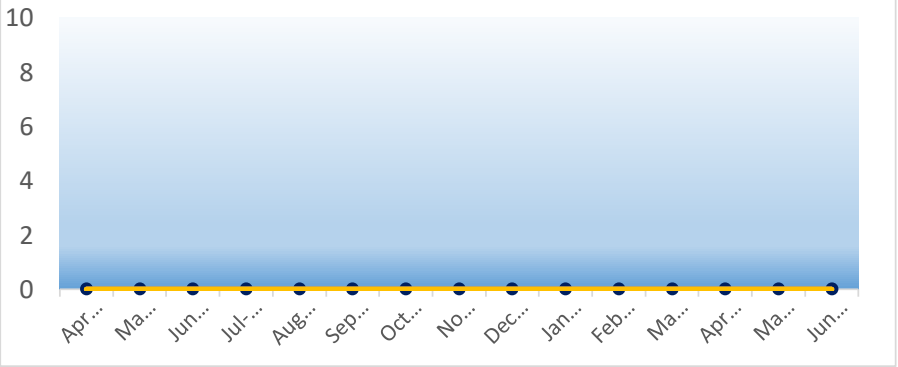
Ambulance handover performance improved to 90.4% in August. There were 20 over 30-minute handover breaches including 1 over 60-minute breach in August.

Indicator	**5.8 A&E - number of 12 hour trolley waits**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Aug-21
Value / RAG rating	0

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

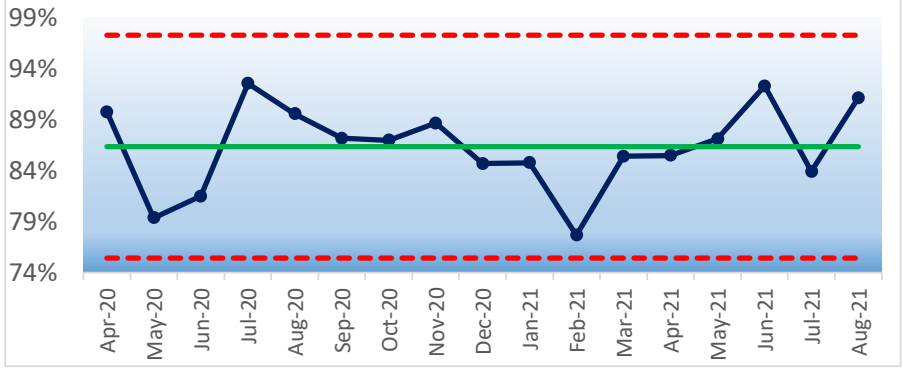
There have been no over 12 hour trolley waits reported in 2021/22 to date.

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	Aug-21
Value / RAG rating	91.2%

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 delivered in August (91.2%). There were 56.5 accountable treatments (62 patients) in August with 5.0 treated outside 62 days.

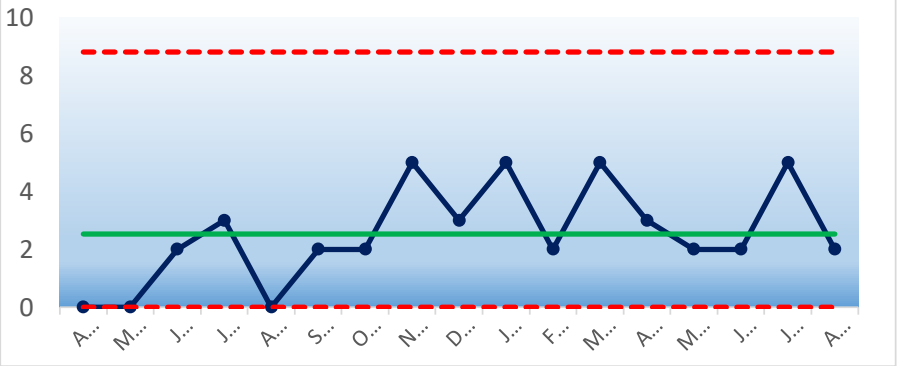
Of the 9 tumour sites treated in August, performance was below 85% for 4 (Colorectal, Gynaecology, Head and Neck, and Lung). All pathway delays will be reviewed by the breach panel at the end of September. Provisional data indicates that 60% (6/10) of patients treated at tertiary centres in August were transferred for treatment by day 38, which is an improvement on than last month (35%), although 20 patients were treated at tertiary centres in July.

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	Aug-21
Value / RAG rating	2

Indicator description

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

SPC chart



Narrative

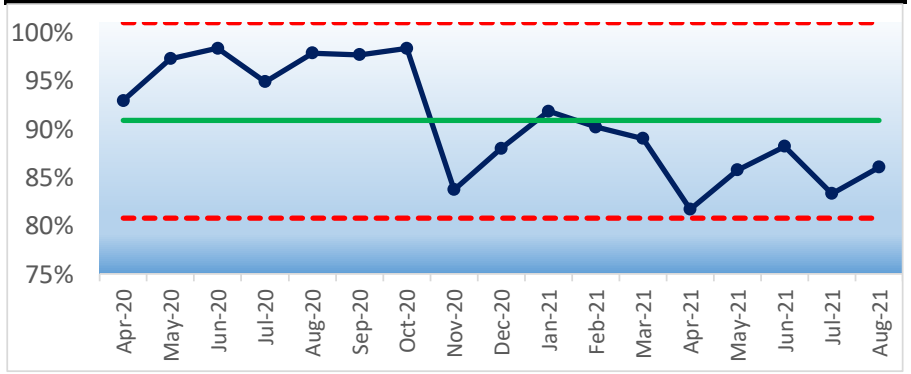
2 patients waited 104+ days for treatment in August (1 x Harrogate colorectal; 1 x Leeds Prostate) – the Leeds patient was transferred for treatment after day 38 (day 51). The Harrogate delays was predominately due to diagnostic complexity and the prostate patient was delayed due to prostatectomy capacity at Leeds. Both patients have now received treatment.

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	Aug-21
Value / RAG rating	86.0%

Indicator description

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

SPC chart



Narrative

881 patients attended their first appointment for suspected cancer in August, which is a 2% decrease on last month (899). 123 patients were seen after day 14 and of these, 51 were breast referrals, which is a significant improvement on last month (108). The average wait for a 2WW breast appointment in August (including Breast Symptomatic) was 14.9 days, which is lower than last month (19.2 days). The backlog for breast appointments was being cleared during August, which should then lead to a recovery in performance by September 2021. Current data for September indicates that the 2WW Breast symptomatic standard is being acheived for the first time since October 2020.

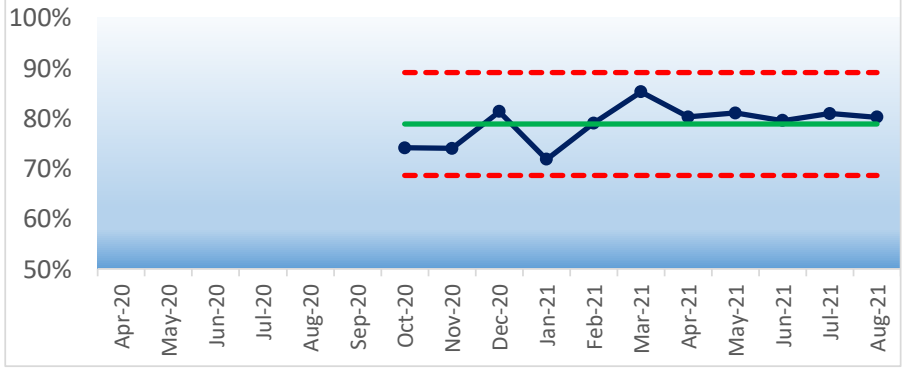
The remaining 14 day delays in August were predominately for Urology and Lower GI referrals - this is due to a lack of capacity for Haematuria clinics and endoscopy.

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	Aug-21
Value / RAG rating	80.2%

Indicator description

From January 2022, Trusts are required to deliver the new 28 days faster diagnosis standard for all suspected cancer referrals. The proposed operational standard is 75%.

SPC chart



Narrative

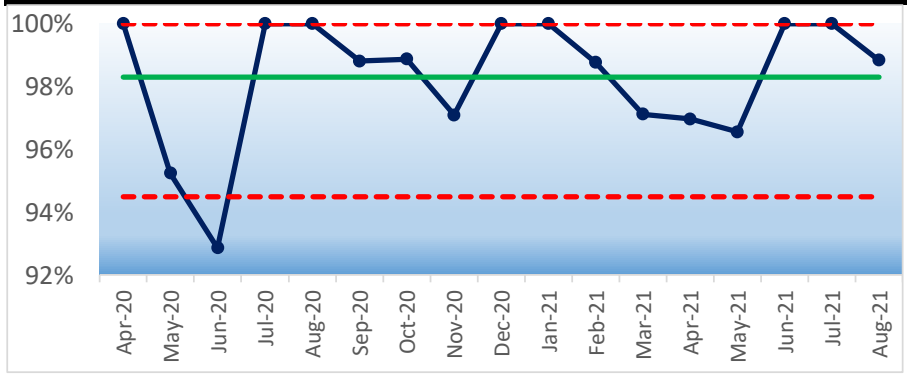
Provisional data indicates that performance remains around 80% for 2WW suspected cancer referrals with August performance at 80.2%, which is above the proposed operational standard of 75%.

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	Aug-21
Value / RAG rating	98.8%

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 85 patients received First Definitive Treatment for cancer in August which is 36.6% fewer patients treated than last month (134), although there was an unusually high number of patients treated in June and July. One Colorectal patient was treated in August after day 31 - this delay was for medical reasons as the patient was not initially fit enough to undergo surgery.

Indicator	**5.13 - Children's Services - 0-12 months and 2-3 years caseload**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	
Value / RAG rating	

Indicator description
This indicator is under development.

SPC chart

Narrative

Indicator	**5.13 - Children's Services - Safeguarding caseload**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	
Value / RAG rating	

Indicator description
This indicator is under development.

SPC chart

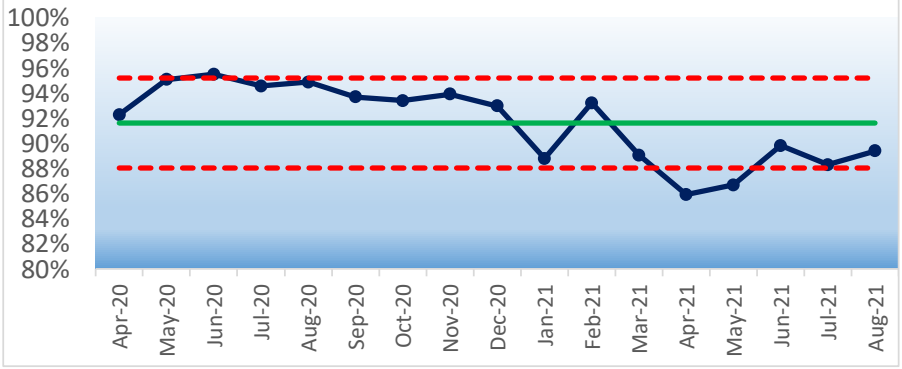
Narrative

Indicator	**5.15 - Children's Services - Ante-natal visits**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Aug-21
Value / RAG rating	89.4%

Indicator description

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

SPC chart



Narrative

89% of eligible pregnant women received an initial antenatal visit in August.

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	Aug-21
Value / RAG rating	96.2%

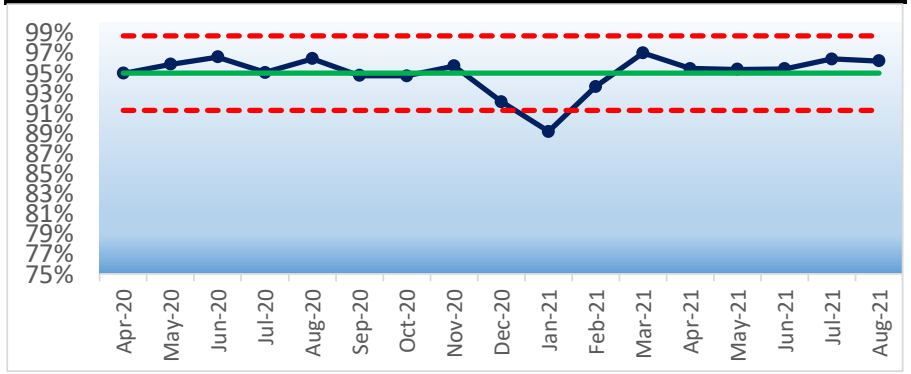
Indicator description

The number of eligible infants who received a face-to-face Health Visitor new birth visit undertaken within 14 days from birth.

Narrative

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

SPC chart

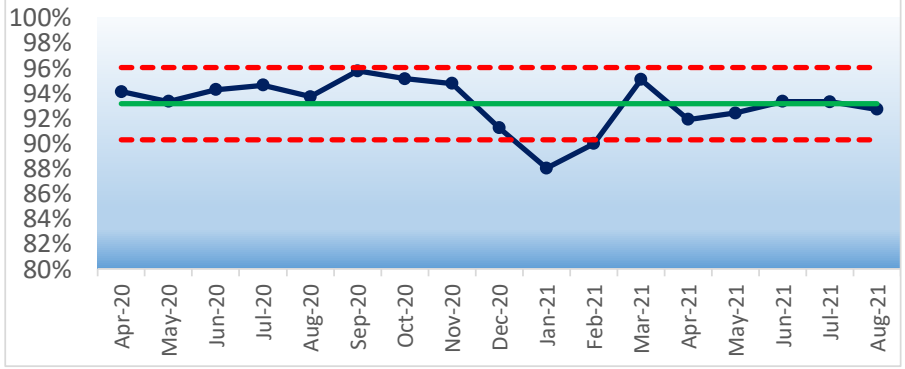


Indicator	**5.17 - Children's Services - 6-8 week visit**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Aug-21
Value / RAG rating	92.7%

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 August.

Indicator	**5.18 - Children's Services - 12 month review**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Aug-21
Value / RAG rating	95.0%

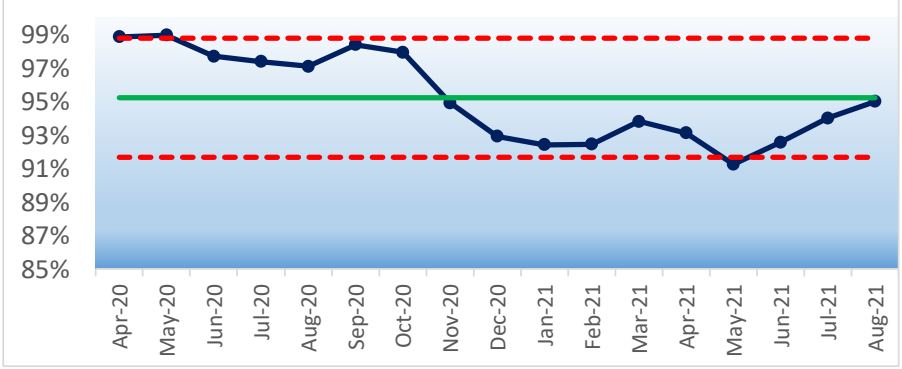
Indicator description

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

Narrative

95% of eligible children received a 12 month review by 15 months of age during August.

SPC chart

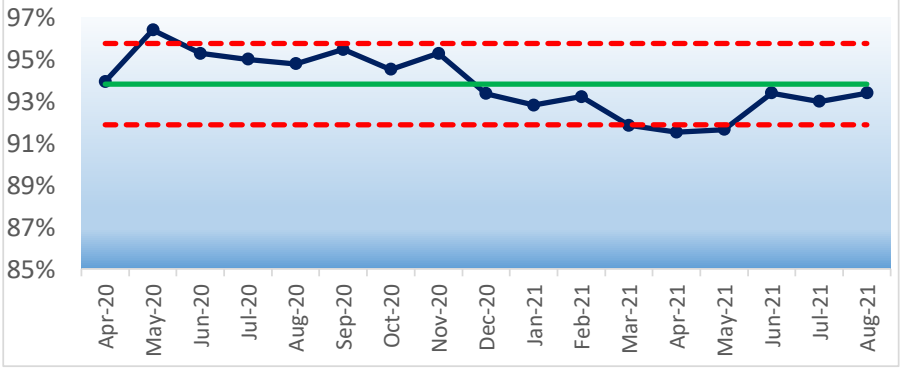


Indicator	**5.19 - Children's Services - 2.5 year review**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Aug-21
Value / RAG rating	93.4%

Indicator description

The number of eligible children receiving a 2-2.5 year review by the time they were 2.5 years.

SPC chart



Narrative

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

Indicator	**5.20 - Children's Services - % children with all 5 mandated contacts**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	
Value / RAG rating	

Indicator description
This indicator is under development.

SPC chart

Narrative

Indicator	**5.21 - Children's Services - Delivery of Immunisation trajectory**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	
Value / RAG rating	

Indicator description
This indicator is under development.

SPC chart

Narrative

Indicator	**5.22 - Children's Services - OPEL level**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	
Value / RAG rating	

Indicator description
This indicator is under development.

SPC chart

Narrative

Indicator	**5.23 - Community Care Adult Teams - performance against new timeliness standards**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	
Value / RAG rating	

Indicator description
This indicator is under development.

SPC chart

Narrative

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

Indicator description
This indicator is under development.

SPC chart

Narrative

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

Indicator description

This indicator is under development.

SPC chart

Narrative

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

Indicator description
This indicator is under development.

SPC chart

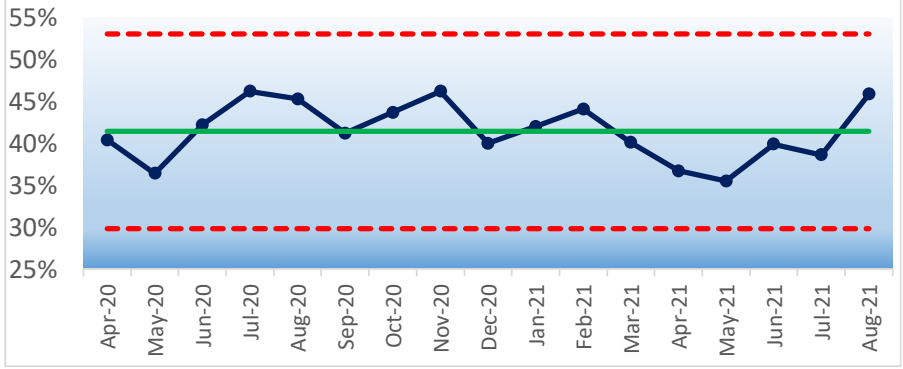
Narrative

Indicator	**5.27 - GPOOH - telephone clinical assessment for URGENT cases within 20 minutes of call prioritisation**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Aug-21
Value / RAG rating	45.9%

Indicator description

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

SPC chart



Narrative

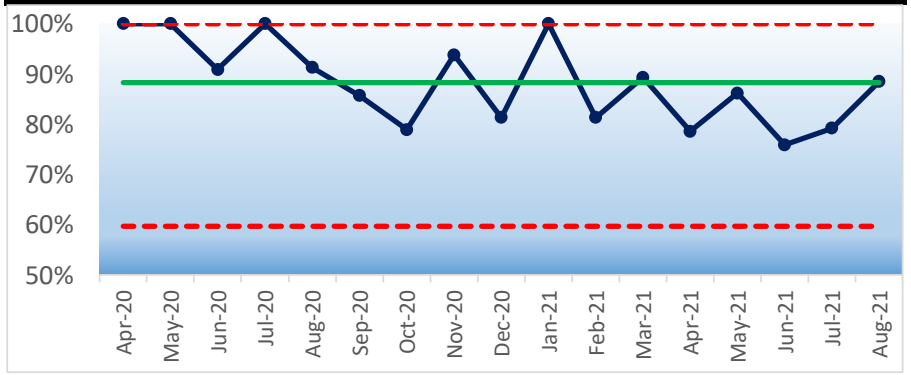
In August, 45.9% of urgent GPOOH cases received a telephone clinical assessment within 20 minutes of call prioritisation which is the second highest month in 24 months yet still below the 95% target. A refresh of roles and responsibilities and a reduction in streaming to GP OOH due to new ED front door model has made an impact.

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	Aug-21
Value / RAG rating	88.5%

Indicator description

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

SPC chart



Narrative

In August, 88.5% of urgent GPOOH cases received a home visit face to face consultation within 2 hours. There has been an increase in the number of face to face consultations requested as the country moves out of the most recent Covid wave and demand and capacity planning is underway looking to see if the 95% target is achievable with the increase.

Integrated Board Report - August 2021

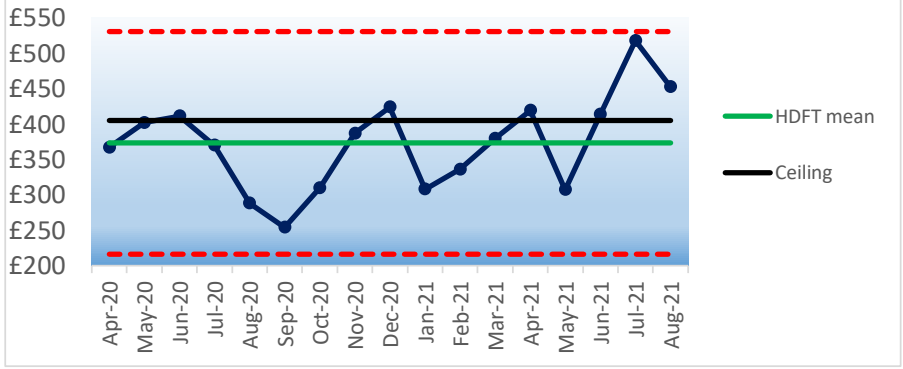
Domain 6 - Efficiency and Finance

Indicator	**6.1 - Agency spend**
Executive lead	Jonathan Coulter, Finance Director
Board Committee	Resources Committee
Reporting month	Aug-21
Value / RAG rating	£453

Indicator description

Expenditure in relation to Agency staff (£'000s). The Trust aims to have less than 3% of the total pay bill on agency staff.

SPC chart



Narrative

Agency spend continues to be a concern for the Trust, with expenditure levels increasing in July and August.

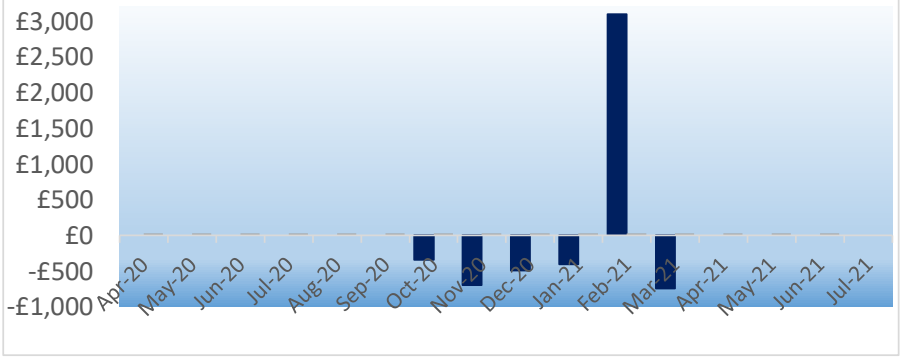
Drivers for this are wide ranging, and a range of actions are being developed across the Trust.

Indicator	**6.2 - Surplus / deficit and variance to plan**
Executive lead	Jonathan Coulter, Finance Director
Board Committee	Resources Committee
Reporting month	Aug-21
Value / RAG rating	£0

Indicator description

Monthly Surplus/Deficit (£'000s). In some months, a deficit is planned for. This indicator reports positive or adverse variance against the planned position for the month.

Trend chart



Narrative

The Trust continues to report a break even position in relation to the position monitored by NHSE/I. This excludes grant income.

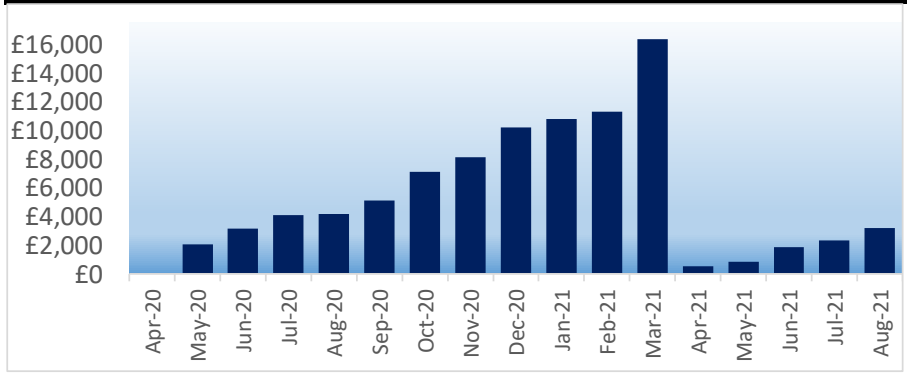
The first half of the year is forecast to achieve plan whilst making appropriate prudent provisions. Guidance is being released for the second half of the financial year which is anticipated to have more challening efficiency requirements whilst also achieving planned care recovery and managing the winter period.

Indicator	**6.3 - Capital spend**
Executive lead	Jonathan Coulter, Finance Director
Board Committee	Resources Committee
Reporting month	Aug-21
Value / RAG rating	£3,188

Indicator description

Cumulative Capital Expenditure by month (£'000s)

Trend chart



Narrative

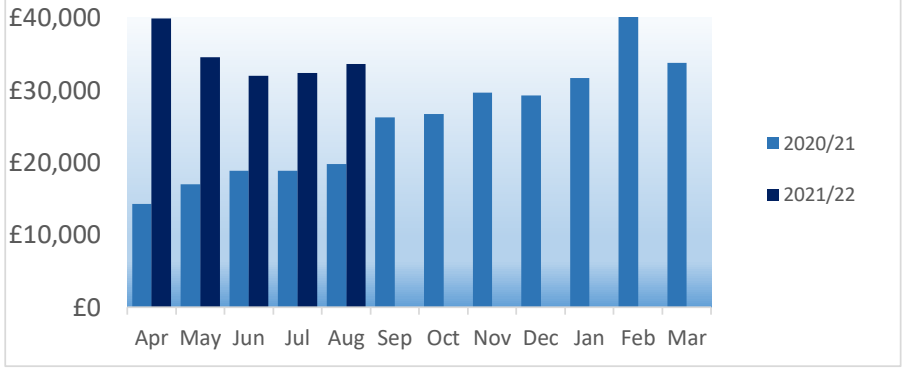
Capital spend continues to be behind plan, with a number of material schemes slipping. Work is ongoing to address this position.

Indicator	**6.4 Cash balance**
Executive lead	Jonathan Coulter, Finance Director
Board Committee	Resources Committee
Reporting month	Aug-21
Value / RAG rating	£33,600

Indicator description

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

Trend chart



Narrative

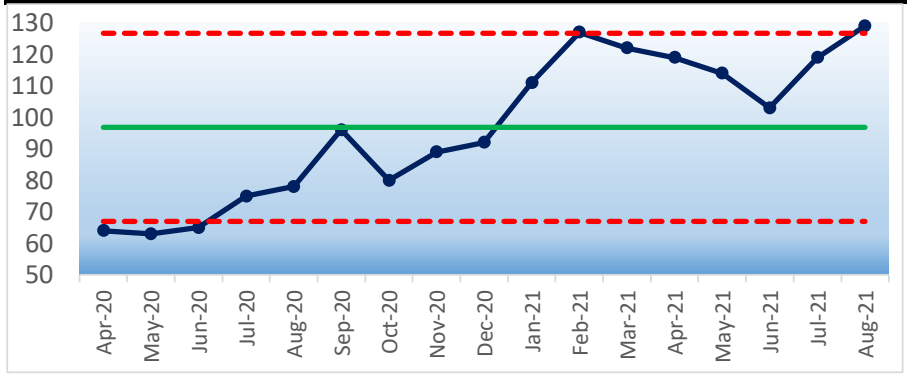
The Trust continues to report a favourable cash balance, whilst also maintaining positive payment terms with suppliers.

Indicator	**6.5.1 - Long stay patients - stranded (>7 days LOS)**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Aug-21
Value / RAG rating	129

Indicator description

The average number of patients that were in the hospital with a length of stay of over 7 days (previously defined as stranded patients by NHS Improvement). The data excludes children, as per the NHS Improvement definition.

SPC chart



Narrative

The number of long stay patients (> 7 days) increased in August and is now in line with the long term historical levels prior to the pandemic.

For the patients in hospital as at 31/08/21, 20 did not meet the criteria to reside and 204 did (they have been assessed as requiring treatment that can only be provided in hospital). Of the 20 that were assessed as not meeting the criteria to reside, 3 were awaiting internal interventions (e.g. a consultant to say they could be discharged, test results etc). Of the 17 who were, external delays were the main reasons they had not been discharged that day.

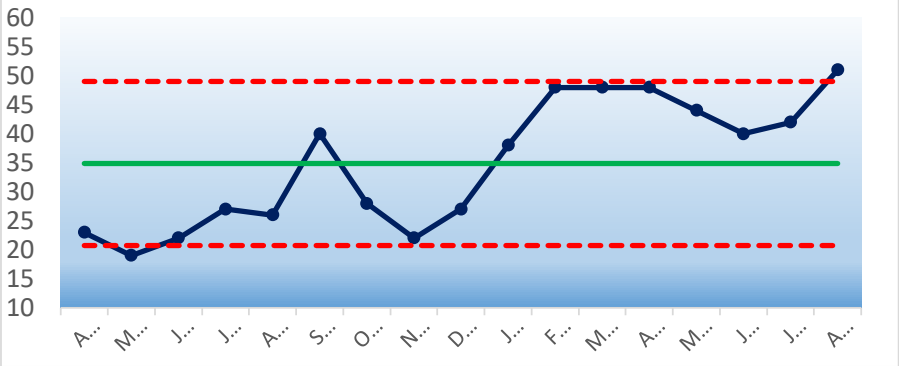
A process is underway to relaunch the discharge policy once the new guidance is issued and also get the system in that makes the delays visible every day along with their cause.

Indicator	**6.5.2 - Long stay patients - superstranded (>21 days LOS)**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Aug-21
Value / RAG rating	51

Indicator description

The average number of patients that were in the hospital with a length of stay of over 21 days (previously defined as super-stranded patients by NHS Improvement). The data excludes children, as per the NHS Improvement definition.

SPC chart



Narrative

The number of long stay patients (> 21 days) increased in August but remains below the long term historical levels. For the patients in hospital as at 31/08/21, 20 did not meet the criteria to reside and 204 did (they have been assessed as requiring treatment that can only be provided in hospital). Of the 20 that were assessed as not meeting the criteria to reside, 3 were awaiting internal interventions (e.g. a consultant to say they could be discharged, test results etc). Of the 17 who were, external delays were the main reasons they had not been discharged that day.

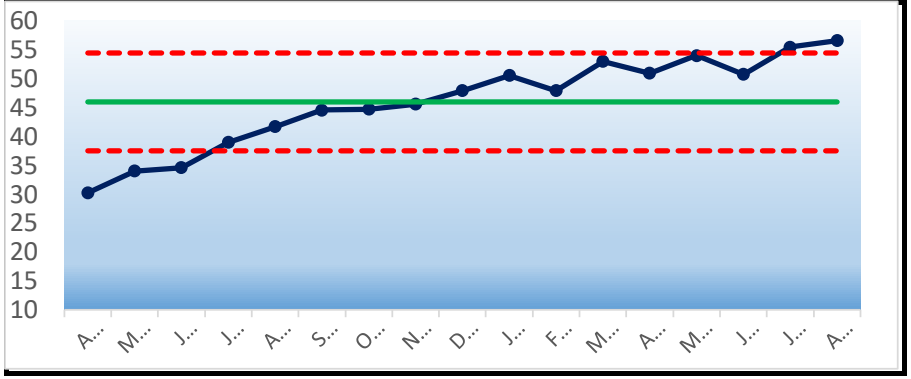
A process is underway to relaunch the discharge policy once the new guidance is issued and also get the system in that makes the delays visible every day along with their cause.

Indicator	**6.6 - Occupied bed days per 1,000 population**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Aug-21
Value / RAG rating	56.5

Indicator description

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

SPC chart



Narrative

Data is presented for this indicator for the first time this month. As can be seen on the chart, occupied bed days have steadily increased since the start of the pandemic period. By comparison, in the 2 years prior, occupied bed days per 1,000 population averaged 57.8, just above the current position.

Indicator	**6.7.1 Length of stay - elective**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Aug-21
Value / RAG rating	2.8

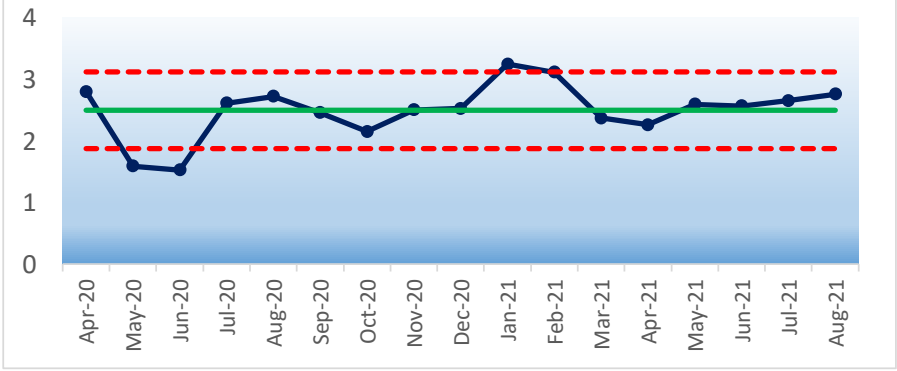
Indicator description

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

Narrative

Elective length of stay is above our local stretch target of 2.5 days. The current elective programme is prioritising longer wait, more critically ill patients, so there will inevitably be an increase in LoS for these more complex patients.

SPC chart

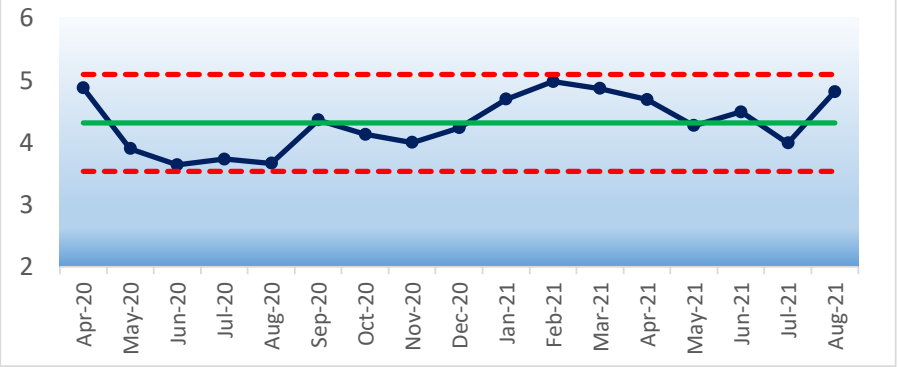


Indicator	**6.7.2 Length of stay - non-elective**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Aug-21
Value / RAG rating	4.8

Indicator description

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

SPC chart



Narrative

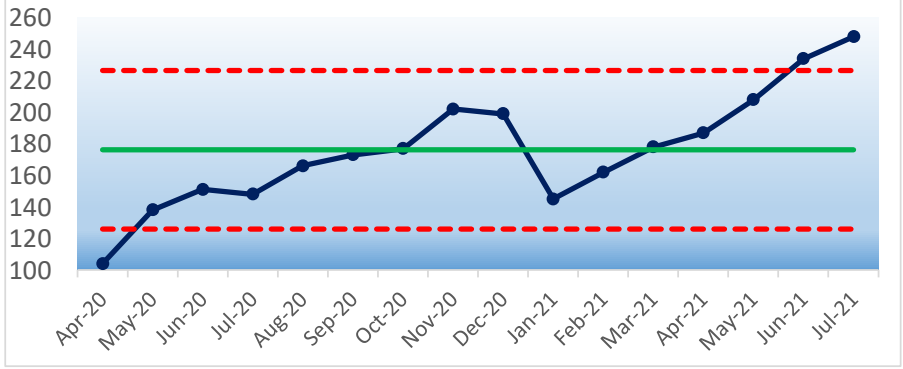
Non-Elective length of stay increased to 4.8 days in August.

Indicator	**6.8 - Avoidable admissions**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Jul-21
Value / RAG rating	248

Indicator description

The number of avoidable emergency admissions as per the national definition. The admissions included are those where the primary diagnosis of the patient does not normally require a hospital admission.

SPC chart



Narrative

There were 248 avoidable admissions in July. The most common diagnoses remain as urinary tract infections, pneumonia and upper respiratory tract infections in children. This equates to 12% of all emergency admissions. Excluding children and admissions via CAT/SDEC, the figure was 121.

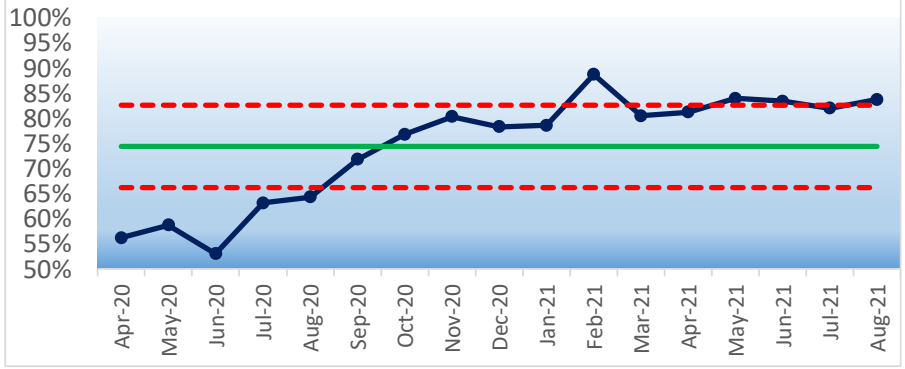
Although the trend is currently increasing, it remains below pre-Covid levels - the average per month in 2018/19 was 270. We have amended the RAG rating this month to reflect this - with performance classed as green due to being below 2018/19 levels.

Indicator	**6.9 - Theatre utilisation (elective sessions)**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Aug-21
Value / RAG rating	83.7%

Indicator description

The percentage of time utilised during elective theatre sessions (i.e. those planned in advance for waiting list patients). The utilisation calculation excludes cancelled sessions.

SPC chart



Narrative

Theatre utilisation remains below the local intermediate target of 90%.

Indicator	**6.10 - Day case conversion rate**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Aug-21
Value / RAG rating	1.9%

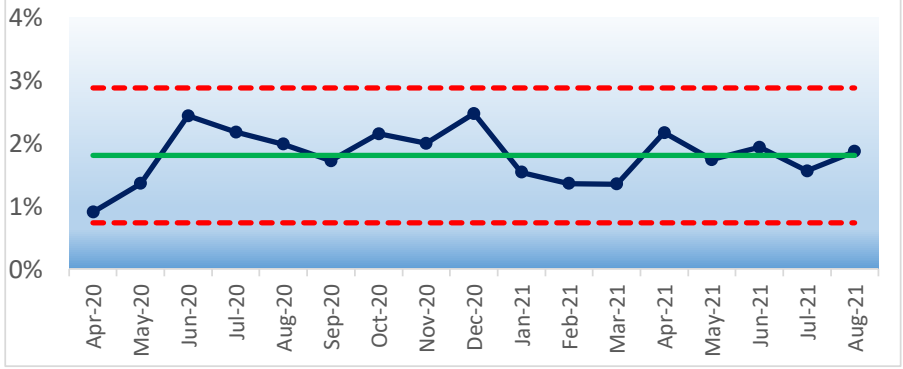
Indicator description

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

Narrative

1.9% (41 patients) of intended day case admissions in August stayed in hospital overnight or longer.

SPC chart



Integrated Board Report - August 2021

Domain 7 - Activity

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

Indicator description
This indicator is under development.

SPC chart

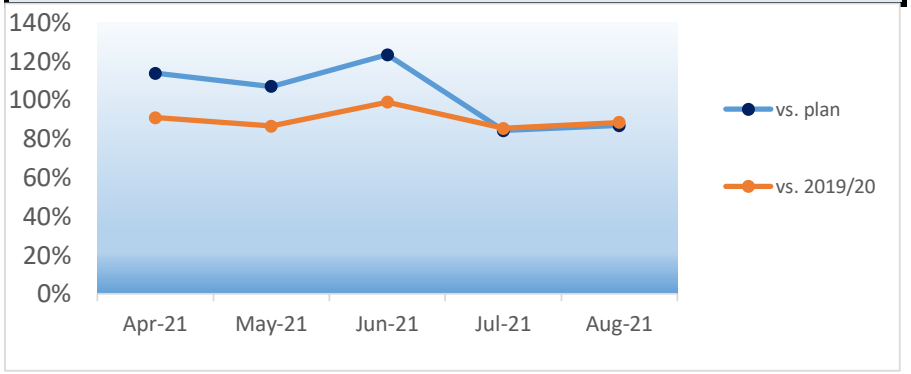
Narrative

Indicator	**7.2 - Outpatient activity (consultant led) against plan and 2019/20 baseline**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Aug-21
Value / RAG rating	86.7% / 88.3%

Indicator description

Outpatient activity (consultant led) against plan and 2019/20 baseline. The data includes new and follow up attendances.

Trend chart



Narrative

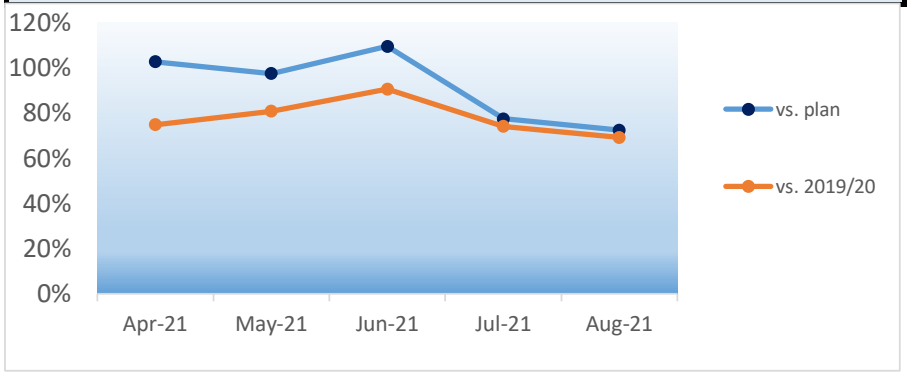
Outpatient activity was 13% below plan in August with both new and follow up attendances at a similar level below plan, meaning the Trust has not delivered the Elective Recovery Fund (ERF) requirements.

Indicator	**7.3 - Elective activity against plan and 2019/20 baseline**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Aug-21
Value / RAG rating	72.3% / 69.1%

Indicator description

Elective activity against plan and 2019/20 baseline. The data includes both elective inpatient and elective day case admissions.

Trend chart



Narrative

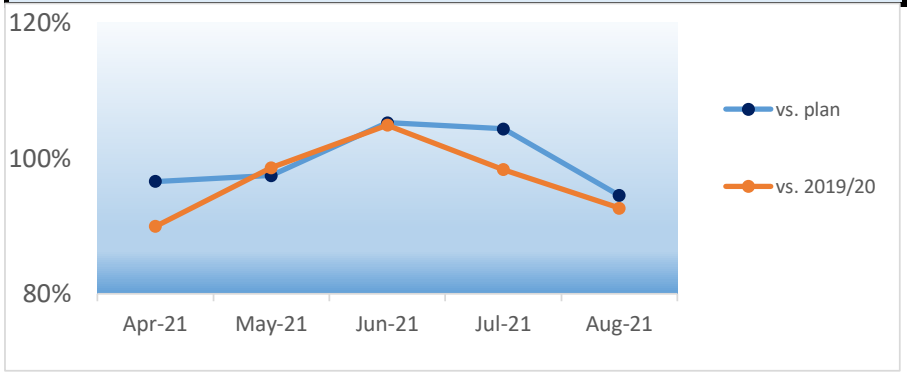
Elective admissions were 28% below plan in August. As a result, the Trust has not delivered the Elective Recovery Fund (ERF) requirements.

Indicator	**7.4 - Non-elective activity against plan and 2019/20 baseline**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Aug-21
Value / RAG rating	94.5% / 92.6%

Indicator description

Non-elective activity against plan and 2019/20 baseline.

Trend chart



Narrative

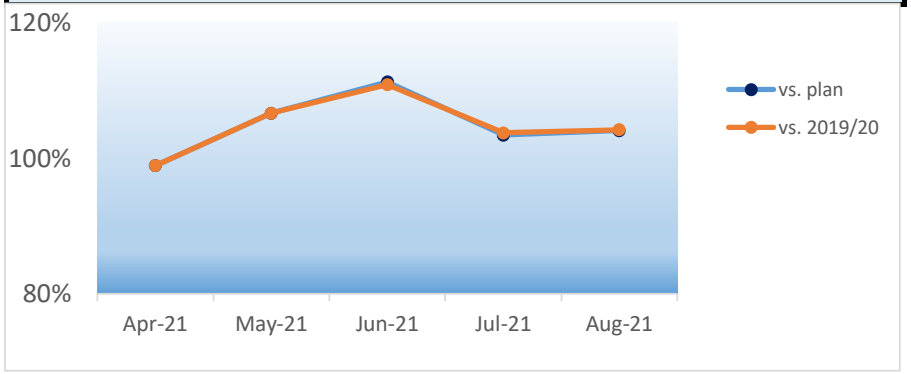
Non-elective activity was 6% below plan in August.

Indicator	**7.5 - Emergency Department attendances against plan and 2019/20 baseline**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Aug-21
Value / RAG rating	104.0% / 104.1%

Indicator description

Emergency Department attendances against plan and 2019/20 baseline.

Trend chart



Narrative

Emergency Department attendances were 4% above plan in August.

Board of Directors (Public)
29th September 2021

Title:	Finance Position September 2021
Responsible Director:	Finance Director
Author:	Finance Director Deputy Director of Finance Head of Financial Management

Purpose of the report and summary of key issues:	The report has been developed to give information and assurance on the financial position as reported as at the end of August 2021. The position includes information on Revenue, Capital and Payment Practice. The Committee is asked to note the contents of the paper.	
BAF Risk:	AIM 1: To be an outstanding place to work	
	BAF1.1 to be an outstanding place to work	x
	BAF1.2 To be an inclusive employer where diversity is celebrated and valued	
	AIM 2: To work with partners to deliver integrated care	
	BAF2.1 To improve population health and wellbeing, provide integrated care and to support primary care	
	BAF2.2 To be an active partner in population health and the transformation of health inequalities	
	AIM 3: To deliver high quality care	
	BAF3.1 and 3.4 To provide outstanding care and outstanding patient experience	
	BAF3.2 To provide a high quality service	x
	BAF3.3 To provide high quality care to children and young people in adults community services	
	BAF3.5 To provide high quality public health 0-19 services	
	AIM 4: To ensure clinical and financial sustainability	
	BAF4.1 To continually improve services we provide to our population in a way that are more efficient	x
	BAF4.2 and 4.3 To provide high quality care and to be a financially sustainable organisation	x
	BAF4.4 To be financially stable to provide outstanding quality of care	x
Corporate Risks	No Change	
Report History:	Information within the reported is supported by Directorate Board discussions, and the monthly Resource Review sessions.	
Recommendation:	The Board is asked to note and discuss the contents of this report.	

4.1 Director of Finance Report

Harrogate and District NHS Foundation Trust

Matters of concern & risks to escalate

- There continue to be a number of areas of pressure that are being offset by underspends in relation to activity delivery and the 0-19 service vacancies
- The wards are overspent against current establishment
- There remains slippage within our capital programme, which continues to be forecast
- Allocation for H2 expected in September, and our run rate is higher currently than at the end of 2019/20, which we will need to manage and reduce

Major actions commissioned & work underway

- Options development for H2 planning
- Finalise the ward establishments & funding
- Executive team review and challenge of Capital Slippage following Capital Oversight Group Options Review.

Positive news & assurance

- Delivery of the financial plan to date and forecast delivery for H1
- Ward establishments partially finalised with agreement on registered nursing and bed numbers per ward. Currently being updated on ledger and Allocate
- National Costing submission has been completed, output of which will be available in coming months. This will inform updates to model hospital and other benchmarking

Decisions made & decisions required of the Board

- Following last months session agreement has been reached on targets for productivity programme

6.3 Director of Finance Report

Harrogate and District NHS Foundation Trust

Matters of concern & risks to escalate

- There continue to be a number of areas of pressure that are being offset by underspends in relation to activity delivery and the 0-19 service vacancies
- The wards are overspent against current establishment
- There remains slippage within our capital programme, which continues to be forecast
- Allocation for H2 expected in September, and our run rate is higher currently than at the end of 2019/20, which we will need to manage and reduce

Major actions commissioned & work underway

- Options development for H2 planning
- Finalise the ward establishments & funding
- Executive team review and challenge of Capital Slippage following Capital Oversight Group Options Review.

Positive news & assurance

- Delivery of the financial plan to date and forecast delivery for H1
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- National Costing submission has been completed, output of which will be available in coming months. This will inform updates to model hospital and other benchmarking

Decisions made & decisions required of the Board

- Following last months session agreement has been reached on targets for productivity programme

Board of Directors (Public)
29th September 2021

Title:	Operational Performance Update
Responsible Director:	Chief Operating Officer
Author:	Chief Operating Officer

Purpose of the report and summary of key issues:	To inform the Trust Board of the month 5 position regarding operational performance	
BAF Risk:	AIM 1: To be an outstanding place to work	
	BAF1.1 to be an outstanding place to work	
	BAF1.2 To be an inclusive employer where diversity is celebrated and valued	
	AIM 2: To work with partners to deliver integrated care	
	BAF2.1 To improve population health and wellbeing, provide integrated care and to support primary care	X
	BAF2.2 To be an active partner in population health and the transformation of health inequalities	X
	AIM 3: To deliver high quality care	
	BAF3.1 and 3.4 To provide outstanding care and outstanding patient experience	X
	BAF3.2 To provide a high quality service	X
	BAF3.3 To provide high quality care to children and young people in adults community services	X
	BAF3.5 To provide high quality public health 0-19 services	X
	AIM 4: To ensure clinical and financial sustainability	
	BAF4.1 To continually improve services we provide to our population in a way that are more efficient	X
	BAF4.2 and 4.3 To provide high quality care and to be a financially sustainable organisation	X
	BAF4.4 To be financially stable to provide outstanding quality of care	
Report History:	Monthly Trust Board Update	
Recommendation:	It is recommended that Trust Board note the items contained within this report.	

Harrogate and District NHS Foundation Trust

Trust Board- Operational Update

September 2021

Russell Nightingale
Chief Operating Officer

Operational Update September 2021 (August Performance)

NHS Harrogate and District

Matters of concern & risks to escalate

- Elective recovery: No weekend working uptake and limited evening work underway combined with holiday and theatre staffing gaps highlight a difficult August position in number of theatre lists running *(7.3.1)*
- 176 elective theatres lists ran out of a possible 224 (78.5%) lost lists primarily due to theatre staffing across August
- Two week wait cancer performance – 86% performance against target, trajectory still on track for September achievement *(5.1)* main issues now in Urology due to sickness and annual leave.
- Referral to treatment waiting list continued to increase in August as the Trust continued at full capacity (whilst maintaining social distancing) to stem increased referral demand - longer waits in T&O, Ophthalmology and Community Dental
- Referral to treatment 92nd centile is 40 weeks *(5.1.3)*
- Demand for new outpatient ECHO has increased by 37% based on 2019 demand c.70 referrals *(5.3)*

Major actions commissioned & work underway

- ED Front Door trial continues at weekends for the month of September
- Children's and Community directorate – workforce actions and tracking of pressures, 0-19 Band 6 roles are currently experiencing a 8.4% vacancy rate. Combined with an increase in referrals, Trust wide support is starting to mitigate in short term
- Additional community dental sites to be AGP enabled and scheduling process now in place, robust 6-4-2 model now rolled out and performance increasing
- York independent sector capacity links established, 90 patients in total sent from HDFT
- Amending Paediatric Yorkshire Ambulance Service boundary to support LTHT, discussion regarding 111 change also
- Byland ward refurbishment now underway due to finish in September
- Inaugural Operational Away day 10/09/21 to set operational priorities with team has concluded
- Continuing to support LTHT and YTH with Endoscopy demand c.150 patients per month
- Providing System aid to York as it continues to declare OPEL 3 / 4

Positive news & assurance

- Cancer 62 day wait target achieved at 91.2% *(5.9.1)*
- Cancer 28 days faster diagnosis standard achieved at 80.2% *(5.11)*
- 52+ weeks continue to reduce ahead of trajectory at 932 patients *(5.1.4)*
- 4-hour ED performance – August performance increased to 80.4%, continued increase in presentations, 8% above 2019/20 levels, incorrect front door model. New model trialled from 16/07, initial data collection highlighting positive improvements. Benefits realisation for model to SMT in September *(5.6)*
- Job description for Primary Care Practitioner (GP) written and advertised with 3 applicants. Interviews planned for September
- 2ww Breast patients now booking under two weeks *(5.1)*
- Zero 12-hour breaches and 1 x 60 minute ambulance breach in August *(5.8)*
- Complex Community Dental 52-week recovery ahead of recovery trajectory *(5.1.4)*
- Selby UTC/ Ripon MIU CQC Urgent and Emergency Care Survey outcome - "Better than Expected"

Decisions made & decisions required of Trust Board

- ARCHS increased 35 patient bed model in the community approved at resource committee
- All new HDH GP Out of Hours posts to be advertised with the ED element included in the job description to widen the workforce pool
- Urgent Care Practice Educator has developed a training programme to be run in conjunction with an external training course to develop ENPs into Urgent Care Practitioners (UCP). This will widen their scope of practice and enable them to work in both the urgent care stream and as the front door streamer

Children's and Community

Harrogate and District NHS Foundation Trust

Community Dental Services

Performance Information	Current	Last Week
Current Waiting List Size:	2,500	2,464
No. Waiting for 1st Appointment:	1,510	1,487
No. Waiting for Outpatient Treatment:	751	744
No. Waiting for GA Treatment:	237	233
Longest Waiter:	114	113
Average Weekly Referrals:	59	65
Weekly Outpatient Capacity:	93	93
Weekly GA Capacity:	10	10
Outpatient Backlog Clearance Time (Weeks):	25	25
GA Backlog Clearance Time (Weeks):	24	23

Community 0-19 Services

Section	Performance Indicator Description	Apr	May	Jun	Q1	Jul
Community services	Health Visiting – % of infants receiving a new born visit within 14 days of birth - **North Yorkshire**	92.6%	90.3%	92.3%	**91.7%**	94.0%
	Health Visiting – % of infants receiving a new born visit within 14 days of birth - **Durham**	96.1%	96.0%	96.3%	**96.1%**	97.6%
	Health Visiting – % of infants receiving a new born visit within 14 days of birth - **Darlington**	91.1%	97.6%	97.2%	**95.3%**	93.8%
	Health Visiting – % of infants receiving a new born visit within 14 days of birth - **Middlesbrough**	96.4%	97.4%	92.7%	**95.5%**	95.8%
	Health Visiting – % of infants receiving a new born visit within 14 days of birth - **Stockton**	89.4%	89.7%	92.4%	**90.5%**	93.3%
	Health Visiting – % of infants receiving a new born visit within 14 days of birth - **Gateshead**	96.5%	96.2%	97.9%	**96.9%**	98.8%
	Health Visiting – % of infants receiving a new born visit within 14 days of birth - **Sunderland**	98.9%	99.6%	98.3%	**98.9%**	96.2%
	% of 2-2.5 year reviews completed by the time child turns 2.5 years - **North Yorkshire**	82.6%	85.6%	91.9%	**86.7%**	90.9%
	% of 2-2.5 year reviews completed by the time child turns 2.5 years - **Durham**	90.1%	87.6%	90.4%	**89.4%**	89.8%
	% of 2-2.5 year reviews completed by the time child turns 2.5 years - **Darlington**	97.8%	98.9%	98.8%	**98.5%**	94.9%
	% of 2-2.5 year reviews completed by the time child turns 2.5 years - **Middlesbrough**	97.3%	94.9%	94.1%	**95.4%**	94.2%
	% of 2-2.5 year reviews completed by the time child turns 2.5 years - **Stockton**	92.9%	94.4%	91.8%	**93.0%**	90.5%
	% of 2-2.5 year reviews completed by the time child turns 2.5 years - **Gateshead**	95.0%	97.1%	97.2%	**96.4%**	95.5%
	% of 2-2.5 year reviews completed by the time child turns 2.5 years - **Sunderland**	97.8%	97.7%	94.5%	**96.7%**	95.9%
	Community Podiatry - % patients seen within 18 weeks	98.9%	99.5%	99.0%	**99.1%**	99.4%

July OPEL Level – 2

<u>0-19 Services</u>
Flexibility given to 0-5 services around delivery of universal visits as part of recovery & safeguarding pressures.
Despite this delivery remains strong across all contract areas.

<u>Safeguarding</u>
The volume of safeguarding strategies involving 0-19 teams remains high, impacting on capacity within these teams to deliver their preventative role.

<u>Community Dental</u>
Due to historical mismatch between capacity and demand, exacerbated by the loss of capacity due to CV19, community dental has a significant volume of patients waiting over 52 weeks. Plans in place to link with clinical teams across HCV to embed best practise

<u>Adult Community Nurse Staffing</u>
Increased complexity of care being referred to service
All teams working at or above capacity
23% vacancy gap over summer period
Incentivising shifts with NHSP over summer
Approved case to support increase in B7

Planned Care Recovery

Harrogate and District NHS Foundation Trust

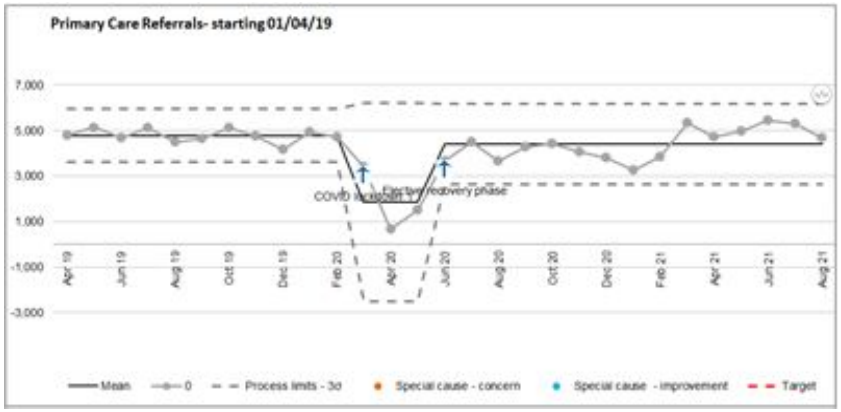
	Apr-21					May-21					Jun-21					Jul-21					Aug-21						Sep-21					
Point of Delivery	Apr Actual	Apr Plan	Apr 2019/20	% Booked vs Plan	% Booked vs 19/20	May Actual	May Plan	May 2019/20	% Booked vs Plan	% Booked vs 19/20	Jun Actual	Jun Plan	Jun 2019/20	% Booked vs Plan	% Booked vs 19/20	01-31 Jul Actual	Jul Plan	Jul 2019/20	% Booked vs Plan	% Booked vs 19/20	01-31 Aug Actual	Adtnl	Aug Plan	Aug 2019/20	% Booked vs Plan	% Booked vs 19/20	01-11 Sep Actual	12-30 Sep Booked	Sep Plan	Sep 2019/20	% Booked vs Plan	% Booked vs 19/20
Total Outpatients	**13,099**	**11,526**	**14,433**	**114%**	**91%**	**13,006**	**12,246**	**15,136**	**106%**	**86%**	**14,483**	**11,850**	**14,793**	**122%**	**98%**	**13,907**	**15,798**	**16,268**	**88%**	**85%**	**11,981**	**150**	**13,175**	**13,534**	**92%**	**90%**	**4,155**	**10,453**	**15,177**	**14,868**	**96%**	**98%**
New Outpatients (Cons Led)	4,294	3,823	4,849	112%	89%	4,326	3,924	4,973	110%	87%	4,950	4,004	5,007	124%	99%	4,616	5,216	5,556	88%	83%	3,961	50	4,243	4,557	95%	88%	1,292	3,366	5,065	5,103	92%	91%
Follow Up Outpatients (Cons Led)	8,805	7,703	9,584	114%	92%	8,680	8,322	10,163	104%	85%	9,533	7,846	9,786	122%	97%	9,291	10,582	10,712	88%	87%	8,020	100	8,932	8,977	91%	90%	2,863	7,087	10,112	9,765	98%	102%
Elective Daycases (excl endoscopy)	1,502	1,495	1,797	100%	84%	1,608	1,633	1,896	98%	85%	1,715	1,427	1,649	120%	104%	1,591	1,661	1,855	96%	86%	1,502	0	1,585	1,779	95%	84%	548	887	1,545	1,663	93%	86%
Elective day case endoscopy	657	617	1,099	106%	60%	809	848	1,079	95%	75%	775	829	1,055	93%	73%	738	1,133	1,201	65%	61%	660	0	1,159	1,226	57%	54%	223	483	1,162	1,180	61%	60%
Elective Daycase Total	**2,159**	**2,112**	**2,896**	**102%**	**75%**	**2,417**	**2,481**	**2,975**	**97%**	**81%**	**2,490**	**2,256**	**2,704**	**110%**	**92%**	**2,329**	**2,794**	**3,056**	**83%**	**76%**	**2,162**	**0**	**2,744**	**3,005**	**79%**	**72%**	**771**	**1,370**	**2,707**	**2,843**	**79%**	**75%**
Elective Inpatients	**196**	**185**	**253**	**106%**	**77%**	**222**	**229**	**297**	**97%**	**75%**	**239**	**226**	**293**	**106%**	**82%**	**191**	**322**	**353**	**59%**	**54%**	**207**	**0**	**260**	**290**	**80%**	**71%**	**74**	**66**	**255**	**274**	**55%**	**51%**
Non Elective IP	**1,773**		**1,967**		**90%**	**1,953**		**1,981**		**99%**	**1,979**		**1,888**		**105%**	**2,079**		**2,115**		**98%**	**1,831**			**1,976**						**2,034**		

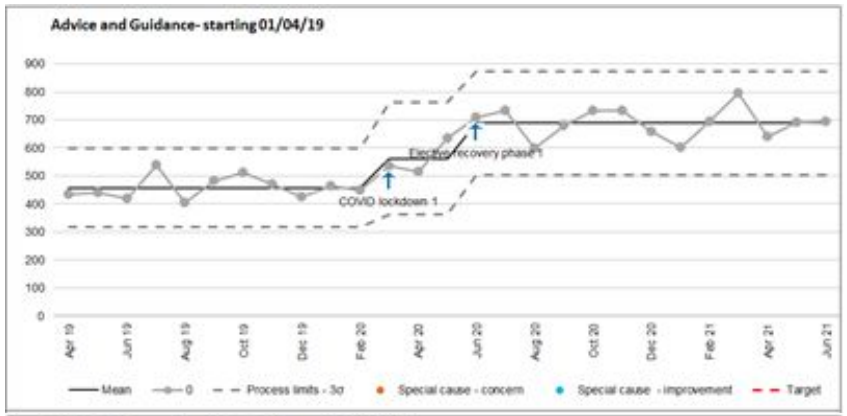
Apr 2021 v Plan	>=95%	80-94%	<80%			May 2021 v Pla	>=95%	80-94%	<80%			Jun 2021 v Plan	>=95%	80-94%	<80%			Jul 2021 v Plan	>=95%	80-94%	<80%			Aug 2021 v Plan	>=95%	80-94%	<80%			Sep 2021 v Plan	>=95%	80-94%	<80%
Apr 2021 v 2019/	>=70%	60-69%	<60%			May 2021 v 20	>=75%	60-74%	<60%			Jun 2021 v 2019	>=80%	65-79%	<65%			Jul 2021 v 1019	>=95%	80-94%	<80%			Aug 2021 v 2019	>=95%	80-94%	<80%			Sep 2021 v 2019	>=95%	80-94%	<80%

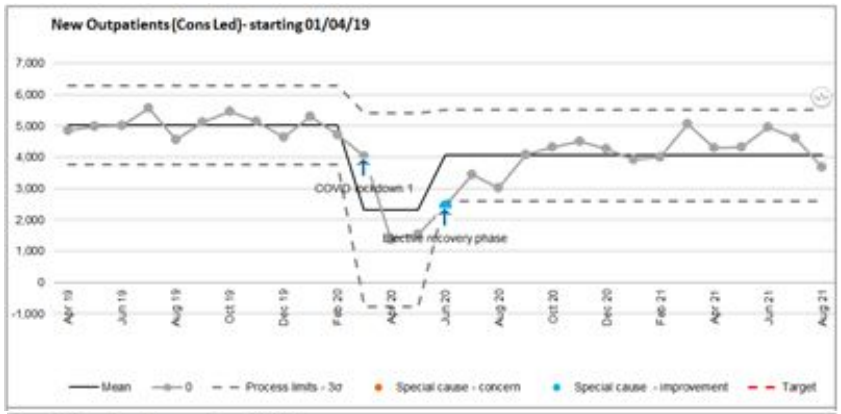
- All points of delivery are above the Elective Recovery Fund requirement of 70%, 75% and 80% for Q1
- Q2: July and August activity was below plan and the increased ERF target of 95% on all points of delivery
- To mitigate the WLI changes and annual leave rollover dynamic, clinical sessions are in place to ensure most clinically pressured activity is covered
- The Trust increased beds on the Elective Surgical Unit remain in place to help mitigate increased activity levels
- The 5th room to support capsule endoscopy remains operational and Endoscopy lists are available seven days per week, there is currently a reduction in demand for Endoscopy, so HDFT continue to support LTHT and YTH with endoscopy work c.150 patients per month to increase activity levels
- Outpatient forecast for September is on plan, increasing elective admissions continues to be the main focus, 12-week dedicated project support in theatres commencing in October

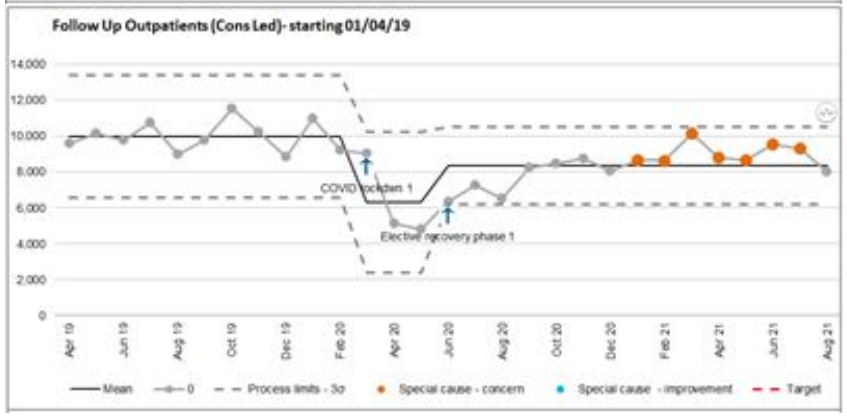
Elective Recovery

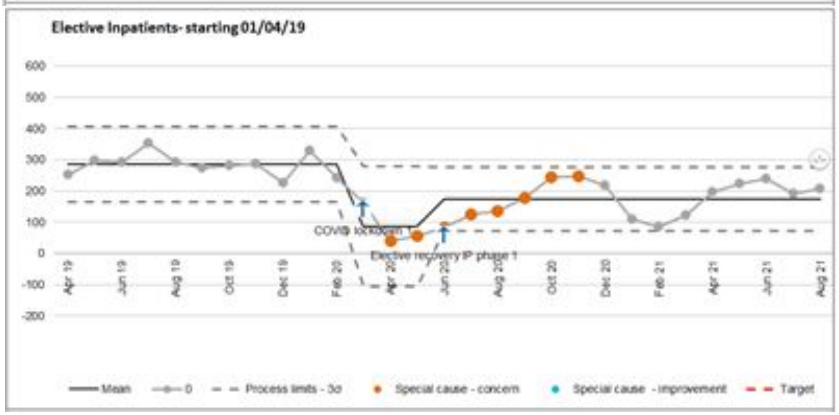
NHS
Harrogate and District
NHS Foundation Trust

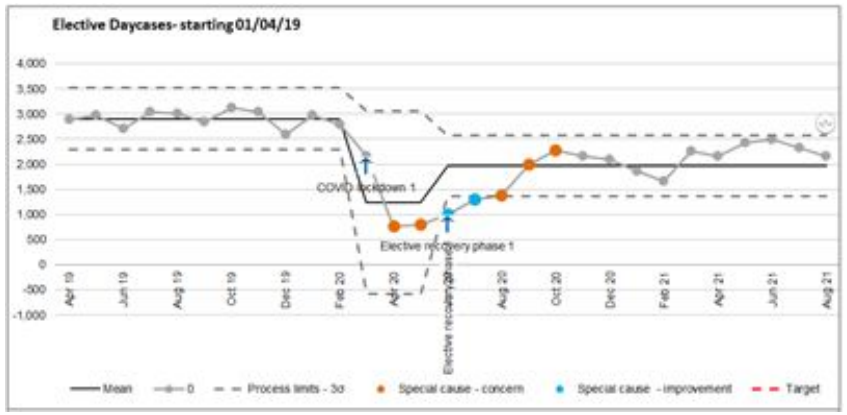






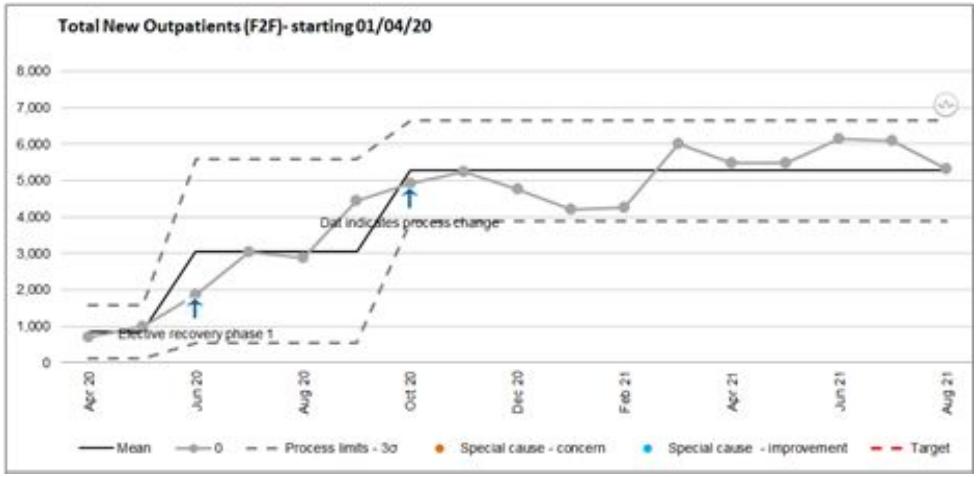


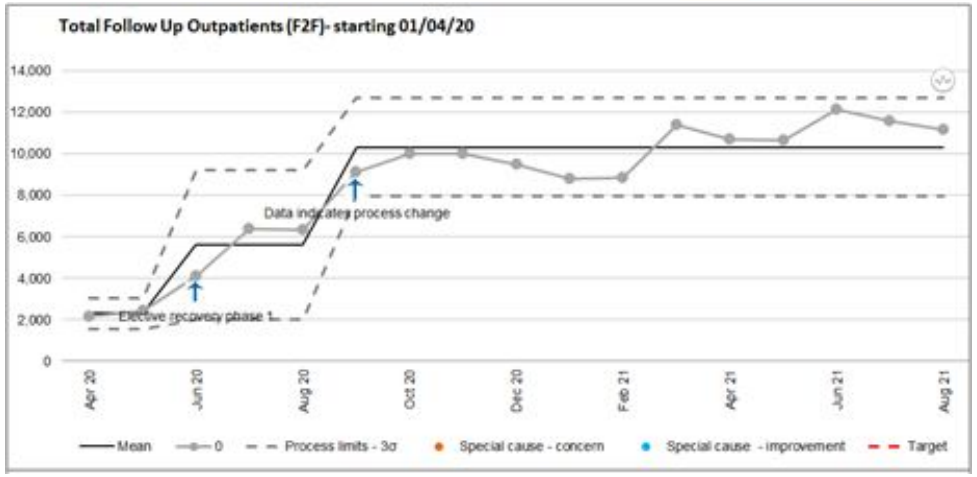


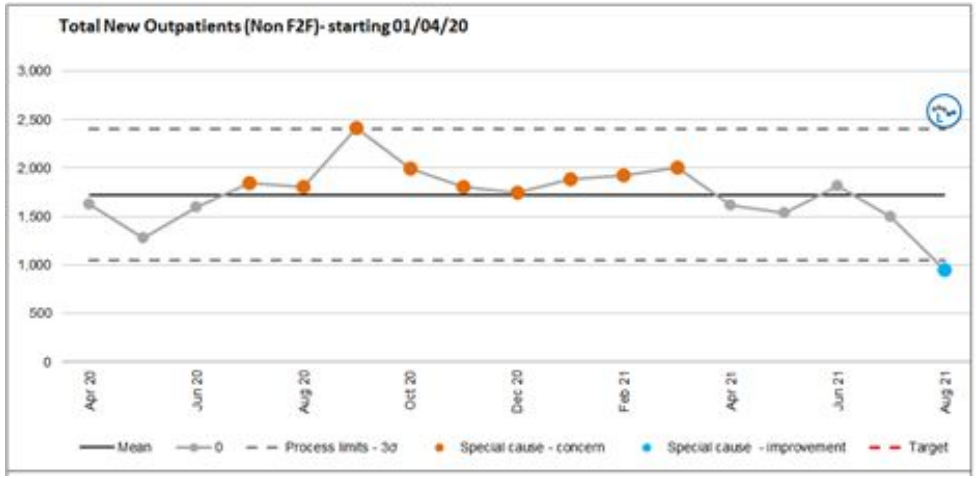


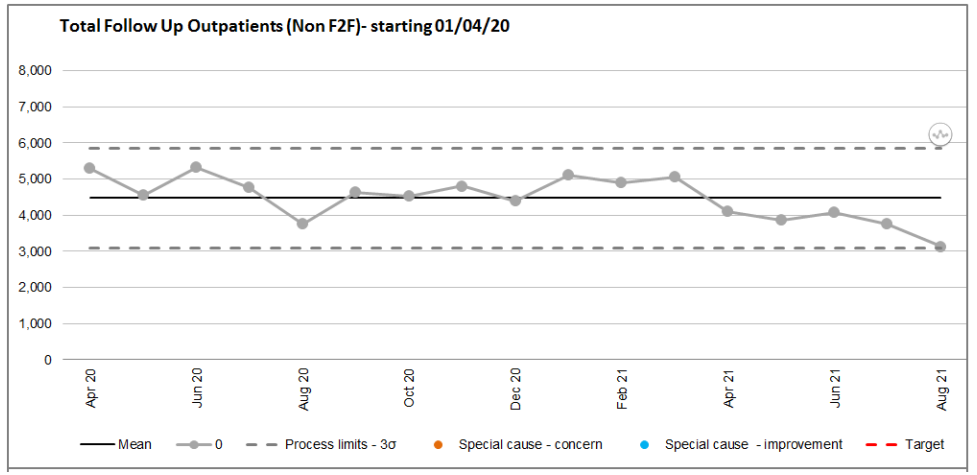
Elective Recovery

Harrogate and District NHS Foundation Trust







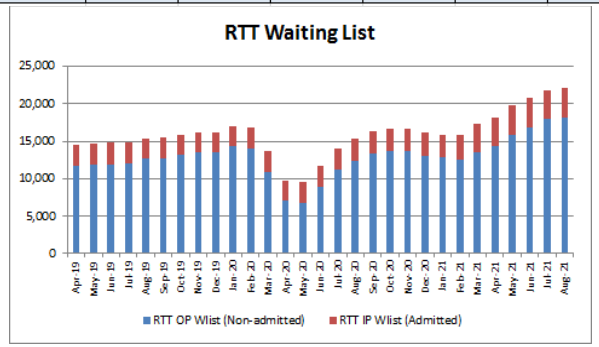


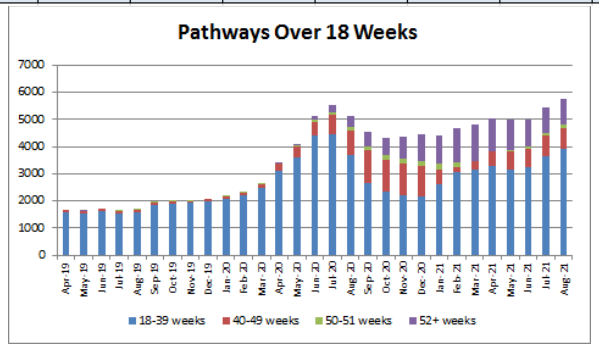
- Total outpatient activity decreased in August to levels achieved in April and May, reflecting annual leave and challenges relating to staffing. Attendances were below plan and the increased ERF target of 95%
- Non face to face outpatient attendances have reduced since March, August attendances have reduced following June's increase, year-to-date position 24%. This features and is discussed in the weekly Access meeting and the Outpatient Transformation programme team is working closely with services to increase where appropriate
- Elective admissions reduced in August however have remained above the mean level since April.
- Elective theatres now fully up and running however staffing remained challenging throughout August as a result of sickness and staff isolating
- Theatres and Endoscopy staff have now returned to elective sessions
- Focus remains on stepping levels of activity back up to 2019/20 levels

Referral to Treatment (RTT)

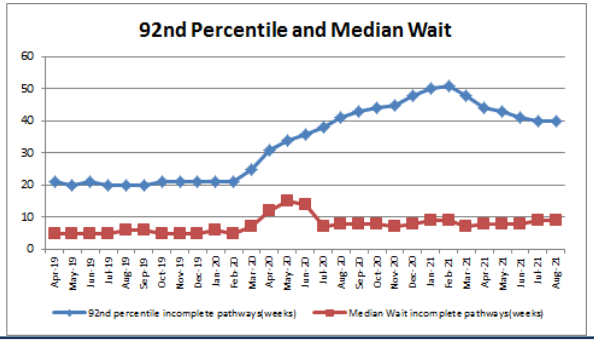
NHS Harrogate and District NHS Foundation Trust

	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
No. of pathways 18-39 weeks	3,101	3,627	4,418	4,463	3,699	2,674	2,342	2,224	2,185	2,615	3,047	3,173	3,310	3,168	3,255	3,657	3,922
No. of pathways 40-49 weeks	270	397	498	709	910	1,216	1,186	1,145	1,120	527	211	299	521	666	644	735	748
No. of pathways 50-51 weeks	17	32	67	74	106	138	168	208	179	219	155	11	21	62	91	90	127
No. of pathways 52+ weeks	18	53	139	293	421	524	639	789	974	1,075	1,268	1,345	1,201	1,087	1,006	988	955
Total >18weeks	3,406	4,109	5,122	5,539	5,136	4,552	4,335	4,366	4,458	4,436	4,681	4,828	5,053	4,983	4,996	5,470	5,752
Total RTT List	9,754	9,593	11,659	14,039	15,345	16,379	16,730	16,733	16,197	15,877	15,878	17,323	18,182	19,746	20,631	21,785	22,168





Weeks Band	Not Rec	P1A	P1B	P2	P3	P4	P5	P6	Total
0-2	314	0	1	79	133	228	0	0	755
3-4	57	0	0	48	102	156	0	0	363
5-6	20	0	0	22	97	161	0	0	300
7-8	2	0	0	29	97	161	0	0	289
9-10	0	0	0	14	92	167	0	0	273
11-12	1	0	0	6	50	161	0	0	218
13-14	1	0	0	2	30	145	0	0	178
15+	0	0	0	11	311	1,984	4	0	2,310
Total	395	0	1	211	912	3,163	4	0	4,686

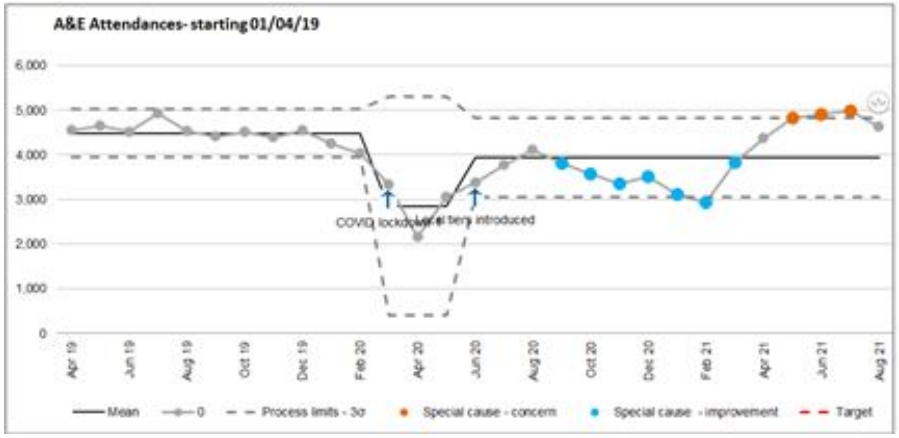


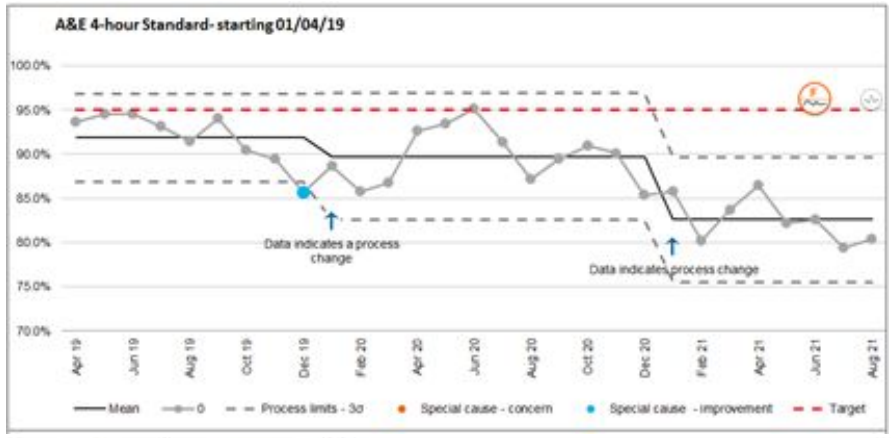
RTT - The Trust had 22,168 patients waiting at the end of August, this is an increase of 377 patients on the July position.
There are 955 patients waiting over 52 weeks, this is below the trajectory of 1,058 and a 3.3% decrease from the July position.
The 92nd centile and median wait in August remains at 40 weeks and 9 weeks respectively highlighting grip on the scheduling process.
Of the 4,686 patients waiting for a procedure, 37% are Orthopaedics, 19% General Surgery and 12% Ophthalmology.

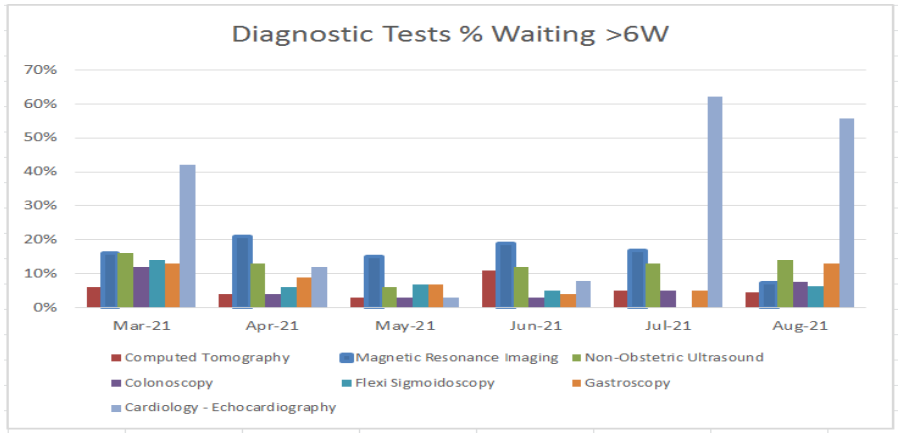
Clinical Prioritisation & Review - Clinical prioritisation and review continues for elective patients, 98.5% of patients waiting having been allocated a P1-6 national classification. The majority of those yet to be classified (314/395) have been waiting <=2 weeks and work is progressing to ensure these are rapidly coded. This information is tracked weekly at the Access meeting.

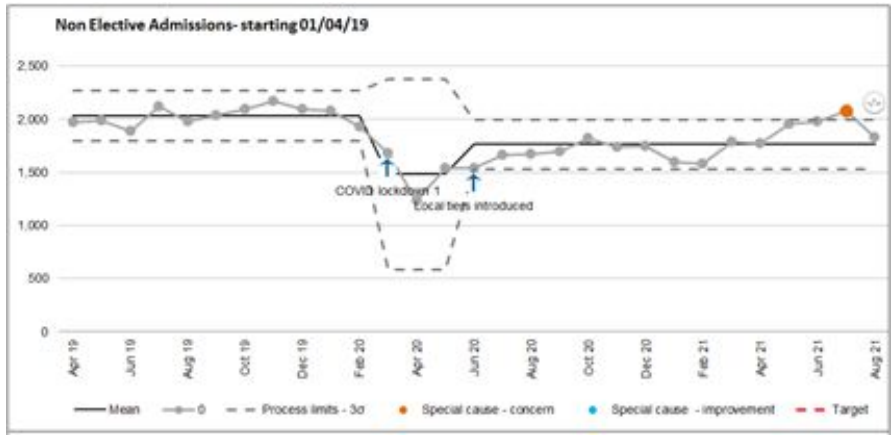
87.6% of P2 patients have been waiting less than 28-days and there is still a large element of patient choice owing to Covid-19. An RCA is completed for every patient not booked within the required time parameters with a subsequent harm review if a breach.

Urgent Care and Diagnostics





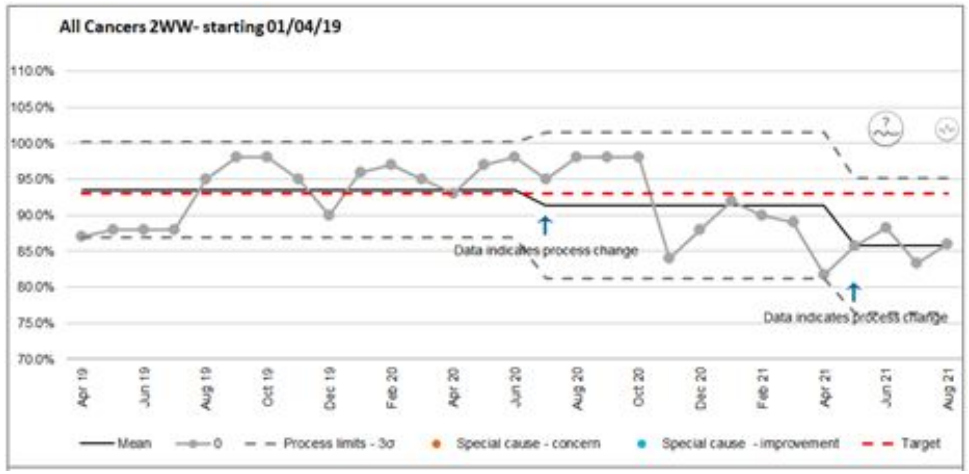


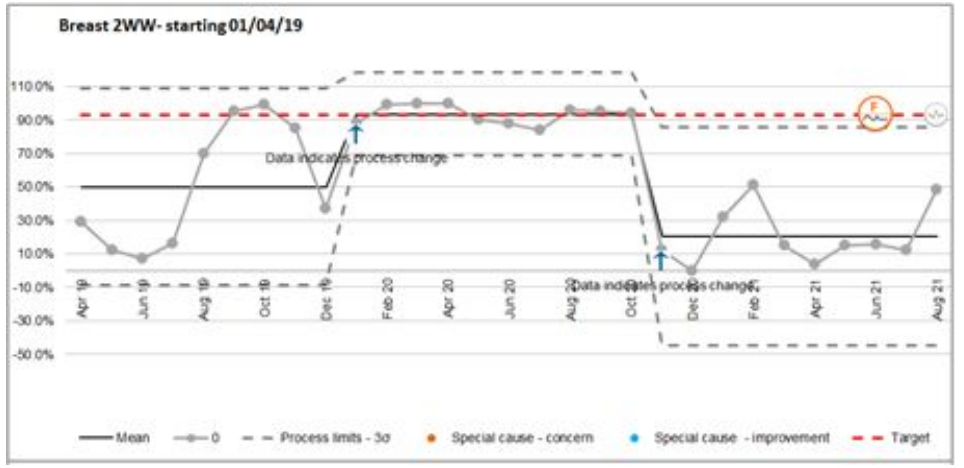


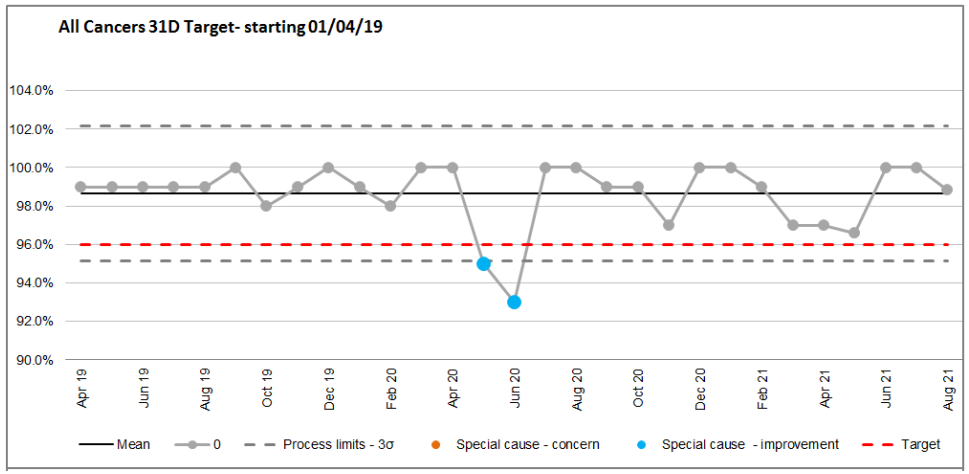
- Performance against the A&E 4-hour standard remained below 95% in August at 80.4%. The 95th percentile wait was 6-hours 43- minutes.
- There were zero 12 hour breaches in August.
- There were 20 x 30-minute handover breaches and 1 x 60-minute ambulance handover breach in August
- ED attendances have continued to increase since February of this year (8% growth YoY), with attendances being above the process limits and 2019/20 levels since May, this continues to be a real challenge to flow through the department.
- The Kaizen ED action plan continues to be worked through with piloting of processes showing positive results
- A UEC dashboard enables monitoring of ED flow and performance to increase visibility.
- Diagnostic waits beyond 6-weeks continue to decrease with focus maintained on reducing the backlog, with the exception of Echocardiography that has 45 patients waiting beyond 6-weeks owing to an increase in demand.

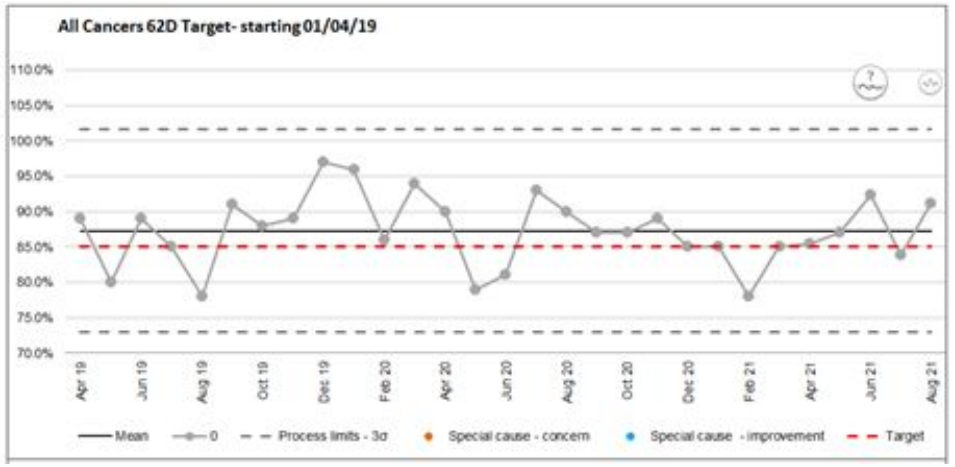
Cancer

NHS
Harrogate and District
NHS Foundation Trust









- The 62-day standard was met in August with a performance of 91%
- The 2-week wait standard was not delivered with a performance of 86%
- At the end of August 60 patients remain on an open cancer pathway over 62 days and 6 patients over 104 days. This remains one of the smallest PTL backlogs nationally when adjusted for size, however remains a key area of focus. The main tumour site breaching is colorectal; demand and capacity analysis is underway to understand the shortfall and how to remedy the high breach numbers. The colorectal pathway has now resumed 'straight to test' which was stopped during the C19 pandemic, this should help the position
- The number of breast 2WW and non-cancer related breast symptomatic referrals received continue to be higher than the number of weekly appointment slots available. Additional breast clinic work to improve the position is now underway including outsourcing work to a private service provider with additional clinics in place. The backlog has now been cleared and the team are delivering the standard. Primary 2ww issues now in Urology.

Board of Directors Meeting
29th September 2021

Title:	**Director of Workforce & OD Report**
Responsible Director:	Director of Workforce & OD
Author:	Deputy Director of Workforce & OD

Purpose of the report and summary of key issues:	This report details Organisational Development priorities in terms of:- • Major Actions Commissioned and Actions underway • Positive News and Assurance • Any Matters of Concerns and Risks to Escalate	
BAF Risk:	AIM 1: To be an outstanding place to work	
	BAF1.1 to be an outstanding place to work	x
	BAF1.2 To be an inclusive employer where diversity is celebrated and valued	x
	AIM 2: To work with partners to deliver integrated care	
	BAF2.1 To improve population health and wellbeing, provide integrated care and to support primary care	
	BAF2.2 To be an active partner in population health and the transformation of health inequalities	
	AIM 3: To deliver high quality care	
	BAF3.1 and 3.4 To provide outstanding care and outstanding patient experience	
	BAF3.2 To provide a high quality service	
	BAF3.3 To provide high quality care to children and young people in adults community services	
	BAF3.5 To provide high quality public health 0-19 services	
	AIM 4: To ensure clinical and financial sustainability	
	BAF4.1 To continually improve services we provide to our population in a way that are more efficient	
	BAF4.2 and 4.3 To provide high quality care and to be a financially sustainable organisation	
	BAF4.4 To be financially stable to provide outstanding quality of care	
Corporate Risks	As detailed within the report.	
Report History:	N/A	
Recommendation:	The Board of Directors are requested to receive and accept this report.	

teamHDFT
At our best

NHS
Harrogate and District
NHS Foundation Trust

Board of Directors
Public Board Report
Director of Workforce & Organisational Development

September 2021

1

Director of Workforce and OD Report

Harrogate and District NHS Foundation Trust

Matters of concern & risks to escalate

- **Reciprocal mentoring programme** recruitment underway however uptake is low SMT focus and response required Appendix 2

Major actions commissioned & work underway

- WRES data submitted to NHSE. WRES Annual report and Action Plan prepared and reviewed by People & Culture Committee and SMT. Report attached for approval by the Board prior to external submission.
- WDES data submitted to NHSE. WDES Annual report and Action Plan prepared and reviewed by People & Culture Committee and SMT. Report attached for approval by the Board prior to external submission.
- Gender Pay Gap report prepared and reviewed by People & Culture Committee and SMT. Report attached for approval by the Board prior to external submission.
- Ethnicity Pay Gap report prepared and reviewed by People & Culture Committee and SMT. Report attached for approval by the Board prior to external submission.
- The Inpulse quarterly staff closed on 27 August, with a 14.5% return rate. Results have been sent to line managers and follow-up actions are in place.
- Recruitment to reciprocal mentoring programme is underway.

Positive news & assurance

- NHS Pride week was 6-10 September, and an article was included in our HDFT Bulletin, featuring a video of Steve Russell, speaking about the importance of recognising the immense value our LGBT+ colleagues bring to our services, and emphasising the importance of inclusivity and diversity in 'how we do things around here'.
- Procurement process undertaken and a local organisation called Diverse Mckensie have been secured as our external partner to support our workload.
- Procurement process undertaken to secure our new National Staff Survey Provider – Quality Health – and planning well underway for the launch of our 2021/22 campaign which launches on 27 September an closes on 26 November.
- The West Yorkshire & Harrogate RootOutRacism movement has launched, to which teamHDFT have pledged our support. Our own Becoming An Anti-Racist organisation programme is to be fully aligned and integrated with this movement.
- Single Equality Scheme Strategy due to be ratified at Partnership Forum – 15th September

Decisions made & decisions required of the Board

- (WRES) 2021 Annual Report and Action Plan
- Annual report and Action Plan 2021 (WDES)
- Gender Pay Gap Report
- Ethnicity Pay Gap Report

Board of Directors (Public)
29th September 2021

Title:	**Director of Workforce & OD Report**
Responsible Director:	Director of Workforce & OD
Author:	Deputy Director of Workforce & OD

Purpose of the report and summary of key issues:	WRES 2021 Annual Report and Action Plan In summary the data analysed highlights: • that during recruitment processes the proportion of BME candidates shortlisted and appointed do not mirror the proportion of BME applicants for a fair recruitment process. The data indicates, that of all the applicants, 59% are white and 41% are BME, however the split of those who were shortlisted is 77% white to 23% BME, and the split of those who were appointed is 86% white to 14% BME. This data suggests that more white applicants were progressed through the recruitment process. In terms of Harassment, bullying and abuse / Discrimination data, BME employees experience more abuse from patients or service users, or their relatives in comparison to white employees. In addition data reports BME employees have experienced more discrimination in comparison to white employees.	
BAF Risk:	AIM 1: To be an outstanding place to work	
	BAF1.1 to be an outstanding place to work	x
	BAF1.2 To be an inclusive employer where diversity is celebrated and valued	x
	AIM 2: To work with partners to deliver integrated care	
	BAF2.1 To improve population health and wellbeing, provide integrated care and to support primary care	
	BAF2.2 To be an active partner in population health and the transformation of health inequalities	
	AIM 3: To deliver high quality care	
	BAF3.1 and 3.4 To provide outstanding care and outstanding patient experience	
	BAF3.2 To provide a high quality service	
	BAF3.3 To provide high quality care to children and young people in adults community services	
	BAF3.5 To provide high quality public health 0-19 services	
	AIM 4: To ensure clinical and financial sustainability	
	BAF4.1 To continually improve services we provide to our population in a way that are more efficient	
	BAF4.2 and 4.3 To provide high quality care and to be a financially sustainable organisation	
	BAF4.4 To be financially stable to provide outstanding quality of care	
Corporate Risks	As detailed within the report.	

Report History:	N/A
Recommendation:	The Board are requested to note the content of this report.

Board of Directors Meeting
29th September 2021

WRES 2021 Annual Report and Action Plan

1.0 Executive Summary

1.1 HDFT is working to become an anti-racist organisation.

1.2 The report establishes why this is important, explains the journey we have taken so far, describes our ambition and vision, and outlines six areas of focus – with actions for each. The areas of focus are:

1.2.1 Governance
1.2.2 Leadership and Management
1.2.3 Recruitment
1.2.4 Learning and Development (including Induction)
1.2.5 Career Development
1.2.6 Communications

1.3 It concludes with a description of how we will implement the work and the indicators we will monitor to know if it has been successful.

1.4 In summary the data analysed suggests that during recruitment processes the proportion of BME candidates shortlisted and appointed do not mirror the proportion of BME applicants for a fair recruitment process. The data indicates, that of all the applicants, 59% are white and 41% are BME, however the split of those who were shortlisted is 77% white to 23% BME, and the split of those who were appointed is 86% white to 14% BME. This data suggests that more white applicants were progressed through the recruitment process.

1.5 In terms of Harassment, bullying and abuse / Discrimination data, BME employees Experience more abuse from patients or service users, or their relatives in comparison to white employees. In addition data reports BME employees have experienced more discrimination in comparison to white employees.

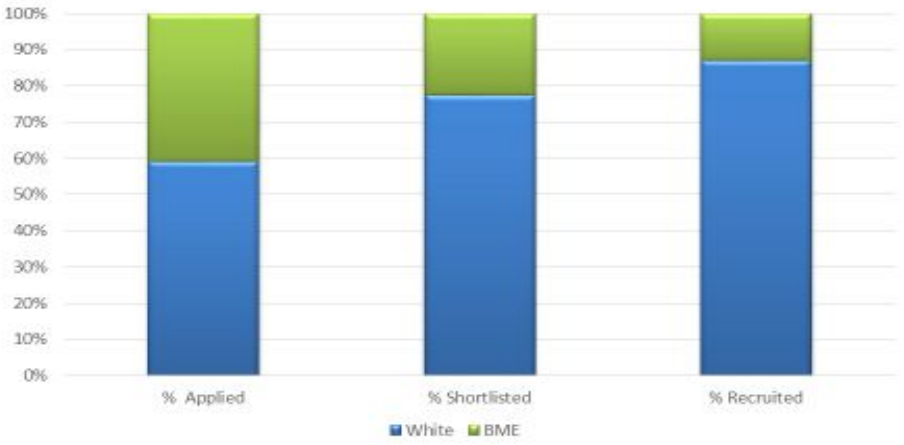
2.0 Introduction: Why are We Doing This?

2.1 HDFT is working to become an anti-racist organisation. This forms part of our ambitious At Our Best programme, which works to improve culture within HDFT, and will help to further embed the behaviours we value around kindness, integrity, teamwork and equality.

2.2 There are overriding moral reasons why we are seeking to become and anti-racist organisation. We also know that diverse teams, where members feel a sense of belonging, are more likely to be able to provide high quality care. There are legal reasons why this is important, too, including our general duty under the Public Sector Equality Duty to have due regard to the need to eliminate discrimination; to advance equality of opportunity; and to foster good relations.

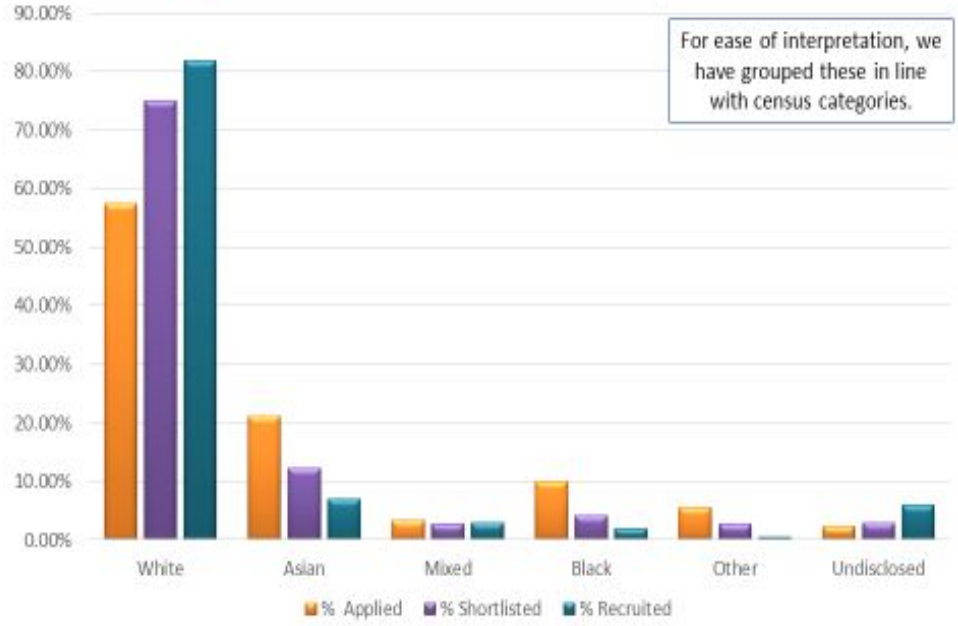
2.3 There is evidence that racism (both direct and indirect) affects people throughout their time with HDFT, starting from the time that they apply to work here. HDFT data shows us that Black, Asian and Minority Ethnic Group (BAME) applicants are less likely to be shortlisted for jobs, and, if shortlisted, then even less likely to be recruited. This is illustrated in the graphs shown over the page:

Snapshot – Recruitment - Inequalities in shortlisting and recruitment



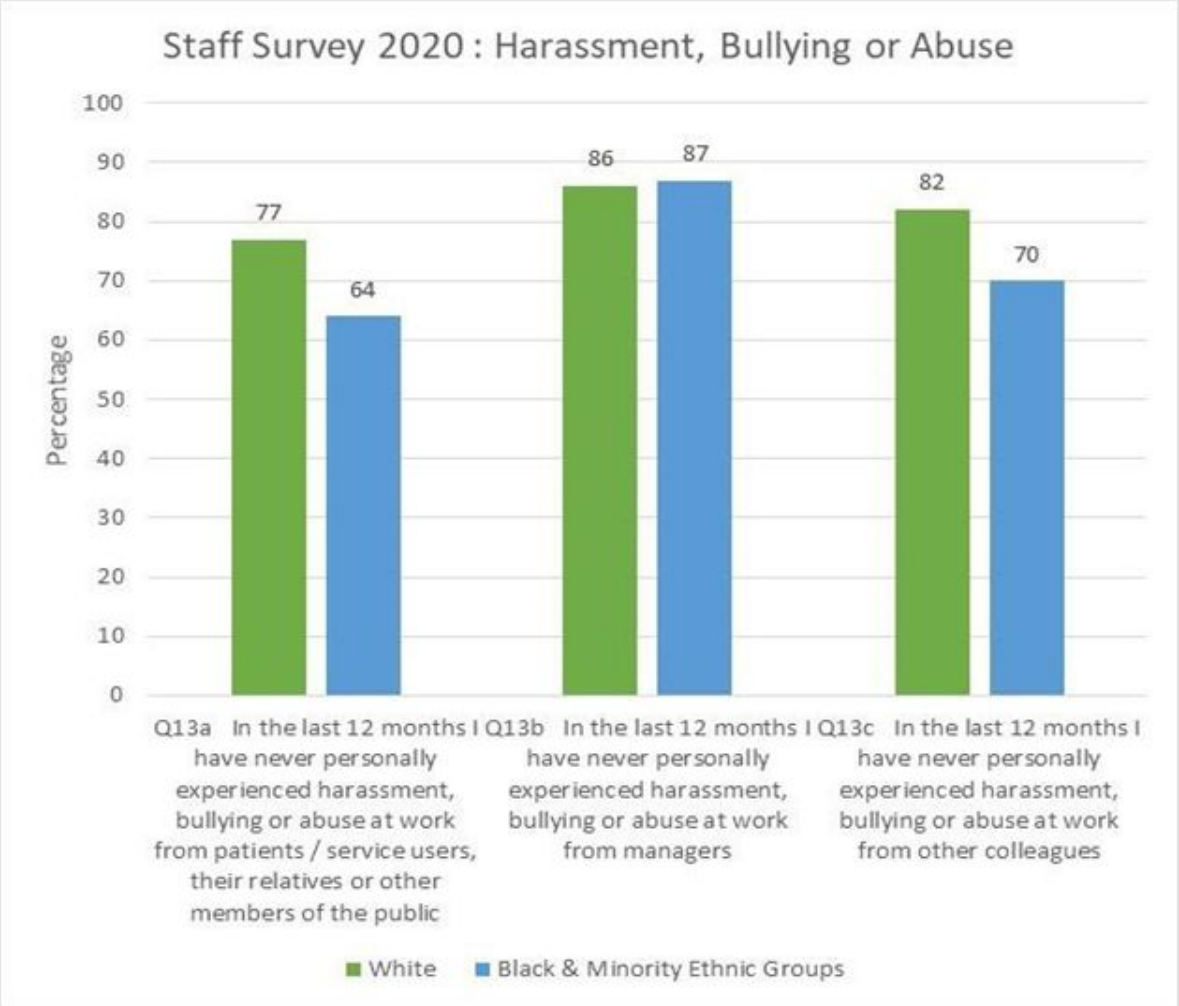
You matter most

Snapshot - Recruitment- Inequalities in shortlisting and recruitment

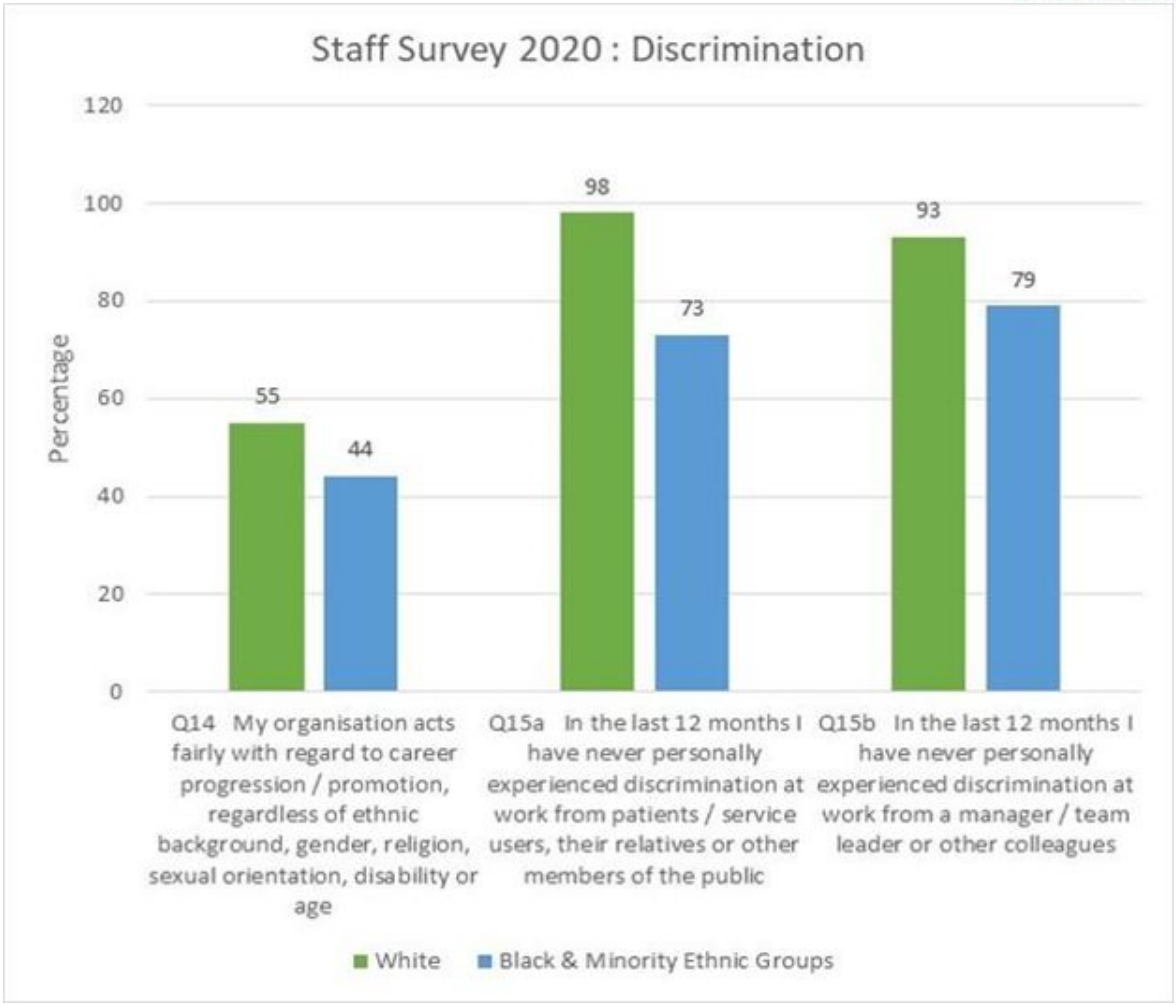


You matter most

2.4 Racism at HDFT goes beyond just recruitment. Colleagues from BAME groups are significantly more likely to experience discrimination as well as harassment, bullying, and abuse from other colleagues as well as from patients, patients' relatives or members of the public. BAME colleagues also experience significantly higher levels of discrimination from managers, team leaders, and other colleagues. You are more likely to experience physical violence as a BAME colleague. This is illustrated in the graph shown below:



2.5 Evidence indicates that less than half of our BAME colleagues (44%) feel that the organisation behaves fairly in relation to remuneration, promotion and career progression compared to white colleagues (55%). These data are further reinforced by the personal experiences of BAME colleagues, some of whom have told us how they have come to expect to face discrimination as part of their work at HDFT. This is illustrated in the graph shown over the page. There is also evidence showing that there is an ethnicity pay gap at HDFT – see Appendix 1 for the HDFT Ethnicity Pay Gap Report – 31.03.21.



2.6 The case for change is not yet widely enough understood at HDFT, with some white colleagues insisting that the unequal experiences had by BAME colleagues "wouldn't happen here". The evidence shows that they do happen here. And they are happening now. The message from the Board of Directors is: "We have to be honest with ourselves: Black, Asian and Minority Ethnic people aren't treated equally, and without ally-ship, and thinking about equality and diversity in everything we do, there will be another moment when we become outraged at an injustice because we haven't made enough change."

3.0 The Journey so far

3.1 In recent years we have fulfilled statutory reporting requirements with regard to our Workforce Race Equality Scheme and Equality Delivery System 2 and delivered related action plans, but this has not achieved the step-change in the reduction of racism which we require. The Workforce Race Equality Scheme Report and Action Plan (shown in Appendix 2) has informed the development of the re-prioritised actions proposed later in this report.

3.2 In late 2019 The EDI Lead role was re-established following a number of years of disestablishment.

3.3 We have an active BAME Staff network which, including allies, now has 59 members. It provides HDFT with a fantastic opportunity to drive forward race equality and to change the lived experiences of its BAME colleagues. The network has had good involvement in meetings and campaigns (e.g. Black History Month, cultural calendar to raise awareness of diversity), and has made links and shared learning with the LGBT+ and Disability networks at HDFT.

3.4 In 2020 equality, diversity and inclusion was identified as a workstream within the Trust's At Our best culture improvement programme. This led to a clear articulation of our ambitions and some key priorities for this agenda, including an aim to become an anti-racist organisation, "a place where we are more than just not racist – we are actively anti-racist… We will gather clear evidence of our progress as an anti-racist organisation and this will set the standards for all other equality, diversity and inclusion agendas."

3.5 This year, work has progressed on making our recruitment processes fairer from the moment the need for a role is identified, through how the job role and person specification is designed to how the job is advertised and how the selection process is managed. These changes are necessary but not sufficient in themselves to address the inequalities currently evident, so work is progressing now to identify bolder, targeted actions that will accelerate the improvements we need in the way we recruit.

3.6 On 31st March 2021, 20 colleagues joined our first Becoming an Anti-Racist Organisation workshop. 52 ideas for strengthening our approach were brought forward and 12 of these progressed on the day. There was particular interest in improving the representation of the voices of BAME colleagues within existing governance structures. Subsequently, colleagues from this workshop were invited to attend the HDFT Board workshop at the Pavilions, Harrogate on 28th April, during their discussion of the Board's role in helping us to become an anti-racist organisation. Powerful personal experiences were shared and contributions to roundtable discussions by BAME colleagues have informed the further development and prioritisation of our plans for this area of work, as set out later in this report – see Appendix 3 for our Equality, Diversity and Inclusion – Vision and Scope.

3.7 A useful model in terms of assessing individual and organisation maturity is shown in Appendix 4.

4.0 Our Ambition

4.1 Truly anti-racist organisations realise that it is not enough for each who work there to say "I am not racist". We need to fully support and engage with the anti-racism movement, and listen to colleagues' experiences in order to learn. More specifically, we will:

4.1.1 Create and secure support for the compelling case for change
4.1.2 Level the differences between BAME and White colleagues in access to employment, progression and remuneration and in their experience of inclusion across Harrogate & District NHS Foundation Trust (HDFT) and Harrogate Integrated Facilities (HIF). Evidence suggests that improving the lived experience of BAME colleagues improves the lived experience for all colleagues regardless of race
4.1.3 Reject cultural stereotypes and standards
4.1.4 Identify and change policies, processes and practices that reinforce race inequalities
4.1.5 We want all colleagues to become allies so that we can all be courageous and bold in speaking up against all racist behaviours and practices and taking action for change
4.1.6 Look to ourselves in understanding how our own behaviours and actions make an impact on anti-racism
4.1.7 Be curious in seeking to see the world through others' perspectives
4.1.8 Look after our people so that we all feel that we belong to teamHDFT and teamHIF
4.1.9 The impact of race-related micro-aggressions is understood by all and reduced to zero
4.1.10 Reduce racism from colleagues and patients/ service users to zero.

5.0 5 year Vision

5.1 By 2026, TeamHDFT will know we are taking steps towards achieving our ambition of being an anti-racist organisation when:

5.1.1 There is a 30% improvement in BAME colleagues progressing from short list to securing employment, meaning over 100 additional BAME colleagues work for teamHDFT.
5.1.2 A BAME colleague sits on all recruitment panels for roles at band 8a and above.
5.1.3 Through the Listening At Our Best programme, BAME colleagues feel confident that their voice is heard. They feel able to bring their whole selves to work and have a strong sense of belonging at teamHDFT.
5.1.4 There is no glass ceiling for BAME colleagues preventing their career progression at teamHDFT, for example, SAS Grade Doctor securing Consultant level and Band 5 nurses being able to progress through Bands 6 and 7.
5.1.5 BAME colleagues work in a least 10% of Band 8a and above roles.
5.1.6 Cultural diversity is evident through our communications, celebrations and daily catering provision. The physical environment accommodates different cultural needs.
5.1.7 Direct racism is a "never" event; indirect racism is something allies are working to eliminate.

6.0 What will we do next?

6.1 At the Becoming an Anti-Racist Organisation workshop in March, conversation repeatedly returned to the six areas that participants felt would make the biggest difference to anti-racism. These went on to be considered by the Board. Informed by work to date, our current equalities performance, learning from what other organisations have done to tackle racism, and discussions in the two workshops mentioned, below is a proposal for the top 20 actions that should be prioritised in each of these areas in Year 1.

Action	What difference will it make?	Who?	When?
Governance			
1. Include anti-racism performance/ progress on **directorate Boards and HIF Board agendas**.	Ensures that teams are regularly discussing their work on anti-racism. Helps to address the problem that some colleagues "don't quite get it."	Jonathan Coulter, Kat Johnson, Matt Shepherd, Natalie Lyth	July 2021
2. **Protected time for BAME colleagues** who wish to participate in events, networks and meetings.	Being "on shift" is currently cited by some colleagues as a barrier to their involvement. Ensures that BAME colleagues who wish to participate in and/or influence work on anti-racism are supported by their line manager to do so.	Angela Wilkinson and Executive Committee	July 2021
3. **Representation from BAME colleagues in key decision-making forums**, including where temporary incident command arrangements are in place.	Diverse groups make better decisions. Diverse organisations are more likely to deliver higher quality of care and achieve better patient/ service user outcomes.	Jackie Andrews, Claire Jones, Lynn Hughes	October 2021
4. **Create an Equality, Diversity and Inclusion Guardian and a Steering Group** to guide the work.	To further raise the profile of the work at HDFT meets the national NHS requirement to have an EDI guardian and to provide consistent direction on the EDI agenda.	Shirley Silvester	July 2021
5. Undertake a thorough assessment against EDS2 as required.	To comply with statutory requirements and to provide a neutral review across the 4 EDS domains.	Emma Nunez, Shirley Silvester	September 2021

Leadership and Management			
6. **Recognise and/or reward anti-racist behaviour** by theming our approach to the Chairman and Chief Executive's Team of the Month and Making a Difference awards.	By highlighting the practice that we want to encourage, more colleagues are likely to behave that way.	Steve Russell, Angela Schofield	Starts July 2021, with a quarterly theme based on KITE behaviours
7. **Deliver a reciprocal mentoring programme** involving 12 BAME colleagues as mentors and 12 members of Board and SMT as mentees.	To build greater understanding in a bottom up way of the daily lived experience of BAME colleagues to enable senior leaders to take positive action. To expose BAME colleagues to a wider breadth of knowledge, gained from partnership with their mentee.	Shirley Silvester	July 2021-July 2022
8**.** Deliver a programme of training on **how to be an ally.**	To educate non-BAME colleagues in the challenges BAME colleagues face, and how to support colleagues experiencing direct and indirect discrimination.	Shirley Silvester	First programme runs: 14 July – December 2021
9. Launch a programme to support line managers in developing their **generic coaching skills.**	To support high quality well-being conversations (using the RECOVER model) and to embed the behaviours we value in the KITE model.	Shirley Silvester	Starts 1st June then ongoing
10. Ensure all **discretionary pay** is managed and distributed fairly e.g. clinical excellent awards, locum shifts and waiting list initiatives	To ensure that no colleague suffers financial detriment on the basis of their race.	Jackie Andrews, Sarah Sherliker	September 2021
Recruitment			
11. Take **bolder short-term measures** to improve the fairness of recruitment processes.	To propose bolder action to tackle long-standing inequalities more quickly.	Angela Wilkinson, Matt Shepherd	July 2021 - July 2022
Learning and Development			
12. To change the **corporate induction programme** to incorporate clear and strong messaging about our commitment to anti-racism and our KITE behaviours.	To clarify expectations of colleagues' behaviour from on-boarding onwards.	Shirley Silvester	September 2021
13. **Refresh mandatory EDI training** to create a compelling and engaging programme, which includes the voice of BAME colleagues.	To improve the quality of training to make it more impactful so that it improves collective understanding of the wider EDI agenda, the lived experience of BAME colleagues, including micro-aggressions.	Shirley Silvester	TBC
14. Ensure equality of access to **learning and development** for BAME colleagues.	To support fairness in career development.	Shirley Silvester	TBC

Career Development			
15. **To deliver bespoke leadership development** for BAME colleagues.	To ensure better representation of BAME people in leadership roles.	Shirley Silvester	Threshold programme launches 18th May 2021
16. **Confirm aspirational targets** Set aspirational targets for the number of BAME colleagues in band 8a and above positions, and SAS grade doctors being promoted to a more senior level.	To improve decision-making across strategic and operational issues by bringing in diverse views and perspectives.	Steve Russell, Angela Wilkinson, Jackie Andrews, linking to People and Culture Committee	TBC
17. **Deliver development centres** for BAME colleagues.	To provide a supportive process for BAME colleagues to help them stand a fair chance of securing their next career step.	Shirley Silvester	January 2022
Communications			
18. To clarify expectations about **patient and service user behaviours** towards BAME colleagues.	To show that we do not tolerate racist behaviours and to support cultural shift – this is everyone's issue – we all have a role to play in making HDFT a safe, welcoming, inclusive Trust to work in.	Shirley Silvester	August 2021
19. To create and communicate a compelling **case for change,** including the use of directorate/ team/ profession level data.	To "shout from the rooftops" the reasons that we need to act on anti-racism.	Shirley Silvester, Paul Widdowfield	July 2021
20. To promote an **annual diversity calendar**, celebrating key events in different cultures, e.g. Ramadan, Eid.	To enable all colleagues to bring their whole selves to work by sharing and celebrating important events and therefore help to build cultural understanding among non-BAME colleagues.	Shirley Silvester	Ongoing
21: Enhance our understanding of BME employee experience in HDFT by analysing leaver rates and reasons for leaving by grade and ethnicity.	Understand how BME employee experience differs beyond the standard reporting required by the WRES.		
22: Contact all BME leavers in the last two years and request the completion of a BME experience exit questionnaire.	Understand recent BME employee experiences (positive and negative) from people who have left HDFT in the last two years.		
23: Design, implement and evaluate a programme of reverse BME mentoring for all senior staff / directors in HDFT.	Engage both the 'hearts and minds' of senior staff in HDFT by understanding the lived experiences of BME employees.		
24: Design and deliver a series of tackling bias in recruitment	Tackle the risks of bias in our recruitment processes. Reduce the		

workshops for all HDFT. managers.	disparity between applicant success rates for BME and non BME job applicants.		
25: Design and implement a specific BME experience survey which would be sent to all current BME HDFT staff (possibly hosted by an external organisation). This would extend beyond the standard questions included in the annual NHS survey and would give employees the opportunity to provide more detailed feedback relating to their experiences in HDFT. The survey would be supplemented by voluntary discussion / buzz groups hosted by an external specialist provider.	Detailed exploration of the perceptions of BME staff with the aim of identifying specific areas of future development in HDFT.		
26: Repeat the above exercise in 2022-2023 to measure / chart progress.			

7.0 Quality Implications and Clinical Input

7.1 The changes outlined in this report are designed to improve workforce experience by tackling discrimination. We know that happy and engaged teams are more likely to provide high quality care.

8.0 Equality Analysis – Year 1: How will we know the anti-racist organisation programme has made a difference

8.1 The proposal of action to tackle racism will contribute to improving our performance on equalities, diversity and inclusion, particularly in relation to the experience of BAME job applicants and colleagues. The following outputs, outcomes and targets are in development:

Measure	Outputs/Targets/Outcomes in development
Improvement against WRES indicators	TBC
EDS2	Review across all 4 domains
Colleague feedback from Listening At Our Best	30% improvement against base line for equalities questions
Recruitment indicators	Short-term bold measures TBC
BAME colleagues accessing education, learning and development (beyond MEST)	% of BAME colleagues accessing
BAME representation within clinical and corporate governance structures	Meetings to be defined
No. of BAME colleague in Band 8a and above positions	Target to be agreed
Celebration of Diversity events	Identified cultural events celebrated
Equality based Making a Difference Awards made	10 in a 3 month period
Number of BAME development centres run	1 per quarter
Number of BAME colleagues being promoted internally	Target to be agreed

9.0 Risks

9.1 This risks to this programme are:

9.1.1 Ability to make a compelling case for change that colleagues believe in
9.1.2 Embedding ownership of the need to change culture amongst all our senior leaders
9.1.3 Ambitious programme of work, involving sensitive content (white fragility) and the need for difficult conversations about race equality and behaviours, which we have a poor track record of tackling in the past
9.1.4 Incomplete baseline picture for outcome measures – making it difficult to track progress
9.1.5 Alignment between Board of Directors' high expectation and internal capacity to deliver simultaneous actions at pace.

10.0 Conclusion

10.1 By developing and implementing a robust anti-racist organisation programme teamHDFT and HIF can make a positive difference to the lived experience of BAME colleagues and help create a more diverse and inclusive culture. Improvements gained by implementing the action plan will be directly linked to stronger race equality performance which is directly linked to the quality of care provided to our patients, service users and wider community.

11.0 Recommendation

11.1 The Board of Directors is asked to comment on and approve the contents of this paper.

12.0 Supporting Information

12.1 The following papers are Appendices to this report: (not included)

12.1.1 Appendix 1: HDFT Ethnicity Pay Gap Report – 31.03.21
12.1.2 Appendix 2: Workforce Race Equality Scheme Report and Action
12.1.3 Appendix 3: Equality, Diversity and Inclusion – Vision and Scope
12.1.4 Appendix 4: The Maturity Model

Board of Directors (Public)
29th September 2021

Title:	**Director of Workforce & OD Report**
Responsible Director:	Director of Workforce & OD
Author:	Deputy Director of Workforce & OD

Purpose of the report and summary of key issues:	**NHS Workforce Disability Equality Standard (WDES)** In summary this report highlights:- • The proportion of staff experiencing harassment, bullying or abuse is greater for disabled staff in comparison to non-disabled staff, with the exception of abuse from patients in the 2020 Staff Survey, where the level of abuse has been about the same for both disabled and non-disabled staff. • The proportion of both disabled and non-disabled staff that believe that the Trust provides equal opportunities for career progression and promotion has decreased from 2019 to 2020. • The proportion of both disabled and non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties has doubled from 2019 to 2020, with 59% of disable staff reporting feeling pressure in the 2020 Staff survey, compared to 39% of non-disabled staff.	
BAF Risk:	AIM 1: To be an outstanding place to work	
	BAF1.1 to be an outstanding place to work	x
	BAF1.2 To be an inclusive employer where diversity is celebrated and valued	x
	AIM 2: To work with partners to deliver integrated care	
	BAF2.1 To improve population health and wellbeing, provide integrated care and to support primary care	
	BAF2.2 To be an active partner in population health and the transformation of health inequalities	
	AIM 3: To deliver high quality care	
	BAF3.1 and 3.4 To provide outstanding care and outstanding patient experience	
	BAF3.2 To provide a high quality service	
	BAF3.3 To provide high quality care to children and young people in adults community services	
	BAF3.5 To provide high quality public health 0-19 services	
	AIM 4: To ensure clinical and financial sustainability	
	BAF4.1 To continually improve services we provide to our population in a way that are more efficient	
	BAF4.2 and 4.3 To provide high quality care and to be a financially sustainable organisation	
	BAF4.4 To be financially stable to provide outstanding quality of care	
Corporate Risks	As detailed within the report.	
Report History:	N/A	
Recommendation:	The Board are requested to note the content of this report.	

NHS Workforce Disability Equality Standard (WDES)

Annual Report 2021

Harrogate and District NHS Foundation Trust

CONTENTS

1 Introduction

Welcome to our *Workforce Disability Equality Scheme* (WDES) Annual Report 2021.

The report aims to communicate our internal data and metrics for the last twelve months, the progress we have made made to date and a proposed action plan to allow us to continue to develop our approaches, initiatives and activities during 2022 and beyond.

1.1 Background to the Workforce Disability Equality standard (WDES)

The WDES was introduced in 2019 and is designed to improve workplace and career experiences for Disabled people working, or seeking employment, in the NHS.[1.] Commissioned by the NHS Equality and Diversity Council, the WDES is mandated through the NHS Standard Contract.

It consists of ten metrics, based on workforce data and staff feedback from the NHS Staff Survey, which enables NHS organisations to compare the workplace and career experiences of Disabled and non-disabled staff. The data highlights areas which require improvement and it is used to develop and publish an action plan which can then be tracked year on year to demonstrate progress.

The WDES supports our compliance with the Public Sector Equality Duty, as part of the Equality Act 2010.[2.] It reinforces the improvements set out in the NHS Long Term Plan; to champion the insight and strengths of people with lived experience and, to become a model employer of people with a learning disability and of autistic people.[3.] Its function is integral to the NHS People Promise within the NHS People Plan 2021/22, a promise we must all make to each other – to work together and improve the experience of working in the NHS for everyone.[4.]

The WDES complements the existing Workforce Race Equality Standard (WRES) and both are vital to ensuring that the values of equality, diversity and inclusion lay at the heart of the NHS. It is important because it enables NHS organisations to better understand the experiences of their Disabled staff and supports positive change for all employees by creating a more inclusive environment for Disabled people working and seeking employment in the NHS.

1. https://www.england.nhs.uk/about/equality/equality-hub/wdes/
2. https://www.gov.uk/government/publications/public-sector-quick-start-guide-to-the-public-sector-equality-duty
3. https://www.england.nhs.uk/long-term-plan/
4. https://www.england.nhs.uk/ournhspeople/

1.0 Introduction (continued)

1.2 Our Values

Whether you're a patient, a visitor or a member of staff, our Vision sets out what you can expect from us:[5]

Our values describe and define our culture:

- Kind
- Integrity
- Teamwork
- Equality

1.3 Our Commitments to Promoting Equality Opportunity and Access for Employees with Disabilities:

It is clear from our WDES data analysis that we need to improve the experience for our colleagues with disabilities and long-term conditions.

We are committed to delivering our robust WDES action plan as part of the Equality, Diversity and Inclusion strategy; a golden thread which runs through our newly developing and exciting 'Culture Change Programme'.

We all need to treat each other with kindness, civility and compassion and we know that improving the experience of all our colleagues will lead to better care for our patients.

Our recently formed *Disability and Long-Term Illness Staff Network* is still in its infancy, but it will play a vital role in supporting and guiding the organisation to drive forward WDES improvements in the future.

The WDES was developed and continues to be underpinned by the ethos of '*Nothing About Us Without Us'*; focussing on the lived experience of our Disabled colleagues and the importance that any decisions that impact Disabled people must involve them in the decision-making process.

5. https://www.hdft.nhs.uk/about/trust/this-is-us/

2 Executive summary

'The NHS is founded on a core set of principles and values that bind together the diverse communities and people it serves – the patients and public – as well as the staff who work in it.' *NHS Constitution* [6]

2.1 Our Progress in 2020 - 2021:

A combination of the pressures of the *Covid 19* pandemic and our robust organisational commitments in respect of developing the Trust as an Anti Racist organisation (where we are making considerable progress) has meant that some of our planned actions relating to developing approaches to Disability have been delayed slightly. We are therefore proposing to retain the Disability action plan agreed for 2020 / 2021 and commit to implementing the same during 2022.

We are however able to report that we have made *some* progress during the last twelve months and this is summarised both below and overleaf.

In summary the data outlined in Appendix 1 highlights:-

- The proportion of staff experiencing harassment, bullying or abuse is greater for disabled staff in comparison to non-disabled staff, with the exception of abuse from patients in the 2020 Staff Survey, where the level of abuse has been about the same for both disabled and non-disabled staff.

- The proportion of both disabled and non-disabled staff that believe that the Trust provides equal opportunities for career progression and promotion has decreased from 2019 to 2020.

- The proportion of both disabled and non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties has doubled from 2019 to 2020, with 59% of disable staff reporting feeling pressure in the 2020 Staff survey, compared to 39% of non-disabled staff.

2.2 The Profile of our Disabled Employees versus NHS Averages:

The recorded number of disabled employees in the Trust has increased slightly versus last year but is still slightly lower the overall average for the NHS.

	NHS Average:	HDFT:	Variance:
Staff Declaring a Disability	4.8 %	3.5 %	- 1.3 %

2.3 Number of Employees Declaring a Disability:

This increase does however appear to be cumulative representing (albeit somewhat slow) progress in this area.

Year:	Percentage of Staff Declaring a Disability:
2019	2.9 %
2020	3.2 %
2021	3.5 %

2.1 Our Progress in 2020 - 2021: (continued)

2.4 Increase of Disabled Employees by Grade:

We are also pleased to report that out of the 11 reporting 'clusters', (effectively NHS grades by clinical and non clinical staff) only three (clusters) show a year on year decrease of disabled staff. This would appear to indicate that the increase of disabled employees in the Trust is broadly represented and is increasing across most grades for both clinical and non clinical colleagues.

2.3 Declaration Rates – Disability:

Declaration rates by employees are also improving with 10 out of the eleven aforementioned reporting 'Clusters' showing a decrease of non declaration rates of disability by employees.

2.4 Employee Experience:

The annual NHS staff survey showed an overall decrease in reported experiences of bullying, harassment and abuse from patients, managers and colleagues in HDFT.

Whilst reporting rates were once again slightly higher for disabled employees, the disparity between disabled and non disabled employees appears to be closing with a mean difference of just 3.6 % in 2021 versus a 7.2% difference in 2020. (Using the three questions reported in the appendices of this document).

2.5 External Expertise and Consultation:

In August 2021 the trust appointed McKenzie LLP a leading Equality, Diversity and Inclusion specialist (with considerable healthcare experience) to undertake an external review of our approaches to both WDES and WRES. It is likely that in 2022,

McKenzie will undertake some further internal consultation with our employees to understand further employee perceptions and experiences in this area.

2.6 Internal Expertise and Support:

The establishment of an EDI Lead role and the development and launch of staff networks - including the *Disability and Long-Term Illness Staff Network*, has been pivotal in prioritising the EDI agenda, improving staff engagement, driving the focus on and improving the experience and outcomes for our staff.

2.7 Moving Forward:

Our action plan focuses on the steps we need to take to address the areas where we have not made sufficient progress. (Please see pages 15 – 21 of this document)

3: Conclusion and Next steps

We acknowledge there is a lot more to do to continue making improvements and bring positive changes for our Disabled staff, and to welcome more Disabled people into **#teamHDFT**.

Our senior leaders and the Disability and Long-Term Illness Staff Network will be sighted on the progress of our action plan. We will continue to communicate the WDES to all staff across the organisation so we can all be involved in celebrating our achievements.

The WDES will continue, with other work streams, to help ensure that there is momentum and continuous improvement in the workforce disability equality agenda. It will help drive our Culture Change Programme and help meet the goals set out in the People Plan 2020/21.

Having a diverse workforce who feel engaged and supported within the workplace is critical; research shows that how we treat and value our minority staff is a good barometer of how well patients are likely to feel cared for.[7] Our staff experience impacts on patient care, patient safety as well as organisational efficiency.

We will continue to listen with fascination to what our staff with lived experience have to say, we will capture the richness in their stories, and ensure these inform how we deliver the actions in this plan and shift the culture so we can say - Harrogate and District NHS Foundation Trust is the best place to work.

7. https://www.england.nhs.uk/publication/links-between-nhs-staff-experience-and-patient-satisfaction-analysis-of-surveys-from-2014-and-2015/

Appendix 1 WDES metrics report

Detailed below is the organisation's WDES data which was submitted in August 2021 covering the period 1 April 2020 to 31 March 2021

Metric 1 **Percentage of staff in AfC pay bands or medical and dental subgroups and very senior managers (including executive board members) compared with the percentage of staff in the overall workforce.**

(Data source: ESR).

1a. Non-clinical workforce

	Disabled staff in 2020	Disabled staff in 2021	Disabled staff in 2021	Non-disabled staff in 2020	Non-disabled staff in 2021	Non-disabled staff in 2021	Unknown/null staff in 2020	Unknown/null staff in 2021	Unknown/null staff in 2021	Total staff in 2021	Total staff in 2020
	Percentage (%)	Percentage (%)	% points difference (+/-)	Percentage (%)	Percentage (%)	% points difference (+/-)	Percentage (%)	Percentage (%)	% points difference (+/-)	Headcount	Headcount
Cluster 1 (Bands 1 - 4)	3.6%	4.8%	+ 1.2	81.1%	82.6%	+1.5%	15.5%	12.6%	-2.9%	524	533
Cluster 2 (Band 5 - 7)	1.4%	2.0%	+1.6%	81.4%	83.3%	+1.9%	17.1%	14.7%	-2.4%	150	140
Cluster 3 (Bands 8a - 8b)	3.6%	1.9%	-1.7%	85.5%	90.2%	+4.7%	10.9%	7.8%	-3.1%	51	55
Cluster 4 (Bands 8c – 9 & VSM)	0%	5.9%	+5.9%	80.0%	82.4%	+-2.4%	20.0%	11.8%	-8.2%	17	25

1b. Clinical workforce

	Disabled staff in 2020	Disabled staff in 2021	Disabled staff in 2021	Non-disabled staff in 2020	Non-disabled staff in 2021	Non-disabled staff in 2021	Unknown/null staff in 2020	Unknown/null staff in 2021	Unknown/null staff in 2021	Total staff in 2021	Total staff in 2020
	Percentage (%)	Percentage (%)	% points difference (+/-)	Percentage (%)	Percentage (%)	% points difference (+/-)	Percentage (%)	Percentage (%)	% points difference (+/-)	Headcount	Headcount
Cluster 1 (Bands 1 - 4)	3.3%	3.3%	0.0%	78.8%	81.9%	+3.1%	17.9%	14.7%	-3.2%	1020	969
Cluster 2 (Band 5 - 7)	3.4%	3.6%	+0.2%	79.5%	80.4%	+0.9%	20.0%	15.9%	-4.1%	2132	2202
Cluster 3 (Bands 8a - 8b)	5.8%	5.5%	-0.3%	73.5%	78.9%	+5.4%	20.6%	15.6%	-5.0%	128	121
Cluster 4 (Bands 8c – 9 & VSM)	0%	0%	0%	0%	0%	0%	0%	0%	0%	0	6
Cluster 5 (Medical and Dental staff, Consultants)	1.2%	2.5%	+1.3%	68.6%	69.8%	+1.2%	29.0%	27.7%	-1.3%	159	156
Cluster 6 (Medical and Dental staff, Non-consultant career grade)	0%	0.5%	+0.5%	76.9%	74.1%	-2.8%	23.1%	25.3%	+2.2%	186	195
Cluster 7 (Medical and Dental staff, Medical and Dental trainee grades)	3.9%	4.3%	+0.4%	88.4%	90.2%	+1.8%	7.70%	5.6%	-2.1%	162	155

Metric 2 – Relative likelihood of Disabled staff compared to non-disabled staff being appointed from shortlisting across all posts

(Data source: Trust's recruitment data)

	Relative likelihood in 2020	Relative likelihood in 2021	Relative likelihood difference (+-)
Relative likelihood of non-disabled staff being appointed from shortlisting compared to Disabled staff	**1.26**	**1.55**	**+0.29**

Metric 3 – Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure.

(Data source: Trust's HR data)

	Relative likelihood in 2020	Relative likelihood in 2021	Relative likelihood difference (+-)
Relative likelihood of Disabled staff entering formal capability process compared to non-disabled staff	**0.00**	**0.00**	**0.00**

Metric 4 – Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse.

(Data source: Question 13, NHS Staff Survey)

	Disabled staff responses to 2019 NHS Staff Survey	Non-disabled staff responses to 2019 NHS Staff Survey	% points difference (+/-) between Disabled staff and non-disabled staff responses 2019	Disabled staff responses to 2020 NHS Staff Survey	Non-disabled staff responses to 2020 NHS Staff Survey	% points difference (+/-) between Disabled staff and non-disabled staff responses 2020
	Percentage (%)	Percentage (%)		Percentage (%)	Percentage (%)	
4a) Staff experiencing harassment, bullying or abuse from patients/ service users, their relatives or other members of the public in the last 12 months	28.1%	24.1%	+4.0%	22.0%	23.0%	-1%
4b) Staff experiencing harassment, bullying or abuse from managers in the last 12 months	20.0%	10.6%	+9.4%	19.0%	12.0%	+7.0%
4c) Staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months	25.7%	17.6%	+8.1%	22.0%	17.0%	+5.0%

Metrics 5 – 8

(Data source: Questions 14, 11, 5, 28b, NHS Staff Survey)

	Disabled staff responses to 2019 NHS Staff Survey	Non-disabled staff responses to 2019 NHS Staff Survey	% points difference (+/-) between Disabled staff and non-disabled staff responses 2019	Disabled staff responses to 2020 NHS Staff Survey	Non-disabled staff responses to 2020 NHS Staff Survey	% points difference (+/-) between Disabled staff and non-disabled staff responses 2020
	Percentage (%)	Percentage (%)		Percentage (%)	Percentage (%)	
Metric 5 - Percentage of Disabled staff compared to non-disabled staff believing that the trust provides equal opportunities for career progression or promotion.	85.6%	88.5%	-2.9%	49%	56%	-7%
Metric 6 - Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.	26.5%	19.5%	+7%	59%	39%	+20%
Metric 7 - Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.	46.1%	55.0%	-8.9%	42.0%	50.0%	-8.0%
Metric 8 - Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.	N/A	N/A	N/A	N/A	N/A	N/A

Metric 9 – Disabled staff engagement

(Data source: NHS Staff Survey)

	Disabled staff engagement score for 2019 NHS Staff Survey	Non-disabled staff engagement score for 2019 NHS Staff Survey	Difference (+/-) between disabled staff and non-disabled staff engagement scores 2019	Disabled staff engagement score for 2020 NHS Staff Survey	Non-disabled staff engagement score for 2020 NHS Staff Survey	Difference (+/-) between Disabled staff and non-disabled staff engagement scores 2020
a) The staff engagement score for Disabled staff, compared to non-disabled staff.	**6.9**	**7.2**	**-0.3**	**6.9**	**7.3**	**-0.4**

b) Has your trust taken action to facilitate the voices of Disabled staff in your organisation to be heard? Yes

Please provide at least one practical example of action taken in the last 12 months to engage with Disabled staff.

Example 1: The Trust has launched a new Disability and Long-Term Illness Staff Network who have looked at the WDES data in detail and co-produced the WDES Action Plan.

Example 2: Communications have been sent to all staff across the organisation to raise the awareness of the importance of the WDES and to ensure the voices of all staff are included in developing the WDES Action Plan, in particular Disabled staff who are not members of the network and staff who do not wish to declare their disability status. This has included:

- Black and Minority Ethnic (BME) Staff Network
- Lesbian, Gay, Bisexual and Transgender (LGBT+) Staff Network
- All staff via the weekly email bulletin
- Directorate Leads
- Staff Governors
- Occupational Health Department
- Freedom to Speak Up Guardians / Fairness Champions
- Trade Union Colleagues
- Equality Stakeholder Group members

Example 3: The Equality Stakeholder Group - Through insights of people with disabilities across the workforce, many of whom will be patients or service users, and with stakeholders from the community, we are able to think in new and innovative ways about how to deliver high quality compassionate care that have inclusion at their heart.

Metric 10 – Percentage difference between the organisation's board voting membership and its organisation's overall workforce

(Data source: NHS ESR and/or trust's local data)

	Disabled Board members in 2019	Non-disabled Board members in 2019	Board members with disability status unknown in 2019	% points difference (+/-) between Disabled Board members and Disabled staff in overall workforce	Disabled Board members in 2020	Non-disabled Board members in 2020	Board members with disability status unknown in 2020	% points difference (+/-) Between Disabled and non-disabled Board members in 2020
	Percentage (%)	Percentage (%)	Percentage (%)		Percentage (%)	Percentage (%)	Percentage (%)	
Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated by Exec/non-exec and Voting/non-voting.	Exec = 0% Non-exec = 0% Voting = 0% Non-voting = n/a	Exec = 67.0% Non-exec = 86.0% Voting = 77.0% Non-voting = n/a	Exec = 33.0% Non-exec = 14.0% Voting = 23.0% Non-voting = n/a	Total Board = 0% Overall workforce = 2.9% Difference = 2.9 percentage points	Exec = 0% Non-exec = 0% Voting = 0% Non-voting = n/a	Exec = 83.0% Non-exec = 75.0% Voting = 79.0% Non-voting = n/a	Exec = 17.0% Non-exec = 25.0% Voting = 21.0% Non-voting = n/a	Total Board = 0% Overall workforce = 3.2% Difference = 3.2 percentage points

APPENDIX 2 - WDES action plan 2020/21

Metric	Objective	Action/s	Timescales	Lead/s	Why
1	Improve our disability declaration rates to build a more accurate picture of the diversity of our workforce. Improve diverse representation across the workforce, at all levels of Agenda for Change and profession.	1. Work with the Staff Network to raise awareness of the WDES and encourage existing staff to feel confident in declaring their disability status on ESR.	March 2022	Director of W&OD EDI Lead Staff Network Communications and Marketing Manager	To build a more accurate picture of the diversity of our workforce.
		2. Review our recruitment processes to promote our commitment to be an inclusive workplace that welcomes disabled people.	October – December 2021	Recruitment Lead	To celebrate the diversity of our workforce and encourage everyone to bring their whole-self to work.
		3. Complete detailed analysis of data by directorate and profession to identify areas of under-representation and barriers to career progression.	October 2021	HR Analyst EDI Lead Directorate Leads	To understand where we have gaps/under representation.
		4. Continue to work with our existing volunteering and work experience programmes, and our Youth Forum, to promote the wide range of career opportunities across the Trust.	Apr/Jul 2022	EDI Lead Corporate Affairs and Membership Manager Volunteer Services Manager	To become a model employer, be compassionate and inclusive, and improve how we recruit, retain and develop disabled people.
		5. Review models for supported internships for young people with Learning Disabilities.	April 2022	Director of W&OD W&OD Lead EDI Lead	
2	Reduce the inequality in recruitment shortlisting from 1.55 to 1.00. Review recruitment practices and improve awareness of disability and long-term health conditions to ensure the process is equitable and inclusive where everyone can thrive.	1. Engage in the review of our recruitment practices to ensure the lived experiences of staff with disabilities and long-term health conditions are taken into account.	October – December 2021	Director of W&OD Recruitment Lead Staff Network	To improve career progression prospects for Disabled staff (see action 5 below).
		2. Disabled staff to be trained to participate on recruitment panels.	November 2021 – January 2022	Recruitment Lead Staff Network	To ensure the lived experiences of staff with disabilities and long-term health conditions are taken into account – 'We have a voice that counts'.
		3. Staff Network to receive regular review of recruitment activity and provide feedback.	Jan/April/Jul 2022	Recruitment Lead Staff Network	
		4. Review training and education, including 'Pathway to Management', to improve managers' awareness and understanding of disability and long-term health conditions.	January 2022	HR Lead	To ensure diversity in thought when decisions are being made.

		5. Continue to promote awareness and understanding of unconscious bias through the First Line Leaders programme. 6. Take the next step to progress from Disability Confident Committed to Disability Confident Employer (Level 2).	January 2022 November 2021	W&OD Lead EDI Lead	To improve awareness and understanding of disability and long-term health conditions.
3	Promote active engagement and consultation in policy review ensuring that any decisions that impact people with a disability involve them in the decision-making process.	1. Review progress of relative likelihood of Disabled colleagues entering the capability process (on the grounds of performance) and provide update to Staff Network. 2. Engage with the Staff Network when reviewing the Capability policy in Feb/March 2021. 3. Invite Staff Network member on to the Trust's Partnership Advisory Group. 4. Review training and education, including 'Pathway to Management', to improve managers' awareness and understanding of disability and long-term health conditions. 5. Continue to promote awareness and understanding of unconscious bias through the First Line Leaders programme.	February 2022 February 2022 September 2021 January 2022 January 2022	Director of W&OD HR Lead Staff Network HR Lead Staff Network HR Lead Staff Network HR Lead W&OD Lead	To increase the confidence of staff entering into the capability process that they will be treated fairly. To ensure that any decisions that impact people with a disability or long-term health condition involve them in the decision-making process. To improve awareness and understanding of disabilities and long-term health conditions.
4	Reduce the incidence of Disabled colleagues experiencing harassment, bullying and abuse. Support staff to feel confident in reporting incidents of harassment, bullying and abuse.	1. To promote the Culture Change Programme and work together to drive the importance of the WDES throughout the current work streams and future initiatives. 2. To continue listening across a variety of platforms where colleagues feel safe to share their lived experiences. Focus on the drive to eliminate harassment, bullying and abuse and reassure staff that concerns will be acted on appropriately. 3. Raise awareness of the WDES with the Council of Governors and the Equality Stakeholder Group in relation to Metric 4a. Support staff by producing zero-tolerance materials.	October 2021 Oct 2021/Jan/Apr/Jul 2022 January 2022	Culture Change Programme Leads Staff Network EDI Lead Director of W&OD Staff Network EDI Lead EDI Lead Staff Network Communications and Marketing Manager	Part of the overall organisational goal to create an inclusive culture. To ensure that that people with a disability or long-term condition are involved in the Culture Change Programme and are valued in making a difference. To build on the culture of the organisation in order to drive initiatives to reduce harassment, bullying and abuse from members of the public.

		4. Encourage colleagues to participate and provide feedback in the NHS Staff Survey.	November 2021	Director of W&OD HR Lead Staff Network	
		5. Work closely with the Freedom to Speak Up Guardians, Fairness Champions, Staff Governors and Bullying and Harassment Advisors to triangulate learning from themes in relation to the experiences of people with disabilities and long-term health conditions and feedback to senior management team.	Oct 2021 / Jan/Apr/Jul 2022	EDI Lead Freedom to Speak Up Guardians Staff Governors	To encourage people to speak up and be supported in doing so.
		6. In line with the NHS People Plan, focus on work streams to ensure that we create a culture where everyone feels they belong.	January 2022	Culture Change Programme Leads	To promote belonging to #teamHDFT.
5	Reduce inequality in career progress opportunities (between Disabled and non-disabled colleagues). Raise awareness of the value in having inclusive and diverse teams and retain and motivate our talented, experienced, and knowledgeable staff.	1. Monitor selection processes for acting up and secondment positions to identify any potential adverse impact on Disabled staff.	January 2022	Director of W&OD Recruitment Lead	See action 2 above.
		2. Staff Network to host listening events focussing on career development to help the organisation understand where support is needed.	April 2022	Staff Network	Understand the lived experience behind the data.
		3. Raise awareness of the Social Model of Disability.	April 2022	Culture Change Programme Leads Staff Network EDI Lead	Understand and learn why people are disabled by barriers in society, not by their impairment or difference.
6	Reduce level of presenteeism experienced by Disabled staff. To look after our people and ensure we are safe and healthy.	1. Engage with the Staff Network when reviewing policies including the Managing Attendance & Promoting Health and Wellbeing Policy.	July 2022	Director of W&OD HR Lead Staff Network	Create a healthier workplace for staff and improve wellbeing for all.
		2. Continue training and education, including 'Pathway to Management' and First Line Leaders', to improve managers' awareness and understanding of disability and long-term health conditions.	January 2022	HR Lead W&OD Lead	To ensure that any decisions that impact people with a disability or long-term health condition involve them in the decision-making process.
		3. Continue to promote staff health and wellbeing resources and support our colleagues including health and wellbeing conversations and the Employee Assistance Programme (EAP).	Oct 2021 / Jan/Apr/Jul 2022	Health and Wellbeing Group Communications and Marketing Manager Line Managers	To improve awareness and understanding of disabilities and long-term health conditions.

7	Increase percentage of Disabled staff satisfaction rate. To ensure staff feel that their work and contributions are valued.	1. Invite Board Champion on to the Staff Network. 2. Arrange a series of focus groups to listen to staff who do not feel satisfied with the extent to which the organisation values their work. These will be structured to ensure lived experience informs actions as appropriate.	October 2021 December 2022	Staff Network EDI Lead Staff Network	Inclusive leadership is key in recognising and valuing the contribution that Disabled people can make. Insight into lived experience of Disabled staff.
8	Increase percentage of Disabled staff that feel that their request/s for reasonable adjustments have been adequately managed. Ensure disabled staff are given the opportunity to discuss what they need and the support to receive reasonable adjustments in order for them to carry out their work.	1. Engage with the Staff Network when reviewing the Managing Attendance & Promoting Health and Wellbeing Policy regarding reasonable adjustments. 2. Promote reasonable adjustment resources that are available and encourage conversations between the line manager and member of staff where a disability or long-term health condition might impact upon their work.	July 2022 October 2021	Director of W&OD HR Lead Staff Network HR Lead	To ensure that any decisions that impact people with a disability or long-term health condition involve them in the decision-making process. To improve awareness and understanding of disabilities and long-term health conditions. Compliance with the Equality Act 2010.
9	Continue to promote the Staff Network and the WDES and ensure the voices of our staff with disabilities and long-term health conditions are heard.	1. Actively promote the Staff Network and report on their work to the Trust's Senior Management Team. 2. Learn and share good practice through the NHS Employers Diversity and Inclusion Partners Programme. 3. Continue to raise the profile of the Equality Stakeholder Group and focus on removing any social model barriers that may impact on the delivery of high-quality patient care.	Jan/Apr/Jul 2022 Jan/Apr/Jul 2022 Oct 2021 / Jan/Apr/Jul 2022	Staff Network EDI Lead EDI Lead BME Staff Network Co-Chair Non-Executive Directors EDI Lead	Create a culture and environment where Disabled staff feel able to speak up and have a voice Opportunity to report into the organisation's governance structure. Through insights of people with disabilities across the workforce, many of whom will be patients or service users, and with community stakeholders, we will be able to think in new and innovative ways about how to deliver high quality compassionate care that have inclusion at their heart.

10	Reduce the gap between Board representation and overall representation of Disabled staff in the workforce. Increase diversity of Board.	1. Ensure the process for appointment of Executive and Non-Executive Directors encourages diverse applicants, including those who identify as Disabled. 2. As a demonstration of Trust commitment to 'Nothing about us without us' and inclusion, include reciprocal mentoring programme for Disabled staff network members to have mentoring relationship with Board members.	July 2022 July 2022	Director of W&OD Recruitment Lead Director of W&OD Board Champion Staff Network	To demonstrate visible leadership in this area at senior levels. Importance of leadership role models. From hearing insights and lived experiences, Board members will be better informed in making decisions that benefit all staff and patients
All Metrics	To close the gaps between the workplace and career experiences of Disabled and non-disabled staff.	Across all, or multiple metrics, the following actions will champion positive WDES outcomes and improved staff experience: 1. Recognition of the value of the Staff Network across the organisation – benefits the organisation as much as the individual: • Resources • Time – facility time for Network Chairs and time for staff to attend, • Support 2. The WDES will be a standard item on the staff network monthly agenda. 3. Listening with fascination and sharing lived experience – story telling to bring the lived experience alive, which along with the data and the feedback through the Staff Survey gives a whole perspective and has such a powerful impact, e.g. Schwartz Round, Board of Directors' meetings, People and Culture Committee. 4. Reciprocal mentoring – using this model to raise awareness of disabilities and long-term health conditions and promote diversity of thought. 5. Integrate the WDES within mainstream business and governance structures including regular reporting via the Integrated Board Report and as part of the Culture Change Programme.	Oct 2021 / Jan/Apr/Jul 2022 Oct 2021 – July 2022 Oct 2021 – July 2022 July 2022 January 2022		Improve the experience of Disabled staff. Improve the culture of the organisation. Compliance with: • Public Sector Equality Duty, - Equality Act 2010. • NHS Standard Contract. • NHS Long Term Plan. • NHS People Plan, Value in listening to the lived experience of staff to drive change. Raise awareness of WDES and the importance of regular monitoring to track improvements.

		6. Adopt the principles of the 'Social Model of Disability' and 'Nothing About Us Without Us'. 7. Regular communications to bring WDES alive and celebrate achievements. Produce innovate ways to communicate e.g. infographics. 8. Sharing good practice: • Resources and guidance via NHS Employers • Networks – Yorkshire and Humber Regional EDI Leads Network • Staff Networks in other Trusts	October 2021 Oct 2020 – July 2022 Oct 2020 – July 2022		

Note: Explain how Disabled staff have been involved in developing and delivering the actions.

Consultation has been undertaken with the Disability and Long-Term Illness Staff Network members, and Disabled staff across the organisation who are not members of the Staff Network, to review the metrics data and develop the action plans within this report.

Board of Directors (Public)
29th September 2021

Title:	**Director of Workforce & OD Report**
Responsible Director:	Director of Workforce & OD
Author:	Deputy Director of Workforce & OD

Purpose of the report and summary of key issues:	**Gender Pay Gap Report - As at 31 March 2021** In summary this report highlights: • The gender split of the workforce is 85% female to 15% male, however as a greater proportion of the male workforce are in higher banded roles and Medical and Dental positions in comparison to the female workforce, this impacts the gender gap as these roles have a greater hourly rate. • Including Medical and Dental, the mean gender pay gap is 27.61%, meaning males are paid 27.61% more than women. • Excluding Medical and Dental, the mean gender pay gap is 7.40%, meaning males are paid 7.40% more than women.
BAF Risk:	AIM 1: To be an outstanding place to work
	BAF1.1 to be an outstanding place to work: x
	BAF1.2 To be an inclusive employer where diversity is celebrated and valued: x
	AIM 2: To work with partners to deliver integrated care
	BAF2.1 To improve population health and wellbeing, provide integrated care and to support primary care
	BAF2.2 To be an active partner in population health and the transformation of health inequalities
	AIM 3: To deliver high quality care
	BAF3.1 and 3.4 To provide outstanding care and outstanding patient experience
	BAF3.2 To provide a high quality service
	BAF3.3 To provide high quality care to children and young people in adults community services
	BAF3.5 To provide high quality public health 0-19 services
	AIM 4: To ensure clinical and financial sustainability
	BAF4.1 To continually improve services we provide to our population in a way that are more efficient
	BAF4.2 and 4.3 To provide high quality care and to be a financially sustainable organisation
	BAF4.4 To be financially stable to provide outstanding quality of care
Corporate Risks	As detailed within the report.
Report History:	N/A
Recommendation:	The Board are requested to note the content of this report.

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Harrogate and District NHS Foundation Trust

Board of Directors Meeting
29th September 2021

Gender Pay Gap Report- As at 31 March 2021

1. Gender pay gap reporting

Legislation has made it statutory for organisations with 250 or more employees to report annually on their gender pay gap. Government departments are covered by the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 which came into force on the 31 March 2017. These regulations underpin the Public Sector Equality Duty and require the relevant organisations to publish their gender pay gap data annually, including:

- Mean gender pay gap in hourly pay.
- Median gender pay gap in hourly pay.
- Mean bonus gender pay gap.
- Median bonus gender pay gap.
- Proportion of men and women receiving a bonus payment.
- Proportion of men and women in each pay quartile.

The gender pay gap is different to equal pay. Equal pay means that men and women in the same employment who are performing equal work must receive equal pay, as set out in the Equality Act 2010. It is unlawful to pay people unequally because they are a man or a woman.

While the Electronic Staff Record (ESR) facility does not enable the Trust to include non-binary staff as part of the data, the Trust is committed to including staff who have transitioned and is proud to have established our Policy for supporting Transgender patients, services users and staff.

The Trust pays most employees, excepting some medical and dental staff, on the Agenda for Change pay system, and this framework provides assurance that equal pay for equal work is recognised i.e. someone entering the band 5 scale with the same level of qualifications and experience would be paid the same irrespective of gender; they would then have the opportunity to progress up the pay scale annually.

In summary this report highlights:

- The gender split of the workforce is 85% female to 15% male, however as a greater proportion of the male workforce are in higher banded roles and Medical and Dental positions in comparison to the female workforce, this impacts the gender gap as these roles have a greater hourly rate.
- Including Medical and Dental, the mean gender pay gap is 27.61%, meaning males are paid 27.61% more than women.
- Excluding Medical and Dental, the mean gender pay gap is 7.40%, meaning males are paid 7.40% more than women.

2. Harrogate and District NHS Foundation Trust

Harrogate and District NHS Foundation Trust (the Trust) employs more than 4,000 members of staff to provide essential hospital treatment as well as community health services to the population of Harrogate and the local area, across North Yorkshire and Leeds, and children's services in North Yorkshire and the North East in County Durham, Darlington, Middlesbrough, Stockton-On-Tees, Gateshead and Sunderland.

The total number of staff eligible for inclusion in this report was 4,252.

	31 March 2021		31 March 2020	
	Headcount	%	Headcount	%
Female	3,597	85%	3,615	85%
Male	655	15%	616	15%
TOTAL	**4,252**		**4,231**	

Figure 1 illustrates the gender distribution within the Trust at 31 March 2021

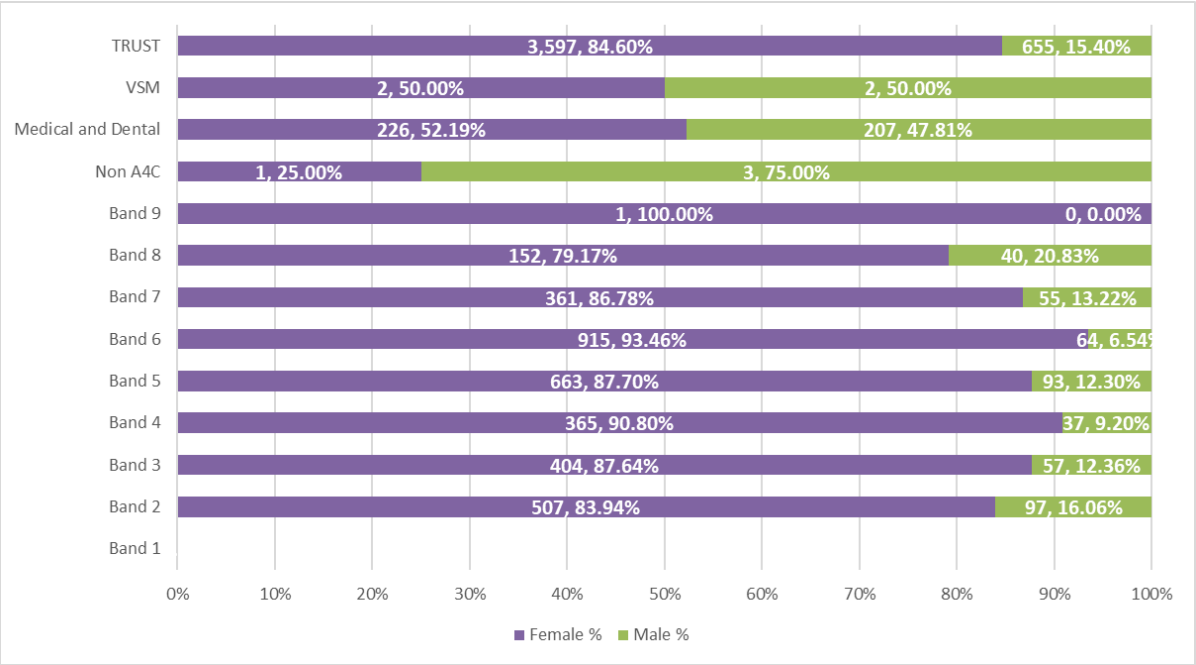
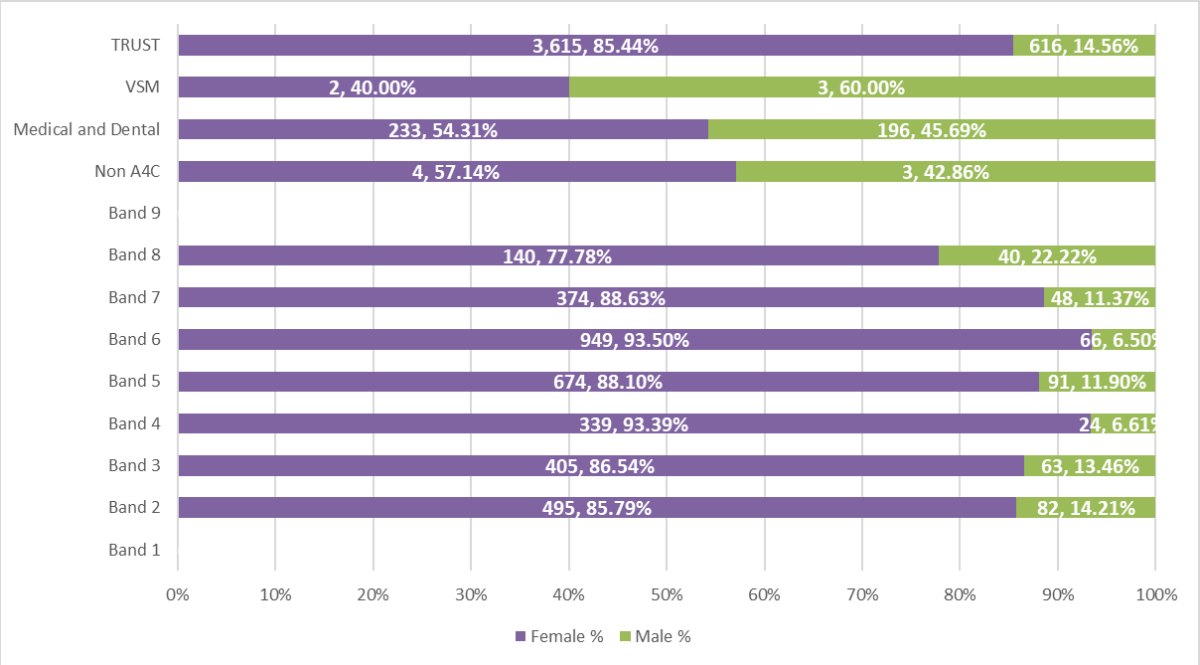


Figure 2 illustrates the gender distribution within the Trust at 31 March 2020



Note - As part of the 2018 pay deal, Band 1 closed to new entrants with effect from 1 December 2018 and all existing staff on a Band 1 contract at the Trust transitioned over to Band 2 from April 2019.

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3. Definitions and scope

The gender pay gap is a measure that shows the difference in average earnings between men and women across an organisation.

The gender pay gap is described in two different terms. Firstly, the difference between the mean of hourly rates of men and the hourly rates of women, and secondly as the difference between the median of hourly rate (men) and hourly rate (women).

Mean and Median

- The "mean" is an average of all hourly rates of pay.
- The "median" is the middle value in a complete list of all hourly rates of pay.

The report is based on rates of pay for the financial year 2020/21. It includes all workers in scope at 31 March 2021. A positive figure indicates a gender pay gap disadvantageous to women; a negative figure indicates the gender pay gap disadvantageous to men:

4. Mean and median gender pay gap in hourly pay

Gender	Mean Hourly Rate 2021	Median Hourly Rate 2021	Mean Hourly Rate 2020	Median Hourly Rate 2020
Male (£)	24.22	18.76	24.48	18.49
Female (£)	17.53	16.04	17.14	15.55

Difference (£)	6.69	2.72	7.34	2.94
Pay Gap %	27.61	14.51	29.98	15.92

* rounded up

- As highlighted in Figure 1, the proportion of female to male staff is much higher in lower bands, which would explain why there is a gender pay gap.
- As shown the Trust is reporting a 27.61% gender pay gap, meaning that based on an average hourly rate men are paid 27.61% more than women.
- The figures also demonstrate that the Trust has a 14.51% median gender pay gap, which was a decrease of 2020's figure of 14.51%.

5. Mean and median bonus gender pay gap

The Trust pays out two types of bonuses, Clinical Excellence Awards (CEA) and Long Service Awards.

CEA are awarded based on the performance of a consultant. The CEA process requires the consultant to apply for the award and their application is then reviewed by a Panel.

The Trust currently employs 154 consultants of whom 78 are male and 76 are female (as at 31.03.21). Of the total workforce, 67 male consultants (85.90%) which are 10.23% of all men employed received a CEA payment and 72 female consultants (94.74%) which are 2.00% of all females employed received a CEA payment.

Gender	Mean Bonus 2021 (£)	Median Bonus 2021 (£)	Mean Bonus 2020 (£)	Median Bonus 2020 (£)
Male	11,332.00	9,124.00	11,267.32	7,540.00
Female	9,117.81	6,108.00	10,069.83	6,032.00
Difference	2,214.19	3,016.00	1,197.49	1,508.00
Pay Gap %	19.54	33.06	10.63	20.00

- This shows an increase in the mean gender bonus gap differential by 8.91%, and a 13.06% increase in the median gender bonus gap difference from 2020 to 2021.
- In 2018 the CEA pay scheme was changed to a non-consolidated, non pensionable pay scheme. 2020 and 2021, the BMA and NHS Employers have agreed a one off payment due to the impact of COVID19. The one off payment for 2020 has already been paid (Oct 2020) however 2021 has not yet been paid but is expected in Oct/Nov of this year.

<u>The Influence of Medical and Dental Staff</u>

Medical and Dental staff have a substantial impact on the Trust's gender pay gap, as individuals in this staff group tend to be paid higher wages than other Trust employees. Although the Trust currently has 78 male consultants and 76 female consultants, because the Trust employs fewer men overall, the number of male consultants as a proportion of the overall male workforce at 11.91% is higher than that of female consultants 2.11% of the female workforce.

To evidence the influence of medical and dental staff driving the percentage gap, the table below shows that taking out the medical and dental staff from the calculations, the pay gap percentage for the average mean hourly rate in 2021 is reduced from 27.61% to 7.40%. The median hourly rate pay gap percentage is almost equal when you take out the medical and dental staff.

Gender	Mean Hourly Rate 2021	Median Hourly Rate 2021	Mean Hourly Rate 2020	Median Hourly Rate 2020
Male (£)	17.48	15.66	16.21	15.19
Female (£)	16.19	15.66	15.64	15.40
Difference (£)	1.29	0.00	0.58	-0.21
Pay Gap %	7.40	-0.01	3.55	-1.40

6. Proportion of men and women receiving a bonus payment

Long Service Awards include a £40 bonus paid to both men and women in recognition of 25, 30, 35, 40 and 50 years' service at the Trust. As this bonus is paid out equally to both men and women it would have no influence on the figures.

Taking both clinical excellence awards and long service awards into account, as a proportion 6.1% of females (219) received a bonus compared to 13.3% of males (87). This is again influenced by the ratio of males in receipt of bonus to the overall number of males.

It should be noted that the Long Service Awards honoured in 2021 were to colleagues who should have received them in 2020, however these were delayed due to the Coronavirus pandemic.

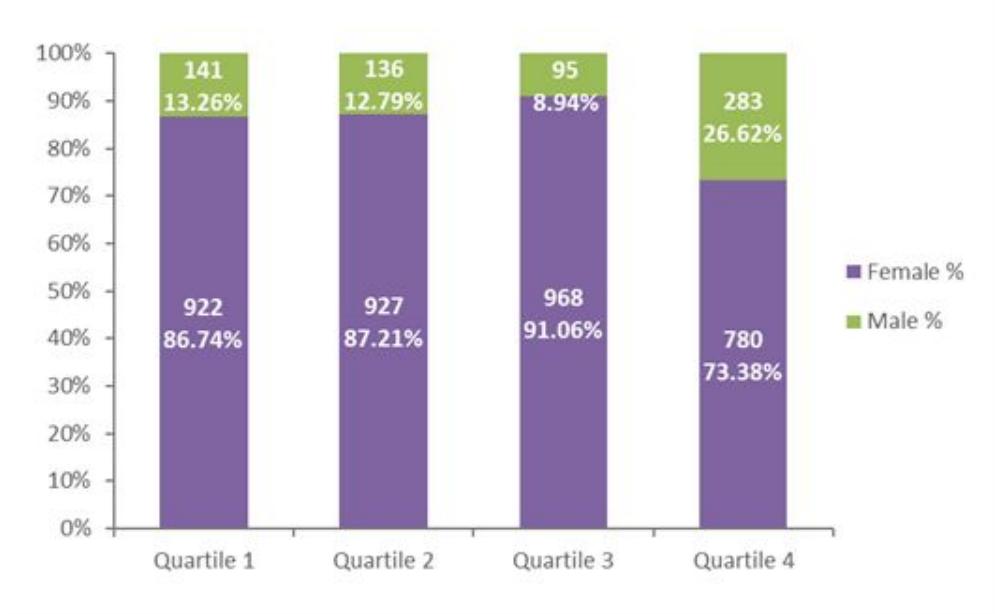
7. Proportion of men and women in each pay quartile

A quartile is where you take the range of data and divide it up. In this case it would be the range of hourly earners divided into four groups. Therefore, Quartile 1 is the lower 25% of staff hourly wages.

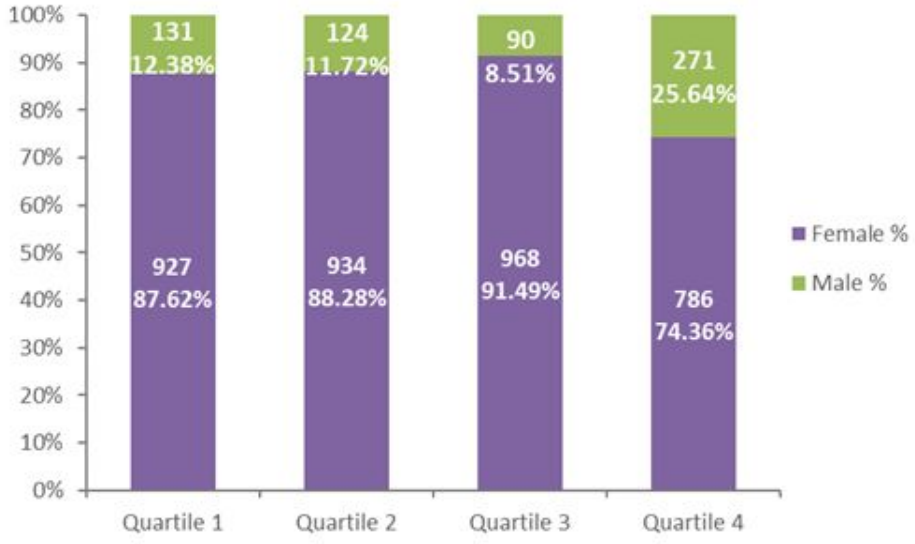
- Quartile 2 – lower middle
- Quartile 3 – upper middle
- Quartile 4 – upper

The graph below shows that the highest proportion of males is found in the upper quartile. In contrast, the lowest proportion of females is found in the upper quartile compared with other quartiles. This is influenced by the large proportion of male doctors and dentists within the Trust. The percentage of females in the upper middle and upper quartiles has decreased from the 2020 figures.

2021



2020



8. Summary and next steps in reducing the gender pay gap

Based on the data at 31 March 2021, women working in HDFT earn 85p for every £1 that men earn when comparing median hourly wages. Their median hourly wage is 14.51% lower than men's.

When comparing mean hourly wages, women's mean hourly wage is 27.61% lower than men's.

Women occupy 73.38% of the highest paid jobs and 86.74% of the lowest paid jobs – women account for 84.60% of the total workforce.

In the 'Medical and Dental' category, the percentage of males increased from 2020.

When comparing mean and median bonus pay, women's bonus pay is 19.54% and 33.06% lower than men's respectively.

The gender pay gap report has been shared with the Trust Board to make informed decisions on actions that are required to improve the gender pay gap.

It can be seen from the data in the report that the influence of medical and dental staff is driving the percentage gap. Removing medical and dental staff from the calculations, the pay gap percentage for the average mean hourly rate in 2021 is reduced from 27.61% to 7.40%. The median hourly rate pay gap percentage is almost equal for males and females when you take out the medical and dental staff meaning men earn £1 for every £1 that women earn when comparing median hourly wages.

Further workforce analysis is required to continue efforts in reducing the gender pay gap and identifying patterns and trends within service areas, departments, and occupations. This will be monitored by the Equality Diversity and Inclusion Steering Group to include:

- Disaggregate the data in different ways to better understand the drivers of the gender pay gap, considering the differences in terms of age, disability and race to provide better insights.
- Promote awareness of opportunities and policies including flexible and agile working arrangements that encourages women to return to careers following maternity and other life events.
- Encourage the take up of shared parental leave, job-share and part-time working and promote flexible working arrangements in vacancies including part-time, job share, compressed hours, home working etc.
- Promote unconscious bias training as part of the First Line Leaders programme and Pathway to Management.
- Develop a Women's Development Network and discuss across each Staff Network.
- Progress Working Carers Passport initiative and welfare discussions for all colleagues.
- Develop talent pipeline and encourage conversations with staff to discuss progression/promotion and goal setting through annual review processes.
- Continue work in relation to encouraging more applications for CEA from women and providing support for individuals who have submitted unsuccessful applications in the past.

Board of Directors (Public)
29th September 2021

Title:	**Director of Workforce & OD Report**
Responsible Director:	Director of Workforce & OD
Author:	Deputy Director of Workforce & OD

Purpose of the report and summary of key issues:	**Ethnicity Pay Gap Report – As at 31st March 2021** In summary this report highlights • The ethnicity split of the workforce is 89% white colleagues to 11% BME colleagues, however as a greater proportion of the BME workforce are in Medical and Dental positions in comparison, this impacts the ethnicity gap as these roles have a greater hourly rate for this group of staff. • Including Medical and Dental, the mean ethnicity pay gap is -21.26%, meaning BME colleagues are paid 21.26% more than white colleagues. • Excluding Medical and Dental, the mean ethnicity pay gap is -0.29%, meaning BME colleagues are paid 0.29% more than white colleagues, which is almost equal.	
BAF Risk:	AIM 1: To be an outstanding place to work	
	BAF1.1 to be an outstanding place to work	x
	BAF1.2 To be an inclusive employer where diversity is celebrated and valued	x
	AIM 2: To work with partners to deliver integrated care	
	BAF2.1 To improve population health and wellbeing, provide integrated care and to support primary care	
	BAF2.2 To be an active partner in population health and the transformation of health inequalities	
	AIM 3: To deliver high quality care	
	BAF3.1 and 3.4 To provide outstanding care and outstanding patient experience	
	BAF3.2 To provide a high quality service	
	BAF3.3 To provide high quality care to children and young people in adults community services	
	BAF3.5 To provide high quality public health 0-19 services	
	AIM 4: To ensure clinical and financial sustainability	
	BAF4.1 To continually improve services we provide to our population in a way that are more efficient	
	BAF4.2 and 4.3 To provide high quality care and to be a financially sustainable organisation	
	BAF4.4 To be financially stable to provide outstanding quality of care	
Corporate Risks	As detailed within the report.	
Report History:	N/A	
Recommendation:	The Board are requested to note the content of this report.	

6

Board of Directors (Public)
29th September 2021

Ethnicity Pay Gap Report - As at 31 March 2021

1. Ethnicity pay gap reporting

Diversity and inclusion are fundamental to the success of an organisation; in the service it provides and in creating a fair, diverse and inclusive environment for its workforce.

Research shows that organisations with diverse workforces and inclusive cultures perform better because they benefit from having a range of lived experiences and deeper understanding and viewpoints in the room. This in turn promotes diverse, creative and innovative decision-making.

The culture of an organisation also depends on these values; a place where people are proud to work, where they feel valued, recognised and supported to develop their true potential.

While there is currently no legal requirement to publish ethnicity pay gap data in the UK, we are reviewing this data alongside our mandated Gender Pay Gap data as good practice and in line with our commitment on closing gaps in workplace inequalities between our Black, Asian and Minority Ethnic (BAME) staff and White staff.

The disclosure of diversity data, such as ethnicity, is optional for staff. The data used in this report is based on a snapshot of data from 31 March 2021 for colleagues who have chosen to disclose their ethnicity. While this is the first time we are reporting on this information, we will continue in the future to track our progress.

Our mean ethnicity pay gap, shows the difference in average pay between BAME colleagues and White colleagues and takes into account all roles at all levels within Harrogate and District NHS Foundation Trust (HDFT). This is different to the concept of equal pay i.e. the comparison in pay received by BAME and White colleagues performing the same roles at the same grade.

HDFT pays most employees, excepting some medical and dental staff, on the Agenda for Change pay system, and this framework provides assurance that equal pay for equal work is recognised i.e. someone entering the band 5 scale with the same level of qualifications and experience would be paid the same irrespective of ethnicity; they would then have the opportunity to progress up the pay scale annually

The report will provide a breakdown of:

- Mean ethnicity pay gap in hourly pay.
- Median ethnicity pay gap in hourly pay.
- Mean bonus ethnicity pay gap.
- Median bonus ethnicity pay gap.
- Proportion of White and BAME colleagues receiving a bonus payment.
- Proportion of White and BAME colleagues in each pay quartile.

In summary this report highlights

- The ethnicity split of the workforce is 89% white colleagues to 11% BME colleagues, however as a greater proportion of the BME workforce are in Medical and Dental positions in comparison, this impacts the ethnicity gap as these roles have a greater hourly rate for this group of staff.
- Including Medical and Dental, the mean ethnicity pay gap is -21.26%, meaning BME colleagues are paid 21.26% more than white colleagues.
- Excluding Medical and Dental, the mean ethnicity pay gap is -0.29%, meaning BME colleagues are paid 0.29% more than white colleagues, which is almost equal.

NOTE - the headcount in this report totals 3,986 employees, compared to 4,252 employees in the gender report, this is because some employees have not declared their ethnicity so are not included in the ethnicity report. This is the reference that only 94% of the workforce have declared their ethnicity.

2. Harrogate and District NHS Foundation Trust

HDFT employs more than 4,000 members of staff to provide essential hospital treatment as well as community health services to the population of Harrogate and the local area, across North Yorkshire and Leeds, and children's services in North Yorkshire and the North East in County Durham, Darlington, Middlesbrough, Stockton-On-Tees, Gateshead and Sunderland.

The total number of staff eligible for inclusion in this report was 3,986 from a workforce of 4,252. The data in this report is based on those who have chosen to disclose their ethnicity which accounts for 94% of the workforce.

	31 March 2021		31 March 2020	
	Headcount	%	Headcount	%
BAME	436	11%	378	9%
White	3,550	89%	3,637	91%
TOTAL	**3,986**		**4,015**	

We must continue to encourage staff to declare their ethnicity. The disclosure rate is important as it reflects how comfortable, or not, people are about sharing these details with us and more broadly whether we are creating an environment where people can truly be themselves.

Figure 1 illustrates the ethnicity distribution within HDFT at 31 March 2021

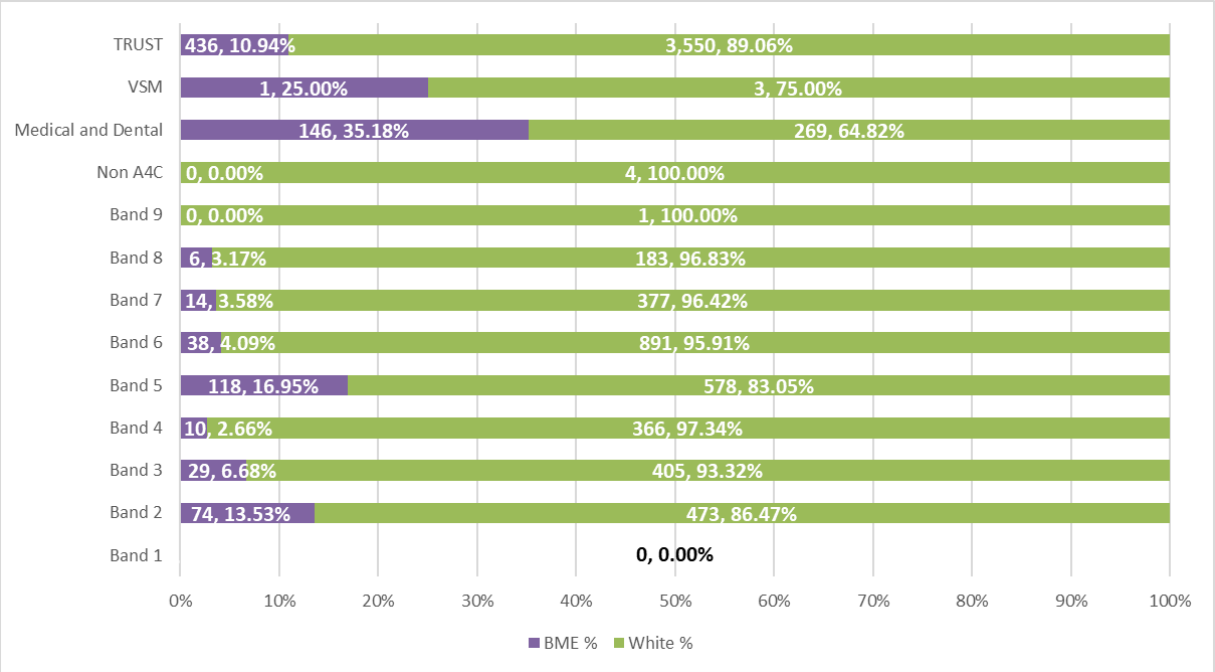
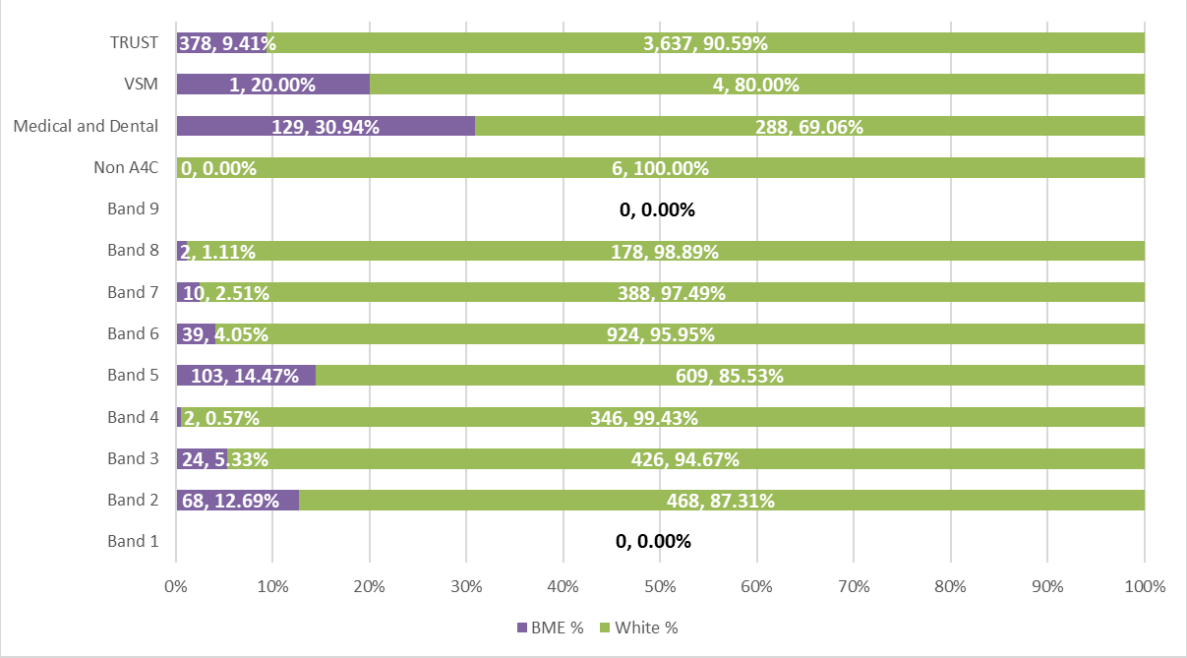


Figure 2 illustrates the ethnicity distribution within HDFT at 31 March 2020



Note - As part of the 2018 pay deal, Band 1 closed to new entrants with effect from 1 December 2018 and all existing staff on a Band 1 contract at HDFT transitioned over to Band 2 from April 2019.

3. Definitions and scope

The Ethnicity Pay Gap is a measure that shows the difference in average earnings between BAME colleagues and White colleagues across an organisation

The report is based on rates of pay for the financial year 2020/21. It includes all workers in scope at 31 March 2021. A figure above zero indicates an Ethnicity Pay Gap disadvantageous to BAME colleagues; a minus figure indicates the ethnicity pay gap disadvantageous to White colleagues.

The Ethnicity Pay Gap is described in two different terms. Firstly, the difference between the mean of hourly rates of White colleagues and the hourly rates of BAME colleagues and secondly as the difference between the median of hourly rates of White colleagues and the median hourly rates of BAME colleagues.

Mean and Median

• The "mean" is an average of all hourly rates of pay.
• The "median" is the middle value in a complete list of all hourly rates of pay.

4. Mean and median ethnicity pay gap in hourly pay

Ethnicity	Mean Hourly Rate 2021	Median Hourly Rate 2021	Mean Hourly Rate 2020	Median Hourly Rate 2020
White (£)	18.30	16.04	17.93	15.58
BAME (£)	22.19	18.08	22.27	18.28
Difference (£)	-3.89	-2.04	-4.34	-2.70
Pay Gap %	-21.26	-12.71	-24.19	-17.30

- As highlighted in Figure 1, the proportion of BAME staff is much higher in the medical and dental staff group than in any other pay band.
- As shown above, HDFT is reporting a minus ethnicity pay gap of -21.26%, meaning that based on an average hourly rate BAME employees are paid 21.26% more than White employees. This is a decrease of 2020's figure of -24.19%.
- The figures also demonstrate that HDFT has a minus median ethnicity pay gap of -12.71%, a decrease of 2020's figure of -17.30%.

5. Mean and median bonus ethnicity pay gap

HDFT pays out two types of bonuses, Clinical Excellence Awards (CEA) and Long Service Awards.

CEA are awarded based on the performance of a consultant. The CEA process requires the consultant to apply for the award and their application is then reviewed by a Panel.

Based on consultants who have declared their ethnicity, HDFT employs 150 consultants of whom 117 identify as White and 33 identify as BAME (as at 31.3.21). Of the total workforce who have declared their ethnicity, 114 White consultants (97.44%) which are 3.21% of all White colleagues employed received a CEA payment and 26 BAME consultants (78.79%) which are 5.96% of all BAME colleagues employed received a CEA payment.

Ethnicity	Mean Bonus 2021 (£)	Median Bonus 2021 (£)	Mean Bonus 2020 (£)	Median Bonus 2020 (£)
White	10,972.02	6,108.00	11,667.70	7,540.00
BAME	6,580.77	6,108.00	5,907.81	6,032.00
Difference	4,391.25	0.00	5,759.89	1,508.00
Pay Gap %	40.02	0.00	49.37	20.00

- This shows a positive reduction in both the mean and median ethnicity bonus gap differential by 9.35% and 20.00% respectively from 2020 to 2021 however the mean pay gap remains significantly high in the favour of White consultants.
- In 2018 the CEA pay scheme was changed to a non-consolidated, non pensionable pay scheme. 2020 and 2021, the BMA and NHS Employers have agreed a one off payment due to the impact of COVID19. The one off payment for 2020 has already been paid (Oct 2020) however 2021 has not yet been paid but is expected in Oct/Nov of this year.

<u>The Influence of Medical and Dental Staff</u>

Medical and Dental staff have a substantial impact on HDFT's Ethnicity Pay Gap, as individuals in this staff group tend to be paid higher wages than other HDFT employees. Although HDFT currently has 117 White consultants and 33 BAME consultants, because HDFT employs fewer BAME colleagues overall, the number of BAME consultants as a proportion of the overall BAME workforce at 7.57% is higher than that of White consultants 3.30% of the overall White workforce.

To evidence the influence of medical and dental staff driving the percentage gap, the table below shows that taking out the medical and dental staff from the calculations, the Ethnicity Pay Gap percentage for the average mean hourly rate in 2021 changes from -21.26% to -0.29% and the median hourly rate pay gap percentage becomes more favourable to White colleagues.

Ethnicity	Mean Hourly Rate 2021	Median Hourly Rate 2021	Mean Hourly Rate 2020	Median Hourly Rate 2020
White (£)	16.45	15.76	15.78	15.40
BME (£)	16.49	15.66	15.25	14.23
Difference (£)	-0.05	0.10	0.53	1.17
Pay Gap %	-0.29	0.66	3.39	7.58

6. Proportion of White and BME colleagues receiving a bonus payment

Long Service Awards include a £40 bonus paid to any member of staff eligible and in recognition of 25, 30, 35, 40 and 50 years' service at HDFT. As this bonus is paid out equally to White colleagues and BAME colleagues it would have no influence on the figures.

Taking both clinical excellence awards and long service awards into account, as a proportion 7.6% of White colleagues (269) received a bonus compared to 7.8% of BAME colleagues (34). It should be noted that the Long Service Awards honoured in 2021 were to colleagues who should have received them in 2020, however these were delayed due to the Coronavirus pandemic.

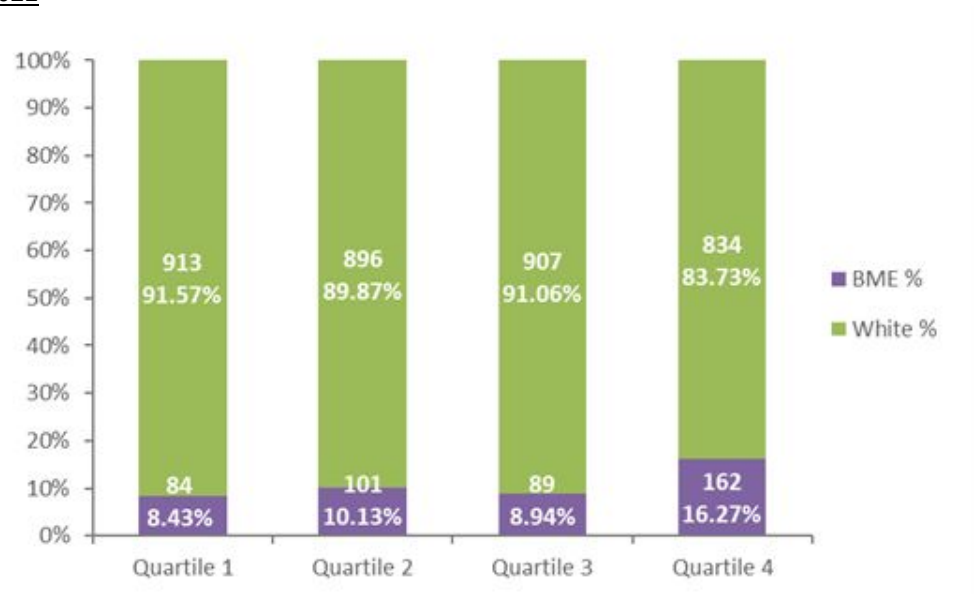
7. Proportion of White and BAME colleagues in each pay quartile

A quartile is where you take the range of data and divide it up. In this case it would be the range of hourly earners divided into four groups. Therefore, Quartile 1 is the lower 25% of staff hourly wages.

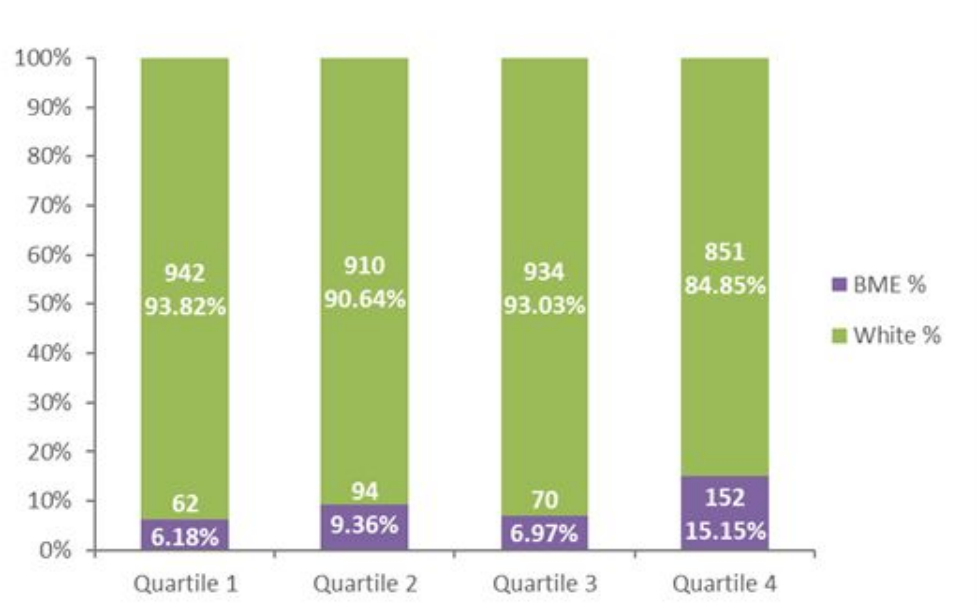
- Quartile 2 – lower middle
- Quartile 3 – upper middle
- Quartile 4 – upper

The graph below shows that the highest proportion of White colleagues is found in the upper middle quartile and lowest quartile. The highest proportion of BAME colleagues is found in the upper quartile compared with other quartiles. This is influenced by the large proportion of BAME doctors and dentists within HDFT. The percentage of BAME in the upper quartile has increased from the 2020 figures.

2021



2020



8. Summary and next steps in reducing the ethnicity pay gap

The data in this report is based on those who have chosen to disclose their ethnicity.

In total, 11% of colleagues who have shared their data identify as BAME, based on a 94% disclosure rate from colleagues across HDFT.

We acknowledge there is a lot more to do to continue making improvements and bring positive changes for our BAME colleagues, and to welcome a more diverse workforce to HDFT. In line with our Workforce Race Equality Standard (WRES) Action Plan and our Recruitment and EDI work streams as part of the 'At our Best' programme, HDFT is committed to increase the ethnic diversity of both our overall and senior workforce, to put a greater focus on recruiting and developing BAME staff, and driving initiatives that will demonstrate that we're serious about real cultural change.

The Ethnicity Pay Gap report has been shared with HDFT Board to make informed decisions on actions that are required to improve the ethnicity pay gap.

It can be seen from the data in the report that the influence of medical and dental staff is driving the percentage gap. Removing medical and dental staff from the calculations (10% of the overall workforce), the pay gap percentage for the average mean hourly rate and median rate in 2020 changes in favour of White staff, providing a reflection of the larger proportion of the workforce.

Further workforce analysis is required to continue efforts in reducing the ethnicity pay gap and identifying patterns and trends within service areas, departments, and occupations. This will be monitored by the Equality Diversity and Inclusion Steering Group to include:

- Our Becoming an Anti-Racist Organisation programme.

- Integrated and systems wide in conjunction with the RootOutRacism movement across West Yorkshire & Harrogate.
- Progressing recruitment, progression and culture will take significant steps to help close this current gap.
- Encourage the take up of shared parental leave, job-share and part-time working and promote flexible working arrangements in vacancies including part-time, job share, compressed hours, home working etc.
- Promote training and education including unconscious bias training as part of the First Line Leaders programme and Pathway to Management.
- Continue to listen to the lived experiences of the BAME and Ally Staff Network, engage with and value their expertise.
- Encourage staff to feel confident in declaring their ethnicity status on ESR.
- Develop talent pipeline and encourage conversations with staff to discuss progression/promotion and goal setting through annual review processes.
- Continue work in relation to encouraging more applications for CEA from BAME consultants and providing support for individuals who have submitted unsuccessful applications in the past.
- Diverse representation on the CEA Panel.

Board Committee Report to the Board of Directors

Committee Name:	Audit Committee
Committee Chair:	Richard Stiff
Date of meeting:	7th September 2021
Date of Board meeting this report is to be presented	29th September 2021

Summary of key issues

The committee continues to meet via Microsoft Teams and be well attended. The committee welcomed Kate Southgate to her first meeting and also Steve Treece and Clare Illingworth observing on behalf of the Council of Governors.

Matters considered included –

- Corporate Risk - The committee received minutes of the Corporate Risk Review Group from April 2021, the latest corporate risk register and an update on the development of risk management arrangements centred on the new Executive Risk Review Group. The committee agreed that the new risk management process is more focused and more likely to support the committee's role. In future the committee will receive a risk report covering meetings held between its meetings rather than detailed minutes of meetings. The committee discussed in particular the absence of a Health and Safety Manager post in the Trust's management structure, the current rating of RTT risks and risks related to on site security arrangements.
- Quality Committee Business - the June 2021 Quality Committee minutes and the Quality Committee Annual Report were received and noted.
- Board Assurance Framework - the Company Secretary gave the committee an update on progress with the revision of the Trust BAF mechanism and reporting.
- Financial Management - the committee received the annual review of the Trust's Treasury Management Policy and the annual report on treasury activity. There was some discussion of the Trust's investment approach in the context on an unfavourable investment market. The updated Policy, including only non-material revisions, was approved.
- Procurement– the quarterly procurement report, including an update on the progress of the Procurement Transformation Programme (PTP), was received. Joint work with LTHT and across WYAAT continues to benefit HDFT with the collaboration achieving savings on expenditure with more expected in future. There was discussion of

plans to improve sustainability in the procurement of PPE and the planned appointment of a procurement officer with a clinical background to enable better informed challenge to clinicians in relation to their purchasing choices.

- Internal Audit - the committee received and approved the updated Audit Yorkshire Internal Audit Charter and considered the regular Internal Audit progress report on the delivery of the 2021/22 internal audit plans for HDFT and HIF. There was discussion of outstanding recommendations and the developing process to address unactioned recommendations which will involve the new Executive Risk Group. Internal Audit colleagues expressed confidence that outstanding actions will be progressed. Actions related to limited assurance reports including discharge to assess, income from overseas visitors and the pathology JV were discussed.
- External Audit – there was no representative of KPMG at the meeting. The committee received and noted their report and the usual sector technical update. A minor error in the year end document provided to the recent Council of Governors meeting was identified - a superseded version may have been circulated. It was noted that the PowerPoint presentation delivered by KPMG at the meeting was however entirely accurate and up to date. The Company Secretary agreed to look into this. There was a discussion on the positioning of climate change risk outlined in the technical update. The annual review of external audit effectiveness was considered. This showed a slight reduction on scores from the previous year. It was noted that the current external audit contract with KPMG expires in March 2022 and that a tender process will begin shortly. Jeremy Cross agreed to be the second NED member of the procurement panel alongside the Audit Committee Chair, representative governors, and senior finance officers.
- There were no single tender actions or post project evaluations for review at this meeting.

The committee will meet next on Tuesday 7th December 2021.

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

None.

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

None.

Board Committee Report to the Board of Directors

Committee Name:	Senior Management Team
Committee Chair:	Steve Russell, Chief Executive
Date of meeting:	18th August 2021
Date of Board meeting this report is to be presented	29th September 2021

Summary of key issues

- It was noted that Amanda Pritchard had been appointed as the new Chief Executive of NHS England on 1st August 2021
- As part of local government reforms to propose unitary authorities, a new North Yorkshire unitary council would operate alongside the existing unitary City of York Council by 2023
- An update was provided on Northumberland 0-19 services
- A new information governance pathway was being piloted
- The Central Alerting System (CAS) was being redesigned internally
- A new Chief Registrar and HEE Clinical Leadership Fellow had both started
- The revised clinical governance framework was continuing to move forward at pace with the inaugural Quality Summit taking place on 4th August 2021
- The "Perfect Ward" demonstration had taken place and procurement had commenced
- The reconfiguration of the Emergency Department was progressing well
- The Quality Account draft was received and noted.
- The Strengthening Maternity and Neonatal Safety Report was received and noted.
- A presentation was received on clinical standards and compliance monitoring at HDFT
- A report was received on a thematic review of missed diagnosis was received
- Workforce updates were received on the increasing sickness rates, staff turnover, appraisal rates and Covid 19 guidance.
- The month 3 financial performance was received and noted. Agency spend had exceed the agency ceiling in July 2021. Efficiencies were noted to be required in the second half of the year and confirmation of allocations were not expected until September.
- A robust discussion occurred regarding the proposed Directorate CIP's including the challenges for 2C's in view of CIP and LA contracts, relationships with partners, activity recovery, opportunities and risks.

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

None

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

None

Harrogate and District NHS Foundation Trust

Board Committee Report to the Board of Directors

Committee Name:	Senior Management Team
Committee Chair:	Steve Russell, Chief Executive
Date of meeting:	22nd September 2021
Date of Board meeting this report is to be presented	29th September 2021

Summary of key issues

- As part of the Chief Executive update information was provided on the recruitment of the Chairman, Chief Executive and other senior posts within the local ICS
- An update and discussion took place in relation to current pressures on the wider NHS community which is impacting acutely on social care and residential care.
- The national shortage of BD blood bottles was highlighted. HDFT have reduced usage by 25% since alert published and have sourced compatible alternatives should they be required
- Digital Aspirant Programme was highlighted. AHLC/CoStratify review of HDFT has been completed and recommendations are due to be presented to the Executive Team later this month.
- 1 new SI has been declared in Theatres – relating to a medication error
- Northumberland 0-19 update was provided with discussions taking place on HR, Finance, Estates and IT programmes in place for the transfer of the team to HDFT
- 0-19 safeguarding was highlighted as an ongoing risk. The risk was monitored and reported daily via an OPEL system. The impact of 12-15 vaccination programme would increase the OPEL risk to a continued Level 3.
- Elective recovery: No weekend working uptake and limited evening work underway combined with holiday and theatre staffing gaps highlight a difficult August position in lists running
- 2WW Cancer performance – 86% performance against target, trajectory still on track for September achievement
- RTT Waiting list continued to increase in August as the Trust continued at full capacity (whilst maintaining social distancing) to stem increased referral demand - longer waits in T&O, Ophthalmology and Community Dental
- Cancer 62 day wait target achieved at 91.2%
- ED performance and activity was reported. An improving trajectory was noted.
- An update was provided on sickness absence with both short term and long

term absence trends and impacts were highlighted. Short term sickness absence was currently having the greatest impact
- Workforce updates were received on staff turnover, appraisal rates and Covid 19 guidance.
- The reciprocal mentoring programme was discussed.
- The Workforce Race Equality Standards (WRES) annual reported was noted and approved with further work required in relation to recruitment and progression.
- The Workforce Disability Equality Standards (WDES) annual report was noted and approved. It was highlighted that a new Chair had been appointed to the Disability Staff Network
- The Gender Pay Gap Report was noted and approved
- The Ethnicity Pay Gap Report was noted and approved
- There continue to be a number of areas of pressure that are being offset by underspends in relation to activity delivery and the 0 -19 service vacancies
- The wards are overspent against current establishment
- There remains slippage within our capital programme, which continues to be forecast
- Allocation for H2 expected in September, and our runrate is higher currently than at the end of 2019/20, which we will need to manage and reduce

As part of the Senior Manager Team development programme two workshops took place. The first was in relation to becoming an anti-racist organisation. The second was in relation to the development of the SMT committee.

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

None

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

None

7

			2021		2022					
Element	**Item**	**Frequency**	**Sept**	**Nov**	**Jan**	**Mar**	**May**	**Jul**	**Sept**	**Nov**
Opening Items	Patient Story	All	x	x	x	x	x	x	x	x
	Declarations	All	x	x	x	x	x	x	x	x
	Minutes	All	x	x	x	x	x	x	x	x
	Action Tracker	All	x	x	x	x	x	x	x	x
	Chairman Report	All	x	x	x	x	x	x	x	x
Chief Executive	Chief Executive Report	All	x	x	x	x	x	x	x	x
	Corporate Risk Register	All	x	x	x	x	x	x	x	x
Quality & Safety	Quality Committee Chair Report	All	x	x	x	x	x	x	x	x
	IBR Metrics	All	x	x	x	x	x	x	x	x
	Director of Nursing, Midwifery and AHPs	All	x	x	x	x	x	x	x	x
	Freedom to Speak Up	Quarterly	x	x		x	x		x	x
	Strengthening Maternity and Neonatal Safety	All	x	x	x	x	x	x	x	x
	Medical Director Report	All	x	x	x	x	x	x	x	x
	Guardian of Safe Working	Quarterly	x	x		x	x		x	x
	Learning from Deaths	Quarterly	x	x		x	x		x	x
	Statement – Eliminating Mixed Sex Accommodation	Annually					x			
	Quality Accounts	Annually					x			
	National Patient Survey	Annually		x						x
	Safeguarding Annual Report	Annually		x				x		
	Health and Safety Annual Report	Annually		x			x			
	IPC Annual Report	Annually	x				x			
	7 Day Working Framework	As required								
People & Culture	People & Culture Chairs Report	All	x	x	x	x	x	x	x	x
	IBT Metrics	All	x	x	x	x	x	x	x	x
	Workforce Report	All	x	x	x	x	x	x	x	x
	Workforce Race Equality Standards	Annually	x				x			
	Workforce Disability Equality Standards	Annually	x				x			
	Public Sector Equality Duty	Annually	x				x			
	Gender Pay Gap	Annually	x				x			
	Medical Revalidation	Annually	x				x			
	Modern Slavery	Annually		x			x			
	National Staff Survey	Annually		x						x
Strategy & Partnerships	Director of Partnership Report	All	x	x	x	x	x	x	x	x
	Trust Strategy	As required								
Resources and Finance	Resource Committee Chairs Report	All	x	x	x	x	x	x	x	x
	IBR Metrics	All	x	x	x	x	x	x	x	x
	Director of Finance report	All	x	x	x	x	x	x	x	x
	Chief Operating Officer Report	All	x	x	x	x	x	x	x	x
	Organisational Development Report	All	x	x	x	x	x	x	x	x

			2021		2022					
Element	**Item**	**Frequency**	**Sept**	**Nov**	**Jan**	**Mar**	**May**	**Jul**	**Sept**	**Nov**
Governance	Audit Committee Chairs Report	All	x	x	x	x	x	x	x	x
	SMT Chairs Report	All	x	x	x	x	x	x	x	x
	Board Assurance Framework	All	x	x	x	x	x	x	x	x
	Board Reporting Framework	All	x	x	x	x	x	x	x	x
	Annual Accounts	Annually					x			
	Going Concern Review	Annually					x			
	Audit Letter	Annually					x			
	Annual Report	Annually					x			
	Emergency Preparedness Statement	Annually					x			
	Self certification and statement	Annually				x				
	Fit and Proper Person	Annually					x			
	Standing Orders	As Required								
	Use of Trust Seal	As required								
	Board Effectiveness Review	Annually						x		
	Certification on training for governors	Annually				x				