Trust Board

Title:	**Corporate Risk Register**
Responsible Director:	Chief Executive
Author:	Associate Director of Quality and Corporate Affairs

Purpose of the report and summary of key issues:	The report provides the Board with key updates and actions since the previous meeting. All Corporate Risks have been reviewed via the Directorate Review Meetings, the Executive Risk Review Meeting and previous Senior Management Team meeting. Details of key indicators, mitigation, target risk ratings and current risk ratings are detailed in the report.	
BAF Risk:	AIM 1: To be an outstanding place to work	
	BAF1.1 to be an outstanding place to work	X
	BAF1.2 To be an inclusive employer where diversity is celebrated and valued	X
	AIM 2: To work with partners to deliver integrated care	
	BAF2.1 To improve population health and wellbeing, provide integrated care and to support primary care	X
	BAF2.2 To be an active partner in population health and the transformation of health inequalities	X
	AIM 3: To deliver high quality care	
	BAF3.1 and 3.4 To provide outstanding care and outstanding patient experience	X
	BAF3.2 To provide a high quality service	X
	BAF3.3 To provide high quality care to children and young people in adults community services	X
	BAF3.5 To provide high quality public health 0-19 services	X
	AIM 4: To ensure clinical and financial sustainability	
	BAF4.1 To continually improve services we provide to our population in a way that are more efficient	X
	BAF4.2 and 4.3 To provide high quality care and to be a financially sustainable organisation	X
	BAF4.4 To be financially stable to provide outstanding quality of care	X
Corporate Risks	All	
Report History:	Previous updates submitted to Public Board meetings, Executive Risk Review Meeting and the Senior Management Team meeting.	
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 (PUBLIC)
JULY 2022

CORPORATE RISK REGISTER

1.0 INTRODUCTION

The Corporate Risk Register consist of operational risk scoring 12 or above. It is reviewed monthly at the Directorate Performance Reviews and at the Executive Risk Management Group. This report provides a summary of the position in July 2022.

2.0 CORPORATE RISKS

2.1 CRR5 – Nursing Shortages

The risk remains with nurse staffing and the risk remains elevated to 16 to reflect the current circumstances. A review of the gathering and analysis of the data in terms of vacancies was underway to ensure the true picture was known.

In terms of mitigation the following were noted:

- Successful bid (87k) to NHSE/I to recruit additional CSWs to bring to zero vacancy (inpatient units)
- Additional focused HCSW recruitment day 26/5/22 and ongoing HCSW recruitment and resulted in 40 offers of posts to HCSWs – on boarding now taking place with total of 36 new recruits remaining in the process
- Redefining of CSW Development Programme to support new recruits, programme has commenced and evaluating well
- Additional work commencing on HCSW progression to Band 3 – competency framework
- Clarity of career progression from CSW to RN and points between
- Agreed 'Home Trust' status with York St John University, have 100% clinical placement capacity at HDFT to support 'growing our own'
- Additional placement capacity agreed to accommodate additional student numbers Which would increase the student intake from 186 currently, to 222 in September '22 and a predicted 237 by 2023
- Exploration of training and education space and accommodation with York St John University for current and new staff members
- International Recruitment and associated funding to increase capacity, continue to review opportunities to increase IR intakes. Expecting 26 new arrivals between June '22 and January '23. There has been a development of 'bootcamp' style courses in preparation for OSCES
- Bid for a further 60 international nurses submitted in July for October '22 and January '23 intake
- Refreshed recruitment and retention operational group recommenced in June with two focused task and finish groups established – one for recruitment and one for retention
- Preceptorship programmes to retain newly qualified and new starters refreshed
- Working with Directorates re bed bases / establishments and staffing models
- Focused work on HealthRoster KPIs and performance of effective rostering practice

The Target Risk is 9 (3x3) – March 2023 (from March 2022).

The Current Risk is 16 (4x4) – June 2022. This is an escalated risk from March 2022, which had a position of 12 (3x4).

2.2 CRR6 – Wellbeing of Staff

Work continues with the support and development programme to assist in colleagues wellbeing. Of note is that a Mental Health Nurse and a Colleague Wellbeing Programme Lead role have both been recruited to and are due to commence in Quarter 4 2021-22. The risk has been escalated from 12 to 16.

The following key actions have taken place:

- Planning combined Flu and Covid Vaccine programme for all colleagues to commence October 2022.
- Recruitment and Retention groups being established to ensure significant programmes of work underway on both topics.
- Task & Finish Group established to review and address Trust-wide feedback arising from national staff survey
- Continued roll out of Healthroster to ensure wards appropriately staffed and purchase of SaferStaffing module underway
- Upgraded ward – to improve environment
- Operational Leadership Management Restructure consultation process underway, which will create more dedicated time to leadership and management in the clinical environment
- Board of Directors Workshop held on 29 June 2022 – SMT workshop to follow this up and agree actions
- Menopause staff support network, and menopause support
- Mental Health Champions in place and being supported in their role
- VIVUP – Employee Assistance Programme receiving increased up-take following promotional campaign
- Strong links with the HCV ICS Resilience Hub continues
- Bi-monthly Health & Wellbeing newsletter to be launched to provide a vehicle for communicating the pathways of support available, showing case studies and normalising the issue.
- Results of welfare funding bid communicated Trust wide on 7 July to demonstrate listening and commitment to improving working environments.
- Leadership Community of Practice to be established for September to support line managers in receiving and responding to Inpulse and National Staff Survey feedback

The Target Risk is 9 (3x3) – March 2023 (from March 2022).

The Current Risk is 16 (4x4) – June 2022. This is an escalated risk from March 2022 which had a position of 12 (3x4).

2.3 Immunisation Services

A review was undertaken of the last 6 months incidents and confirmed that 8 children had received duplicate vaccination in error. The administration of a duplicate vaccine is low harm (especially compared with the risk of not being vaccinated) but it is an unnecessary procedure.

No incidents were noted in April 2022.

RPIW took place 12-15th April to review / amend current processes and develop SOPs to support reduction in unwarranted variation and practice. Pause and learn event took place with the wider team on the 25th April to share the learning from the RPIW and to progress work streams identified.

An experienced Service Manager from 0-19 team seconded to support Clinical Lead with review and transformation of service. Band 7 Leadership capacity increased to support capacity to deliver change.

The Target Risk is 4 (1x4) – March 2023

The Current Risk is 12 (3x4) – May 2022, the risk remains the same as April 2022.

2.4 CRR34 – Autism Assessment

The Current Position is noted as:

- Numbers on the waiting list: 552
- Longest wait: 70 weeks
- Financial year to date delivery 154 completed assessment.

Rolling 6-month average monthly referral rate is at 64 and is higher than baseline commissioned capacity of 40 assessments per month. Capacity is 55 with funded additional capacity until August 22.

Due to continuing higher referral numbers & assessment model (which is in line with NICE recommendations) we are predicting we would end the year with a waiting list of 743 children with a 19 month wait to commence assessment.

The Target Risk is 6 (3x2) – amended to March 2026 from March 2022

The Current Risk is 12 (3x4) – June 2022. This is the same rating as November and December 2021, and January to May 2022.

2.5 CRR41 – RTT

Elective recovery work continues to be a major focus, and we continue to, where possible, increase elective admissions to reduce the gap to pre-COVID levels. The trust have implemented and resourced dedicated project support in theatres that commenced in October 2021 to aid elective recovery.

The current position is as follows:

	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
Total incomplete RTT pathways	17,690	19,476	20,631	21,785	22,168	22,648	22,423	22,714	23,464	23,323	23,900
> 52 weeks	1,190	1,087	1,006	988	955	1,008	1,070	1,097	1,177	1,138	1,157
> 104 weeks	3	5	13	20	23	27	33	34	47	52	50
RTT clock stops	4,790	4,776	5,428	5,001	4,783	4,865	5,381	6,093	4,657	5,245	4,759

	Mar-22	Apr-22	May-22	*Jun-22 (provisional)*
Total incomplete RTT pathways	23,931	24,714	25,384	*25,905*
> 52 weeks	1,140	1,187	1,196	*1,322*
> 78 weeks	187	205	184	*175*
> 104 weeks	22	11	3	*1*
RTT new clock starts	7,621	6,403	7,219	*6,610*
RTT clock stops	5,605	4,290	5,136	*4,264*

Ring fencing of orthopaedic elective capacity is underway alongside a pilot of an LLP model to re-engage weekend and evening lists (commenced 11th June 2022 with lists alternate weekends since)

Clinical prioritisation and review continue for elective patients with 99% of patients waiting having been allocated a P1-6 national classification. The majority of those yet to be classified have been waiting <=2 weeks and work is progressing to ensure these are rapidly coded.

104+ week waiters

Through Quarter 3 and 4, the Trust have been working collectively with our partner Trusts across WYAAT to understand how each Trust could support pressures on waiting lists, redesigning pathways and agreeing governance for identifying capacity to support the treatment of long waiting patients and ensuring consistent communication.

As part of this process HDFT have supported both Bradford Trust and Leeds Teaching Hospitals Trust in the treatment of both ENT and Max Fax paediatric long waiting patients. The patients/carers were contacted and consented to transfer their care to Harrogate and will now receive their treatment before the end of March '22.

Internally the Trust continue to review all patients on the Admitted pathway over 60 weeks and have initiated a weekly PTL meeting. With the service manager, admissions manager and 18-week lead each patient is reviewed to ensure that there are clear plans in place.

The community dental over 104 weeks is now zero. The 1 remaining reported >104 week patient is a orthopaedic patient who is unavailable for surgery until(P6) September – there has been a number of long waiting patients cancelling due to new COVID infection which so far we have been able to mitigate.

All patients over 93 weeks have a date for surgery.

The Target Risk is 6 (3x2) – March 2024, amended from March 2021

The Current Risk is 12 (3x4) –June 2022. This is the same rating as November and December 2021 and January to May 2022.

2.6 CRR61 – ED 4-hour Standard

A&E 4 hour standard remained below the 95% standard in June 2022.

A&E 4 hour standard – remained below the 95% standard in June 2022 at 66.53% (however this figure has improved – highest since Jan 22). There continues to be an increase in presentations, and divert support provided for York Hospital. 6 hour harm indicator - equates to 10 harms due to longer stay in June. 15 – 12hour breaches occurred in June. Improvement in ambulance handover was noted.
The same mitigations are in place – approval for new staffing model has been obtained.
The risk reduction target date has been moved back to September to reflect the timescales of implementing the new streaming model.

The Target Risk is 10 (2x5) – March 2024, amended from March 2021 and target risk updated from (3x3) 9.

The Current Risk is 15 (3x5) –June 2022. This risk rating has been reviewed and upgraded from a 12.

2.7 Health and Safety

Work to formalise the Health and Safety Risk has been undertaken – information from the external report which was presented at SMT has been included in this. Current position with plans to deliver the reduced risk is noted below:

- Exploration of Tendable as a mechanism for audit programme
- Contractor meetings with HIF to ensure that H&S requirements of external contractors are adhered to
- TNA/GAP Analysis to be commenced to understand training needs and gaps for managers re: H&S responsibilities
- Action plan drawn up following external review of H&S compliance, this will be exception reported to revised Health and Safety Committee to capture and monitor ongoing risks
- Review and updating of the Ligature Risk procedure
- Review of Fire Door compliance across the site
- Head of Health and Safety appointed.
- Full site survey for all access control/lockdown to report back on position for improvement

The Target Risk is 9 (3x3) – November 2022 – revised from December 2021

The Current Risk is 12 (3x4) – June 2022 this is the same as November and December 2021 and January to May 2022.

2.8 Pharmacy Aseptic

The Replacement of the Aseptic Unit is required to permanently reduce the risk.
The unit has now closed to allow for replacement of the unit, this will require it to closed for approx 12 months. The impact of this will be mitigated by a combination of: ward based preparation of products, outsourcing products to LTHT and the private sector; HDFT aseptic staff working in the YSTHFT unit to increase its production capacity so it can supply products for HDFT.

A BC was submitted and approved by Trust Board in Mar 22. With the construction of the new unit planned to start in Jun 22 (aligned with the replacement of the Air Handling Unit through the SALIX programme) subject to completion of the procurement process and availability of the chosen contractor to start the work.

Capital funding for 2022/23 has been agreed.

YSTHFT aseptic unit working at reduced capacity and reduced expiry dates for manufactured products (max 24 hours) due to isolators not fully commissioned which poses risk to mutual aid capacity and work flow management. Risk score will be re-assessed in Jul/Aug in light of increased risk at YSTHFT

The risk will be reassessed once the procurement process has been completed; if the process is successful with a contractor appointed and able to meet the planned timescales, it may be appropriate to reduce it below 12 to be a Directorate risk.

The Target Risk is 2 (2x1) – September 2023

The Current Risk is 12 (3x4) – June 2022, this is the same rating at January to May 2022.

2 RECOMMENDATIONS

It is recommended that the information is noted for assurance.

Kate Southgate
Associate Director of Quality and Corporate Affairs
July 2022

Board of Directors (Public)
July 2022

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

Purpose of the report and summary of key issues:	The report provides the Trust Board with key updates and actions since the previous meeting in May 2022. 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.	

HARROGATE AND DISTRICT NHS FOUNDATION TRUST
TRUST BOARD
BOARD ASSURANCE FRAMEWORK

1.0 PURPOSE

The purpose of the report is to present the Q4 Board Assurance Framework to the Trust Board. The Board is asked to consider the proposals regarding the Q4 target risk ratings.

2.0 BACKGROUND

As the Trust Board will be aware, a new Trust Strategy is in development. As such a revised Board Assurance Framework will be developed to align to the new strategic objectives. Current and target risk ratings will be considered and risk appetite levels will be set. These will be presented to Board in September 2022 for review and approval.

Following this approval the relevant sections of the BAF will be reviewed regularly by the relevant Board Committee and in its entirety at Public Board Meetings.

3.0 CURRENT STATUS

Attached at Appendix 1 is the year end risk rating proposals.

It is summarised as follows:

- BAF 1.1 – To be an outstanding place to work. Risk rating currently 12 which is above the target risk of 8. This is due to the impact of the pandemic on staff and their wellbeing. This risk will be re-scoped for the revised BAF.
- BAF 1.2 – To be an inclusive and diverse employer. Risk rating currently 12 which is above the target risk of 8. This is due to the impact of the pandemic on staff and their wellbeing. This risk will be re-scoped for the revised BAF.
- BAF 2.1 – To improve population health and wellbeing. Risk rating currently 9 which is above target risk of 6. This has been impacted on by the role in two ICS. This risk will be re-scoped for the revised BAF.
- BAF 2.2 - To be an active partner in population health and the transformation of health inequalities. Risk rating currently 9 which is above target risk of 6. This has been impacted on by the role in two ICS. This risk will be re-scoped for the revised BAF.
- BAF 3.1 - To provide outstanding care and outstanding patient experience. Target risk rating of 8 met. Risk to be reviewed and revised for new BAF.
- BAF 3.2 - To provide a high quality service. Current risk rating of 16, target risk of 8 not met. This risk will be reviewed and revised for the new BAF to ensure sufficient focus on the development and delivery of the revised clinical strategy.
- BAF 3.3 - To provide high quality care to children and young people in adults community services. The target risk rating of 8 has been met. This risk will be closed.
- BAF 3.4 - To provide outstanding care and outstanding patient experience, The current risk rating of 12 has not met the target risk rating of 6. This is due to the impact on the elective recovery programme. This will be reviewed and included on the Corporate Risk Register going forward.
- BAF 3.5 - To provide a high quality public health 0-19 service. The current risk rating is 16 and has not met the target rating of 8. This will be reviewed and re-scoped for the revised BAF.
- BAF 4.1 - To continually improve services we provide to our population in a way that are more efficient. The target risk rating of 8 has been met and this risk has been closed.

- BAF 4.2 - To provide high quality care and to be a financially sustainable organisation. The target risk rating of 8 has been met, this risk will be further considered and revised for the new BAF.
- BAF 4.3 - To provide high quality care and to be a financially sustainable organisation in relation to digital maturity. The target risk of 8 has not be met and the current risk rating is 12. Further work is required in relation to this risk and it will be reviewed and revised for the new BAF.
- BAF 4.4 - To be financially stable to provide outstanding quality of care. The target risk rating of 8 has been met and this risk will now be closed.

4.0 RECOMMENDATIONS

The Board is recommended to review and close the current Board Assurance Framework in anticipation of opening the new BAF following final revisions to the Trust Strategy.

Kate Southgate
Associate Director of Quality and Corporate Affairs
July 2022

Board Assurance Framework **APPENDIX 1**

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

Risk ID	Principle Objective	Principle Risk to the Delivery of Objective	Inherent Risk Rating			Residual (Current) Risk Rating			Target Risk Score	Target Date Risk Score will be met/closed	Corporate Risks Linked to BAF	Positive Assurance			Gaps in Assurances/Controls	Responsible Committee	Lead Executive Director	July 2022 Updates
			Likelihood	Conseq	Rating	Likelihood	Conseq	Rating				Existing Key Controls	Internal	External				
BAF#1.1	To be an outstanding place to work	There is a risk HDFT's culture will be compromised due to an insufficient focus on the culture of the Trust and the health and wellbeing of staff.	3	4	12	3	4	12	2x4=8	Apr-22	CRR6 – Wellbeing of Staff	Your Voice Vision and Values Programme which incorporates multiple improvement projects/programmes of work First Line Leaders Programme and other development programmes Reciprocal mentoring programme EDI work programme Inpulse Survey and Analysis Exit Interviews Mental Health Nurse – recruited Colleague Wellbeing Programme Lead – recruited Quiet room developed in the Education Centre Refreshed wellbeing intranet Mental Health Champions in place Thrive Wellbeing Conversations	Board of Directors Senior Management Team People and Culture Committee Sarah Armstrong – Non-Executive Director for Wellbeing Guardian	Staff Survey Action Plan	Cultural programmes in place and are being embedded. Data is being analysed by directorates and managers. Actions are being reviewed and implemented. Presentation was made by each directorate at November SMT. Analysis to assess the impacted on these and to determine how well embedded the cultural programmes are in HDFT and HIF remains outstanding.	People and Culture Committee	A Wilkinson, Director of Workforce and OD	Assurance controls and gaps in assurance have been updated as has the related corporate risk register. This scope of this risk will be reviewed for potential inclusion onto the revised BAF
BAF#1.2	To be an inclusive employer where diversity is celebrated and valued.	There is a risk that HDFT's culture may be compromised due to a lack of diversity.	4	5	20	3	4	12	2x4=8	Apr-22	CRR6 – Wellbeing of staff	Your Voice Vision and Values Programme which incorporates multiple improvement projects/programmes of work First Line Leaders Programme and other development programmes Reciprocal mentoring programme EDI work programme Inpulse Survey and Analysis Exit Interviews Becoming and Anti-Racist Work programme EDS2 Programme commissioned	Board of Directors SMT People and Culture Committee Wallace Sampson – Non-Executive Director for Inequality and Diversity	Staff Survey	EDI programme governance paused, a need to re-establish	People and Culture Committee	A Wilkinson, Director of Workforce and OD	Assurance controls and gaps in assurance have been updated. This scope of this risk will be reviewed for potential inclusion onto the revised BAF

2. STRATEGIC OBJECTIVE: TO WORK WITH PARTNERS TO DELIVER INTEGRATED CARE																		
Risk ID	**Principle Objective**	**Principle Risk to the Delivery of Objective**	**Inherent Risk Rating**			**Residual (Current) Risk Rating**			**Target Risk Score**	**Target Date Risk Score will be met/closed**	**Corporate Risk Register**	**Assurances in Controls**			**Gaps in Assurances/Controls**	**Responsible Committee**	**Lead Executive Director**	**July 2022 Update**
			Likelihood	**Conseq**	**Rating**	**Likelihood**	**Conseq**	**Rating**				**Existing Key Controls**	**Internal**	**External**				
BAF#2.1	To improve population health and wellbeing, provide integrated care and to support primary care	There is a risk that the Trust does not maximise its contribution to improving population health and reducing health inequalities because of a lack of strategic relationships with primary care and local authorities and an internal focus which will impact on our strategic ambition to improve population health and wellbeing, provide integrated care and to support primary care.	3	3	9	3	3	9	2x3=6	Apr-23		Medical Director attendance at LMC and HARA with focus on development of an aligned focus on health inequalities as a strategic priority Appointment of Director of Strategy has increased capacity to work with strategic partners	Medical Director Board Report Director of Strategy Board Report SMT	HARA Yorkshire Health Network LMC	This risk could be exasperated due to the potential local government and NHS (integrating care) reorganisation. Currently no strategic Harrogate Place Forum – discussions are ongoing to develop forum. Further work required on Harrogate as an anchor institution.	SMT	M Graham, Director of Strategy J Andrews, Executive Medical Director	This scope of this risk will be reviewed for potential inclusion onto the revised BAF
BAF#2.2	To be an active partner in population health and the transformation of health inequalities	Risk that the population is not able to fully benefit from being part of an integrated care system because our acute services face towards West Yorkshire ICS and our place based population health activities sit within HCV ICS and there is insufficient executive capacity to participate in 2 ICSs.	3	3	9	3	3	9	2x3=6	Apr-23		West Yorkshire ICS and Humber Coast and Vale ICS meetings by Executive Team members	Appointment of Director of Strategy Executive Team are key members of strategic groups across the two ICSs.	ICS Groups eg the Provider Collaborative	The required input across the two local ICS may lead to a lack of clarity of funding arrangements. Requirement for HDFT to be members of two ICS means that Executive capacity needs to spread across two structures rather than one.	SMT	M Graham, Director of Strategy	assurance controls and gaps have been updated to reflect the current position. This scope of this risk will be reviewed for potential inclusion onto the revised BAF

3. STRATEGIC OBJECTIVE: TO DELIVER HIGH QUALITY CARE

Risk ID	Principle Objective	Principle Risk to the Delivery of Objective	Inherent Risk Rating			Residual (Current) Risk Rating			Target Risk Score	Target Date Risk Score will be met/closed	Corporate Risk Register	Assurances in Controls			Gaps in Assurances/ Controls	Responsible Committee	Lead Executive Director	July 2022 Update
			Likelihood	Conseq	Rating	Likelihood	Conseq	Rating				Existing Key Controls	Internal	External				
BAF#3.1	To provide outstanding care and outstanding patient experience	There is a risk to achieving outstanding quality of care and patient experience due to insufficient focus on a culture of quality improvement.	4	4	16	2	4	8	2 x 4 = 8	Apr-22	None	A number of key quality governance changes have taken place to strengthen the line of sight of quality of care and experience in our services. These include establishment of Quality Governance Management Group (QGMG) which includes 3 main fora – Patient Safety Forum, Clinical Effectiveness Forum and Making Experiences Count Forum. These groups will provide Executive level oversight of quality, identify risk and mitigations and triangulate learning and improvement. Governance structure has received a root and branch review and the creation of the three forums above will ensure greater control. Safe Staffing Review completed. Procured Perfect Ward with planned roll out in January and February 2022.	CQC Action Plan Quality Account Caring at Our Best programme Appointment of Quality Matron to support rollout of ward/team accreditation Weekly Quality Summit and Learning Summit in place Complaints back log cleared	CQC Inspections Bi-monthly Assurance meetings with CCG Internal Audit Report – Board to Board reporting – significant assurance	Do not have consistent quality control in place Workforce challenges impacting	Quality Committee	Emma Nunez, Director of Nursing	Current Risk rating reduced from 12 to 8 with the Target Risk met. Assurance controls and gaps in assurance have been updated. This scope of this risk will be reviewed for potential inclusion onto the revised BAF
BAF#3.2	To provide a high quality service	Risk that a number of our clinical services are not operationally and financially sustainable because of the size of population we serve and associated financial income, the changing shape of the clinical workforce and preferences for ways of working and also our ability to deliver sub-specialty programmes of work	4	4	16	4	4	16	2x4 = 8	Apr-23	None	The appointment of the Director of Strategy has given renewed focus and increased resource on the development of the Clinical Strategy and a strategic governance programme is under development	SMT Directorate Oversight on Annual Clinical Plans Quality Committee Board of Directors	WYATT Committee in Common Carnell Farrer report Ongoing Clinical Services review to develop Clinical Strategy Ongoing conversations with WYATT	Trust and Clinical Strategy under development however they are not yet in place.	Quality Committee	J Andrews, Executive Medical Director	Assurance controls and gaps in assurance have been updated. This scope of this risk will be reviewed for potential inclusion onto the revised BAF
BAF#3.3	To provide high quality care to children and young people in adults community services	There is a risk that there is not sufficient visibility of the child in adult pathways which will impact on the individualised care for patients.	4	4	16	2	4	8	2 x 4 = 8	Apr-22	None	'Hopes for Healthcare' sets out our organisational actions following engagement with children and young people on what they want from our services and each Directorate is working towards implementing these. Each Directorate is nominating a children's champion who will provide the Directorate link from the quarterly Children's Champions meeting back to the Directorate. This will be monitored via QGMG.	Adult and Young People Safeguarding Reports CQC Trust Wide Action Plan – now closed.	CQC Outstanding Report OFSTED Reports JTAI Reports	Metrics required to monitor the embedding of CQC Actions. Paediatric Emergency Department – workforce and environment	Quality Committee	Emma Nunez, Director of Nursing	Current Risk rating reduced from 12 to 8 with the Target Risk met. Assurance controls and gaps in assurance have been updated. Risk to be closed.
BAF#3.4	To provide outstanding care and outstanding patient experience	There is a risk that the Trust is unable to deliver treatment and care to the required national standards which may cause patient satisfaction to drop and harm to arise	3	4	12	4	3	12	2 x 3 = 6	Apr 23	CRR41 - RTT	Planned Care Recovery Programme in Place Weekly access meetings to track weekly progress against activity targets Clinical prioritisation of all patients on admitted waiting list to assign (P1-6) priority and regularly review Use of independent sector to increase inpatient, day case and diagnostic capacity Collaboration initiatives with other Acute Trusts Theatres utilisation workstream Elective Recovery progressing, ,Endoscopy Unit now fully operational	SMT/ Resource Committee/ Trust Board reporting Performance Reporting - Resources Review Operational Management Group	NHSE/I Reporting		Quality Committee	Russell Nightingale, Chief Operating Officer	This scope of this risk will be reviewed for potential inclusion onto the revised BAF

BAF#3.5	To provide a high quality public health 0-19 service	There is a risk to providing a preventative 0-19 service because there is a significant rise in safeguarding and there is an inability to recruit and retain sufficient school nurses and health visitors.	5	4	20	4	4	16	2x4=8	Apr-22	CRR5 – Nursing Shortage CRR57 – Safeguarding Demand	Recruitment & Retention Group set up & action plan in place and being progressed (includes skill mix work, setting up services on NHSP, rolling monthly recruitment in line with ward based nursing) Business case submitted to enhance Safeguarding resource which would support the specialist team and 0 -19 service pressures. Would support 'breaking the cycle' by freeing up 0 -19 capacity to undertake preventative work. Request made for support from wider Trust (needs to be nurses with experience of working with children and families) Modelling of demand & capacity (review of current demand & capacity model / demand & capacity review) Development of OPEL to increase visibility of pressure & actions taken Agile / Base & Home working - Developing offers with teams to support alternative ways of working • Work commenced on 0 -19 'Safer staffing' tool Services recommencing face to face contacts, however recognising that many community services have not returned to pre-pandemic arrangements.	SMT/ Quality Committee/ Resource Committee		The national mandate for roll out of Covid vaccinations for healthy 12-15 year olds is likely to impact on ongoing pressures Increased safeguarding activity referrals have continued into 2022 with an increase in workforce pressures. See CRR57 for activity information.		Emma Nunez, Director of Nursing	Current mitigation and gaps in control updated.

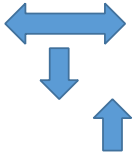
4. STRATEGIC OBJECTIVE: TO ENSURE CLINICAL AND FINANCIAL SUSTAINABILITY

Risk ID	Principle Objective	Principle Risk to the Delivery of Objective	Inherent Risk Rating			Residual (Current) Risk Rating			Target Risk Score	Target Date Risk Score will be met/closed	Change since last Report	Existing Key Controls	Assurances in Controls		Gaps in Assurances/ Controls	Responsible Committee	Lead Executive Director	May 2022 Update
			Likelihood	Conseq	Rating	Likelihood	Conseq	Rating					Internal	External				
BAF#4.1	To continually improve services we provide to our population in a way that are more efficient	Due to a prolonged recovery from CoVid-19 there is a risk that the focus on the Trust's strategic ambitions is compromised, which will Impact upon service transformation and underlying financial improvement	4	4	16	2	4	8	2x4=8	Mar-22	None	Current financial regime; national framework, ICS discussions; engagement in regional and local service transformation programmes; internal transformation programme; alliances with Leeds; membership and engagement with WYAAT WYATT – creating financial framework to look at opportunities. The piece of work is being mirrored internally.	SMT reports and oversight Resource Committee reports and oversight Board of Directors reports and oversight	WYAAT reports and Committee in Common engagement and oversight NHSE/I regulatory oversight	**Internal:** capacity to deliver internal service transformation and the requirement to move to pre Covid levels of activity No new long-term productivity programme currently in place **External:** no governance structure or programme of work with Leeds regarding transformation	Resource Committee	Finance Director	Assurance controls and gaps in control update. Noted that the financial position for 2021-22 will be achieved. However, future funding nationally has not yet been confirmed. Risk is now closed
BAF#4.2	To provide high quality care and to be a financially sustainable organisation	Due to the difficulty of generating sufficient internal funds through inward investment or additional cash releasing savings, there is a risk to long term financial sustainability and ability to invest in capital, which will impact upon the quality of care that can be provided.	4	4	16	2	4	8	2x4=8	Mar-23	None	Capital asset register and planning process; financial plan; current financial regime Strength of balance sheet Engaged with ICS Ongoing discussions with the ICS future allocation Site development group developing plan	Capital Oversight Group H2 efficiency programme	Ongoing discussions based on winter planning and national and regional allocations. H2 planning now in place with efficiency programme.	**Internal:** No efficiency programme	Resource Committee	Finance Director	Assurance controls and gaps in control update. Noted that the capital is available but potential risks as no long term site development plan currently in place. Risk is now closed
BAF#4.3	To provide high quality care and to be a financially sustainable organisation in relatin to digital maturity	There is a risk that the digital maturity of the Trust is restricted because of the insufficient leadership capacity and the inability to invest sufficient resource in infrastructure and new technologies which will result in missed opportunities to improve efficiency and safety	4	4	16	3	4	12	2x4=8	Apr-22	None	Digital Strategy Digital Board Training provided by NHS Digital/NHS Providers NHSI Digital Maturity Programme Working with digital aspirant programme to create strategic outline case for digital funding.	Capital Oversight Group Digital Strategy Group		Ongoing refresh of the Clinical Strategy and the Digital Strategy	Resource Committee	J Andrews, Executive Medical Director	Assurance controls and gaps in control update. This scope of this risk will be reviewed for potential inclusion onto the revised BAF
#4.4	To be financially stable to provide outstanding quality of care	Due to the allocation formula not providing sufficient resources to meet the needs of the unique demography of the local area, there is a risk that standards of care are compromised which will impact on the Trust's ambition to provide outstanding care and its reputation for quality	4	4	16	2	4	8	2x4=8	Apr 22	None	Quality governance arrangements; Contracts with commissioners Annual audit cycle PLACE Assessments 4. ICS and Place based networks Current financial regime	Integrated Board Report Chief Nurse Report Quality Committee minutes Clinical Audit Reports SMT, Resource Committee and Board reports and oversight	CCG Meetings CQC inspection reports Memorandum of Understanding with CCG Memorandum of Understanding with ICS's HARA engagement Relationships with Local Authorities	Lack of system wide financial plan New financial allocations need to be agreed. Chief Executive/Finance Director has with ICS's and regulators Carnell Farrer Review	Resource Committee	J Coulter, Deputy Chief Executive/ Finance Director	Current risk rating updated to 8. Target risk met. Assurance controls and gaps in control update. Noted that the financial position for 2021-22 will be achieved. However, future funding nationally has not yet been confirmed. This scope of this risk will be reviewed for potential inclusion onto the revised BAF

Risk Matrix

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

Changes in Ratings



No change in risk rating since from previous Assurance Framework

Risk rating has been downgraded from previous version

Risk rating has increased from previous version

Progress on Actons

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

Harrogate and District NHS Foundation Trust

3

Board of Directors held in Public
27 July 2022

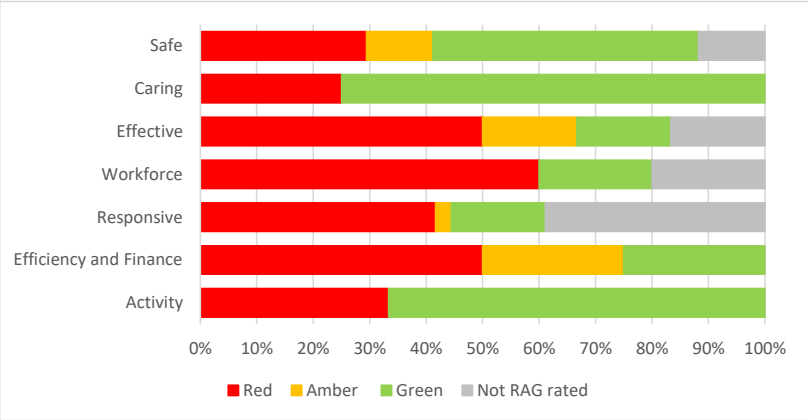
Title:	***Integrated Board Report***
Responsible Director:	Executive Directors
Author:	Head of Performance & Analysis

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

Integrated Board Report - Summary of indicators - June 2022

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

		RAG ratings			
Domain	**Total indicators**	**Red**	**Amber**	**Green**	**Not RAG rated**
Safe	17	5	2	8	2
Caring	4	1	0	3	0
Effective	6	3	1	1	1
Workforce	5	3	0	1	1
Responsive	36	15	1	6	14
Efficiency and Finance	12	6	3	3	0
Activity	9	3	0	6	0
Total	**89**	**36**	**7**	**28**	**18**



Integrated Board Report - Summary of Jun-22 performance

Domain	Indicator number	Indicator name	Latest position
Safe	1.1	Pressure ulcers - hospital acquired - cat 3 or above - per 1,000 bed days	0.32
Safe	1.2	Pressure ulcers - community acquired - cat 3 or above - per 1,000 patient contacts	1.32
Safe	1.3	Inpatient falls per 1,000 bed days	6.5
Safe	1.4	Infection control - C.diff hospital acquired cases due to a lapse in care	0
Safe	1.5	Infection control - MRSA hospital acquired cases due to a lapse in care	0
Safe	1.6	Incidents - ratio of low harm incidents	50.11
Safe	1.7.1	Incidents - comprehensive serious incidents (SI)	3
Safe	1.7.2	Incidents - Never events	1
Safe	1.8.1	Safer staffing levels - fill rate	89.2%
Safe	1.8.2	Safer staffing levels - CHPPD	7.6
Safe	1.9	Maternity - % women seen by a midwife (or healthcare professional) by 12w 6d	96.6%
Safe	1.10	Maternity - % women with Continuity of Care pathway	
Safe	1.11	Infant health - % women smoking at time of delivery	3.7%
Safe	1.12	Infant health - % women initiating breastfeeding	81.8%
Safe	1.13	VTE risk assessment - inpatients	95.6%
Safe	1.14.1	Sepsis screening - inpatient wards	93.8%
Safe	1.14.2	Sepsis screening - Emergency department	92.6%

Domain	Indicator number	Indicator name	Latest position
Caring	2.1.1	Friends & Family Test (FFT) - Patients	92.2%
Caring	2.1.2	Friends & Family Test (FFT) - Adult Community Services	90.6%
Caring	2.2.1	Complaints - numbers received	9
Caring	2.2.2	Complaints - % responded to within time	70%
Effective	3.1	Mortality - HSMR	114.09
Effective	3.2	Mortality - SHMI	1.07
Effective	3.3.1	Readmissions to the same specialty within 30 days - following elective admission	2.1%
Effective	3.3.2	Readmissions to the same specialty within 30 days - following non-elective admission	6.8%
Effective	3.4	Returns to theatre	
Effective	3.5	Delayed Transfer of Care	28.1%
Workforce	4.1	Staff appraisal rate	60.8%
Workforce	4.2	Mandatory training rate	90.0%
Workforce	4.3	Staff sickness rate	4.96%
Workforce	4.4	Staff turnover rate	16.3%
Workforce	4.5	Vacancies	6.25%

Domain	Indicator number	Indicator name	Latest position
Responsive	5.1.1	RTT Incomplete pathways performance - median	11
Responsive	5.1.2	RTT Incomplete pathways performance - 92nd centile	44
Responsive	5.1.3	RTT Incomplete pathways - total	25134
Responsive	5.1.4	RTT Incomplete pathways - 52-<104 weeks	1260
Responsive	5.1.5	RTT Incomplete pathways - 104+ weeks	1
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	68.7%
Responsive	5.4	Outpatient follow-up waiting list - number of follow up patients past due date	
Responsive	5.5	Data quality on ethnic group - inpatients	92.5%
Responsive	5.6	A&E 4 hour standard	71.5%
Responsive	5.7	Ambulance handovers - % within 15 mins	83.2%
Responsive	5.8	A&E - number of 12 hour trolley waits	15
Responsive	5.9.1	Cancer - 62 day wait for first treatment from urgent GP referral to treatment	78.0%
Responsive	5.9.2	Cancer - 62 day wait for first treatment from urgent GP referral to treatment - number of 104 days waiters	5
Responsive	5.10	Cancer - 14 days maximum wait from urgent GP referral for all urgent suspect cancer referrals	73.5%
Responsive	5.11	Cancer - 28 days faster diagnosis standard (suspected cancer referrals)	80.4%
Responsive	5.12	Cancer - 31 days maximum wait from diagnosis to treatment for all cancers	96.2%

Domain	Indicator number	Indicator name	Latest position
Responsive	5.13.1	Children's Services - 0-12 months caseload	1726
Responsive	5.13.2	Children's Services - 2-3 years caseload	1628
Responsive	5.14	Children's Services - Safeguarding caseload	1103
Responsive	5.15	Children's Services - Ante-natal visits	87.6%
Responsive	5.16	Children's Services - 10-14 day new birth visit	95.5%
Responsive	5.17	Children's Services - 6-8 week visit	94.9%
Responsive	5.18	Children's Services - 12 month review	93.1%
Responsive	5.19	Children's Services - 2.5 year review	92.9%
Responsive	5.20	Children's Services - % children with all 5 mandated contacts	
Responsive	5.21	Children's Services - Delivery of Immunisation trajectory	
Responsive	5.22	Children's Services - OPEL level	1/2/3
Responsive	5.23	Community Care Adult Teams - performance against new timeliness standards	
Responsive	5.24	Community Care Adult Teams - Number of virtual beds delivered in Supported Discharge Service	
Responsive	5.25	Community Care Adult Teams - Number of cancelled routine visits	
Responsive	5.26	Community Care Adult Teams - OPEL level	3
Responsive	5.27	Out of hours - telephone clinical assessment for URGENT cases within 20 minutes of call prioritisation	32.0%
Responsive	5.28	Home visit: Face to face consultations started for URGENT cases within 2 hrs	93.1%

Domain	Indicator number	Indicator name	Latest position
Efficiency and Finance	6.1	Agency spend	£ 890
Efficiency and Finance	6.2	Surplus / deficit and variance to plan	£ 157
Efficiency and Finance	6.3	Capital spend	£ 1,506
Efficiency and Finance	6.4	Cash balance	£ 43,156
Efficiency and Finance	6.5.1	Long stay patients - stranded (>7 days LOS)	147
Efficiency and Finance	6.5.2	Long stay patients - superstranded (>21 days LOS)	67
Efficiency and Finance	6.6	Occupied bed days per 1,000 population	57.9
Efficiency and Finance	6.7.1	Length of stay - elective	2.56
Efficiency and Finance	6.7.2	Length of stay - non-elective	5.05
Efficiency and Finance	6.8	Avoidable admissions	240
Efficiency and Finance	6.9	Theatre utilisation (elective sessions)	85.0%
Efficiency and Finance	6.10	Day case conversion rate	2.4%

Domain	Indicator number	Indicator name	Latest position
Activity	7.1	GP Referrals against 2019/20 baseline	111.1%
Activity	7.2.1	Outpatient activity (consultant led) against plan (new and follow up)	119.9%
Activity	7.2.2	Outpatient activity (consultant led) against 2019/20 baseline (new and follow up)	90.2%
Activity	7.3.1	Elective activity against plan	111.0%
Activity	7.3.2	Elective activity against 2019/20 baseline	78.4%
Activity	7.4.1	Non-elective activity against plan	104.4%
Activity	7.4.2	Non-elective activity against 2019/20 baseline	100.7%
Activity	7.5.1	Emergency Department attendances against plan	91.3%
Activity	7.5.2	Emergency Department attendances against plan, 2019/20 baseline	106.2%

Integrated Board Report - List of indicators

Domain	Indicator number	Indicator name	Clinical Directorate(s) metric is applicable to	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Exec Lead	Committee reported to:	Monthly RAG thresholds: Red	Amber	Green
Safe	1.1	Pressure ulcers - hospital acquired - cat 3 or above - per 1,000 bed days	PSC, LTUC	0.37	0.00	0.61	0.34	0.55	1.06	0.61	0.74	0.80	0.50	0.75	0.58	1.21	1.28	0.32	EN	Quality	>0		0
Safe	1.2	Pressure ulcers - community acquired - cat 3 or above - per 1,000 patient contacts	LTUC	1.38	1.36	0.61	1.01	1.25	0.66	0.56	0.89	1.51	0.88	1.24	0.74	1.11	0.56	1.32	EN	Quality	>0		0
Safe	1.3	Inpatient falls per 1,000 bed days	PSC, LTUC	5.1	6.1	4.9	5.9	7.4	8.6	6.0	7.6	8.0	8.0	6.7	9.1	6.9	6.1	6.5	EN	Quality	above HDFT average for 2021/22 (7.0)	0-20% below HDFT average for 2021/22	>20% below HDFT average for 2020/21
Safe	1.4	Infection control - Hospital acquired C.difficile cases, lapse in care identified	All	0	0	1	0	0	1	1	1	1	0	0	0	0	0	0	EN	Quality	>29 YTD (total cases)		<=29 YTD (total cases)
Safe	1.5	Infection control - Hospital acquired MRSA cases, lapse in care identified	All	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	EN	Quality	>0 YTD		0 YTD
Safe	1.6	Incidents - ratio of low harm incidents	All	16.49	21.29	19.98	27.63	19.58	25.29	50.76	66.71	43.38	37.50	56.65	39.91	27.62	41.78	50.11	EN	Quality	HDFT in bottom 25% of Acute Trusts	HDFT in middle 50% of Acute Trusts	HDFT in top 25% of Acute Trusts
Safe	1.7.1	Incidents - comprehensive serious incidents (SI)	All	3	1	4	1	3	0	0	1	2	6	1	1	5	5	3	EN	Quality	>0		0
Safe	1.7.2	Incidents - Never events	All	0	1	0	0	0	0	0	0	0	1	1	1	0	1	1	EN	Quality			
Safe	1.8.1	Safer staffing levels - fill rate	All	93.8%	93.1%	92.5%	92.6%	90.1%	85.9%	86.2%	89.6%	88.0%	81.2%	80.8%	81.5%	81.1%	87.0%	89.2%	EN	Quality	<80%	80% - 95%	>=95%
Safe	1.8.2	Safer staffing levels - CHPPD	All	8.6	8.4	8.6	8.0	7.9	7.8	7.2	7.5	7.4	7.1	6.8	6.8	6.9	7.4	7.6	EN	Quality	tbc		
Safe	1.9	Maternity - % women seen by a midwife (or healthcare professional) by 12w 6d	PSC	99.4%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	96.6%	99.3%	95.7%	99.2%	100.0%	98.6%	97.6%	96.6%	EN	Quality	<90%		>=90%
Safe	1.10	Maternity - % women with Continuity of Care pathway	PSC																EN	Quality			
Safe	1.11	Infant health - % women smoking at time of delivery	PSC	6.6%	2.9%	7.4%	5.2%	3.0%	4.3%	3.0%	7.2%	4.6%	6.6%	5.6%	4.2%	5.8%	6.4%	3.7%	EN	Quality	>15%		<=15%
Safe	1.12	Infant health - % women initiating breastfeeding	PSC	83.6%	82.6%	84.8%	83.8%	79.2%	87.4%	81.1%	88.2%	85.9%	83.5%	81.7%	86.2%	82.9%	84.6%	81.8%	EN	Quality	<75%		>=75%
Safe	1.13	VTE risk assessment - inpatients	PSC, LTUC	96.7%	97.1%	96.9%	96.3%	96.6%	95.7%	97.1%	96.8%	96.3%	95.9%	95.7%	95.5%	96.1%	96.3%	95.6%	EN	Quality	<95%		>=95%
Safe	1.14.1	Sepsis screening - inpatient wards	All	91.8%	96.1%	93.2%	93.5%	92.5%	90.8%	91.5%	89.8%	92.3%	89.3%	90.6%	87.7%	88.6%	93.0%	93.8%	EN	Quality	<90%		>=90%
Safe	1.14.2	Sepsis screening - Emergency department	LTUC	85.9%	89.2%	88.9%	86.6%	88.0%	88.8%	89.3%	92.5%	92.9%	91.9%	94.6%	94.8%	94.0%	92.2%	92.6%	EN	Quality	<90%		>=90%
Caring	2.1.1	Friends & Family Test (FFT) - All Patients	All	94.2%	92.7%	93.7%	93.7%	92.8%	93.3%	93.4%	92.7%	93.9%	94.7%	92.0%	91.8%	94.8%	92.7%	92.2%	EN	Quality	<90%		>=90%
Caring	2.1.2	Friends & Family Test (FFT) - Adult Community Services	CC	94.7%	95.5%	96.5%	96.1%	95.3%	96.0%	90.5%	90.5%	95.4%	96.6%	98.7%	97.3%	94.4%	91.9%	90.6%	EN	Quality	<90%		>=90%
Caring	2.2.1	Complaints - numbers received	All	14	24	18	20	31	19	13	9	18	11	14	22	17	10	9	EN	Quality	above HDFT average for 2021/22 (18)		On or below HDFT average for 2021/22 (18)
Caring	2.2.2	Complaints - % responded to within time	All		50%	35%	56%	56%	48%	50%	53%	53%	53%	55%	58%	72%	79%	70%	EN	Quality	<95%		>=95%
Effective	3.1	Mortality - HSMR	All	94.45	95.61	91.58	95.56	98.45	99.68	102.34	105.86	108.72	113.26	113.15	114.09				JA	Quality	Higher than expected		Within expected range or below expected
Effective	3.2	Mortality - SHMI	All	0.964	0.978	0.988	1.008	1.021	1.047	1.066	1.062	1.073	1.077	1.074					JA	Quality	Higher than expected		Within expected range or below expected
Effective	3.3.1	Readmissions to the same specialty within 30 days - following elective admission - as % of all elective admissions	All	1.8%	1.6%	1.6%	1.8%	2.1%	1.6%	2.0%	1.5%	1.5%	1.5%	1.9%	1.5%	1.9%	2.1%		RN	Resources	> 3%	2% - 3%	<= 2%
Effective	3.3.2	Readmissions to the same specialty within 30 days - following non-elective admission - as % of all non-elective admissions	All	9.5%	8.2%	7.3%	8.2%	8.4%	7.9%	8.0%	7.4%	7.4%	8.9%	7.2%	8.5%	8.6%	6.8%		RN	Resources	> 10%	8% - 10%	<= 8%
Effective	3.4	Returns to theatre	PSC																RN	Resources	tbc		
Effective	3.5	Delayed Transfer of Care - % inpatients not meeting the criteria to reside	LTUC	22.0%	14.5%	20.6%	24.0%	10.6%	21.9%	24.7%	7.4%	20.4%	20.8%	25.0%	12.0%	30.9%	24.5%	28.1%	RN	Resources	> 17.5%	15% - 17.5%	<= 15%
Workforce	4.1	Staff appraisal rate	All	56.3%	58.3%	58.9%	55.9%	55.2%	54.0%	52.8%	58.2%	59.8%	56.3%	63.0%	63.9%	56.9%	63.7%	60.8%	AW	People and Cultu	<70%	70% - 90%	>=90%
Workforce	4.2	Mandatory training rate	All	91.7%	92.1%	92.0%	92.0%	87.0%	86.0%	86.0%	85.0%	85.0%	85.0%	85.0%	86.0%	85.0%	87.0%	90.0%	AW	People and Cultu	<50%	50% - 75%	>=75%
Workforce	4.3	Staff sickness rate	All	3.74%	3.94%	4.04%	4.77%	5.02%	5.26%	6.04%	5.53%	5.42%	6.67%	5.74%	5.54%	5.90%	4.44%	4.96%	AW	People and Cultu	>3.9%		<=3.9%
Workforce	4.4	Staff turnover rate	All	12.9%	13.0%	13.3%	13.5%	14.2%	14.5%	14.6%	13.8%	13.7%	14.3%	14.8%	15.7%	15.7%	16.0%	16.3%	AW	People and Cultu	>15%		<=15%
Workforce	4.5	Vacancies	CC	4.98%	6.06%	6.40%	6.53%	6.25%	6.23%	5.61%	6.98%	8.89%	8.16%	8.05%	7.22%	5.84%	6.04%	6.25%	AW	People and Cultu	tbc		
Responsive	5.1.1	RTT Incomplete pathways performance - median	All	8	8	8	9	9	10	10	9	10	10	10	9	10	10	11	RN	Resources	>10	08 - 10	<=8
Responsive	5.1.2	RTT Incomplete pathways performance - 92nd centile	All	44	43	41	40	40	41	41	41	42	43	43	43	44	43	44	RN	Resources	>24	18 - 24	<=18
Responsive	5.1.3	RTT Incomplete pathways - total	All	18156	19476	20631	21785	22168	22648	22423	22714	23464	23323	23900	23931	24714	25384	25134	RN	Resources	>15,000	14,000 - 15,000	<=14,000
Responsive	5.1.4	RTT Incomplete pathways - 52-<104 weeks	All	1196	1082	993	968	932	1008	1037	1063	1130	1086	1107	1118	1176	1193	1260	RN	Resources	>0		0
Responsive	5.1.5	RTT Incomplete pathways - 104+ weeks	All	3	5	13	20	23	24	33	34	47	52	50	22	11	3	1	RN	Resources	>0		0
Responsive	5.2.1	RTT waiting times - by ethnicity	All																RN	Resources			
Responsive	5.2.2	RTT waiting times - by level of deprivation	All																RN	Resources			

Domain	Indicator number	Indicator name	Clinical Directorate(s) metric is applicable to	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Exec Lead	Committee reported to:	Monthly RAG thresholds: Red	Amber	Green
Responsive	5.2.3	RTT waiting times - learning disabilities	All																RN	Resources			
Responsive	5.3	Diagnostic waiting times - 6-week standard	All	79.7%	85.4%	79.2%	75.1%	74.0%	80.5%	79.7%	86.1%	82.4%	78.7%	81.9%	76.5%	66.0%	69.2%	68.7%	RN	Resources	<99%		>=99%
Responsive	5.4	Outpatient follow-up waiting list - number of follow up patients past due date	All																RN	Resources			
Responsive	5.5	Data quality on ethnic group - inpatients	All	93.0%	95.3%	94.6%	94.3%	94.8%	93.6%	94.3%	94.5%	92.8%	92.5%	92.9%	92.5%	93.7%	93.4%	92.5%	RN	Resources	<97%		>=97%
Responsive	5.6	A&E 4 hour standard	LTUC	86.3%	82.7%	82.6%	79.4%	80.6%	83.7%	75.9%	76.0%	68.9%	71.5%	65.6%	61.9%	66.2%	68.1%	71.5%	RN	Resources	<90%	90-95%	>=95%
Responsive	5.7	Ambulance handovers - % within 15 mins	LTUC	92.8%	91.8%	86.5%	87.6%	89.1%	92.8%	86.1%	89.2%	88.4%	92.9%	89.8%	87.2%	90.3%	89.2%	83.2%	RN	Resources	<90%	90-95%	>=95%
Responsive	5.8	A&E - number of 12 hour trolley waits	LTUC	0	0	0	0	0	0	8	2	23	4	37	25	43	18	15	RN	Resources	>0		0
Responsive	5.9.1	Cancer - 62 day wait for first treatment from urgent GP referral to treatment	LTUC	85.5%	87.1%	93.5%	84.1%	91.7%	89.1%	81.8%	80.7%	84.8%	79.8%	83.2%	87.6%	78.3%	86.1%	78.0%	RN	Resources	<85%		>=85%
Responsive	5.9.2	Cancer - 62 day wait for first treatment from urgent GP referral to treatment - number of 104 days waiters	LTUC	3	2	2	5	2	6	3	3	3	2	3	6	8	4	5	RN	Resources	>0		0
Responsive	5.10	Cancer - 14 days maximum wait from urgent GP referral for all urgent suspect cancer referrals	LTUC	81.7%	85.8%	88.2%	83.4%	86.0%	92.2%	83.8%	82.5%	87.3%	84.6%	92.5%	87.9%	85.9%	89.6%	73.5%	RN	Resources	<93%		>=93%
Responsive	5.11	Cancer - 28 days faster diagnosis standard (suspected cancer referrals)	LTUC	69.6%	71.7%	68.7%	70.3%	73.9%	73.4%	78.7%	77.0%	77.7%	74.6%	79.5%	80.6%	79.0%	76.1%	80.4%	RN	Resources	<70%	70-75%	>= 75%
Responsive	5.12	Cancer - 31 days maximum wait from diagnosis to treatment for all cancers	LTUC	97.0%	96.6%	100.0%	100.0%	98.9%	94.6%	99.1%	100.0%	97.5%	98.0%	98.1%	98.1%	97.3%	98.1%	96.2%	RN	Resources	<96%		>=96%
Responsive	5.13.1	Children's Services - 0-12 months caseload	CC	1457	1455	1459	1453	1545	1503	1876	1698	1871	1779	1642	1658	1531	1591	1726	RN	Resources	tbc		
Responsive	5.13.2	Children's Services - 2-3 years caseload	CC	1625	1591	1496	1583	1476	1536	1662	1762	1784	1857	1708	1918	1701	1806	1628	RN	Resources	tbc		
Responsive	5.14	Children's Services - Safeguarding caseload	CC	951	1026	1118	1006	727	1002	992	947	986	992	980	1278	910	1177	1103	RN	Resources	tbc		
Responsive	5.15	Children's Services - Ante-natal visits	CC	85.9%	86.7%	89.8%	88.3%	89.4%	86.8%	86.0%	80.1%	80.0%	75.3%	78.7%	75.9%	83.1%	86.2%	87.6%	RN	Resources	<75%	75% - 90%	>=90%
Responsive	5.16	Children's Services - 10-14 day new birth visit	CC	95.4%	95.4%	95.4%	95.7%	95.4%	93.2%	94.0%	92.6%	95.7%	95.6%	95.4%	93.5%	95.4%	94.7%	95.5%	RN	Resources	<75%	75% - 90%	>=90%
Responsive	5.17	Children's Services - 6-8 week visit	CC	91.9%	92.4%	93.3%	93.3%	92.7%	90.1%	89.7%	89.7%	90.7%	91.4%	93.3%	93.4%	92.1%	93.8%	94.9%	RN	Resources	<75%	75% - 90%	>=90%
Responsive	5.18	Children's Services - 12 month review	CC	93.1%	91.2%	92.6%	94.0%	95.0%	93.5%	95.1%	93.8%	92.5%	92.8%	93.7%	90.9%	89.9%	91.2%	93.1%	RN	Resources	<75%	75% - 90%	>=90%
Responsive	5.19	Children's Services - 2.5 year review	CC	91.5%	91.7%	93.4%	92.3%	92.8%	92.2%	90.9%	91.7%	92.3%	91.5%	92.0%	91.7%	92.7%	91.6%	92.9%	RN	Resources	<75%	75% - 90%	>=90%
Responsive	5.20	Children's Services - % children with all 5 mandated contacts	CC																RN	Resources	<75%	75% - 90%	>=90%
Responsive	5.21	Children's Services - Delivery of Immunisation trajectory	CC																RN	Resources			
Responsive	5.22	Children's Services - OPEL level	CC									2/3	2/3	1/2/3	2/3	1/2/3	1/2/3	1/2/3	RN	Resources	tbc		
Responsive	5.23	Community Care Adult Teams - performance against new timeliness standards	CC																RN	Resources	tbc		
Responsive	5.24	Community Care Adult Teams - Number of virtual beds delivered in Supported Discharge Service	CC																RN	Resources			
Responsive	5.25	Community Care Adult Teams - Number of cancelled routine visits	CC																RN	Resources			
Responsive	5.26	Community Care Adult Teams - OPEL level	CC									3	3	3	3	3	3	3	RN	Resources			
Responsive	5.27	Out of hours - telephone clinical assessment for URGENT cases within 20 minutes of call prioritisation	LTUC	36.7%	35.5%	39.9%	38.6%	34.5%	40.6%	40.3%	38.5%	28.5%	39.1%	41.1%	32.5%	30.8%	33.6%	32.0%	RN	Resources	<95%		>=95%
Responsive	5.28	Home visit: Face to face consultations started for URGENT cases within 2 hrs	LTUC	78.6%	86.2%	75.9%	79.2%	88.5%	97.4%	90.5%	86.7%	83.3%	92.9%	94.4%	93.5%	97.2%	93.6%	93.1%	RN	Resources	<95%		>=95%
Efficiency and Finance	6.1	Agency spend	All	£ 419	£ 307	£ 414	£ 517	£ 453	£ 429	£ 389	£ 485	£ 745	£ 685	£ 630	£ 829	£ 654	£ 752	£ 890	JC	Resources	>3% of pay bill	1% - 3%	<= 1%
Efficiency and Finance	6.2	Surplus / deficit and variance to plan	All	£ -	£ -	£ -	-	-	-	-	-	-	-	-	-	-£ 265	-£ 471	£ 157	JC	Resources	>1% behind plan	0 - 1% behind plan	On plan
Efficiency and Finance	6.3	Capital spend	All	£ 518	£ 834	£ 1,856	£ 2,330	£ 3,188	£ 4,274	£ 8,006	£ 10,861	£ 11,503	£ 14,559	£ 17,301	£ 29,657	£ 500	£ 905	£ 1,506	JC	Resources	>25% behind plan	10% - 25% behind plan	On plan or <10% behind plan
Efficiency and Finance	6.4	Cash balance	All	£ 39,900	£ 34,587	£ 32,007	£ 32,386	£ 33,600	£ 42,000	£ 40,738	£ 40,119	£ 46,027	£ 44,921	£ 44,615	£ 42,004	£ 40,077	£ 40,671	£ 43,156	JC	Resources	>10% behind plan	0 - 10% behind plan	On plan
Efficiency and Finance	6.5.1	Long stay patients - stranded (>7 days LOS)	All	119	114	103	119	129	121	146	151	152	162	177	162	167	165	147	RN	Resources	>90	70-90	<=70
Efficiency and Finance	6.5.2	Long stay patients - superstranded (>21 days LOS)	All	48	44	40	42	51	47	56	67	65	71	86	79	83	79	67	RN	Resources	>40	30-40	<=30
Efficiency and Finance	6.6	Occupied bed days per 1,000 population	All	50.8	53.9	50.7	55.3	56.4	52.8	60.5	58.4	61.6	61.8	57.8	63.7	61.2	62.6	57.9	RN	Resources	>60	55-60	<=55
Efficiency and Finance	6.7.1	Length of stay - elective	All	2.26	2.60	2.57	2.66	2.76	2.31	2.22	2.35	2.78	3.17	2.24	2.43	2.25	1.84	2.56	RN	Resources	>2.75	2.5-2.75	<=2.5
Efficiency and Finance	6.7.2	Length of stay - non-elective	All	4.69	4.27	4.49	3.99	4.81	4.82	4.72	5.26	5.76	5.37	5.80	5.39	5.86	5.52	5.05	RN	Resources	>4.5	4-4.5	<=4.0
Efficiency and Finance	6.8	Avoidable admissions	All	189	219	242	263	228	206	240	267	229	222	202	238	253	240		RN	Resources	>270		<=270
Efficiency and Finance	6.9	Theatre utilisation (elective sessions)	PSC	81.2%	83.9%	83.4%	82.0%	83.7%	82.4%	80.4%	81.0%	84.7%	81.3%	75.7%	78.0%	79.8%	79.4%	85.0%	RN	Resources	<85%	85%-90%	>=90%

Domain	Indicator number	Indicator name	Clinical Directorate(s) metric is applicable to	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Exec Lead	Committee reported to:	Monthly RAG thresholds: Red	Amber	Green
Efficiency and Finance	6.10	Day case conversion rate	PSC	2.2%	1.7%	1.9%	1.6%	1.6%	1.5%	1.9%	1.1%	1.7%	1.3%	1.9%	1.6%	1.8%	1.8%	2.4%	RN	Resources	>2%	1.5%-2%	<=1.5%
Activity	7.1	GP Referrals against 2019/20 baseline	All	95.4%	94.1%	113.1%	99.6%	101.1%	112.0%	97.1%	109.1%	111.5%	99.9%	109.7%	167.2%	99.7%	108.8%	111.1%	RN	Resources	<95%		>=95%
Activity	7.2.1	Outpatient activity (consultant led) against plan (new and follow up)	All	113.7%	106.9%	123.2%	84.2%	87.0%	93.3%	103.2%	111.6%	111.3%	96.1%	103.1%	110.9%	112.6%	133.5%	119.9%	RN	Resources	<95%		>=95%
Activity	7.2.2	Outpatient activity (consultant led) against 2019/20 baseline (new and follow up)	All	90.8%	86.5%	98.7%	85.3%	88.6%	95.2%	80.1%	100.6%	95.9%	84.7%	93.8%	117.7%	84.4%	115.1%	90.2%	RN	Resources	<95%		>=95%
Activity	7.3.1	Elective activity against plan	All	102.5%	97.3%	109.3%	77.4%	75.4%	84.9%	99.4%	104.1%	105.2%	95.8%	88.7%	101.6%	123.2%	111.8%	111.0%	RN	Resources	<95%		>=95%
Activity	7.3.2	Elective activity against 2019/20 baseline	All	74.8%	80.6%	90.4%	73.9%	69.6%	80.7%	72.9%	79.7%	84.9%	72.7%	73.3%	112.7%	76.1%	99.0%	78.4%	RN	Resources	<95%		>=95%
Activity	7.4.1	Non-elective activity against plan	All	96.5%	97.4%	105.2%	104.3%	94.5%	93.5%	95.2%	87.1%	89.4%	84.3%	85.2%	105.5%	100.5%	98.5%	104.4%	RN	Resources	<95%		>=95%
Activity	7.4.2	Non-elective activity against 2019/20 baseline	All	89.9%	98.6%	104.8%	98.3%	92.7%	90.6%	94.1%	84.1%	88.8%	84.7%	84.5%	119.1%	90.4%	97.8%	100.7%	RN	Resources	<95%		>=95%
Activity	7.5.1	Emergency Department attendances against plan	LTUC	98.9%	106.6%	111.2%	103.4%	104.0%	105.7%	101.5%	99.2%	91.9%	95.6%	94.4%	114.92%	92.1%	92.7%	91.3%	RN	Resources	<95%		>=95%
Activity	7.5.2	Emergency Department attendances against plan, 2019/20 baseline	LTUC	98.9%	106.6%	110.8%	103.7%	104.1%	105.7%	106.5%	104.3%	96.6%	98.3%	97.6%	149.7%	95.6%	97.3%	106.2%	RN	Resources	<95%		>=95%

Integrated Board Report - June 2022

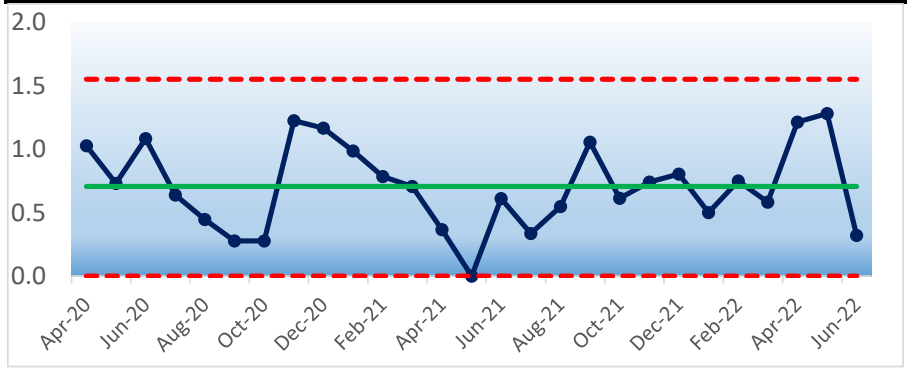
Domain 1 - Safe

Indicator	**1.1 - Pressure ulcers - hospital acquired - cat 3 or above - per 1,000 bed days**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Jun-22
Value / RAG rating	0.32

Indicator description

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

SPC chart



Narrative

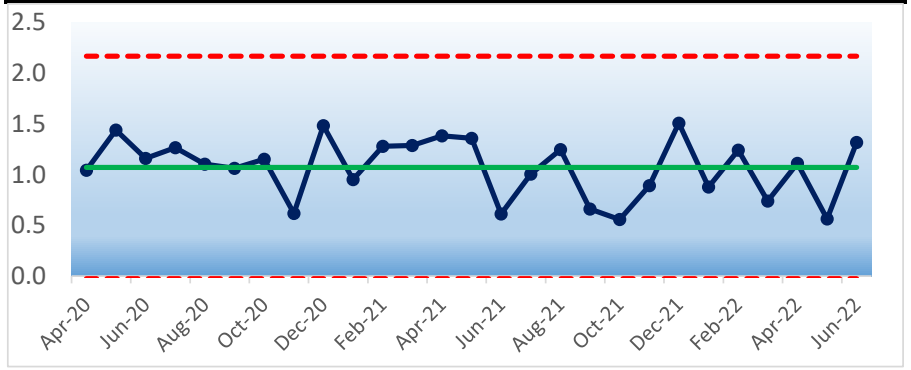
Reduction in hospital acquired pressure ulcers noted in June - intensive support to ward areas from TVN team in supporting the correct categorisation of skin damage and appropriate reporting.

Indicator	**1.2 - Pressure ulcers - community acquired - cat 3 or above - per 1,000 patient contacts**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Jun-22
Value / RAG rating	1.32

Indicator description

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

SPC chart



Narrative

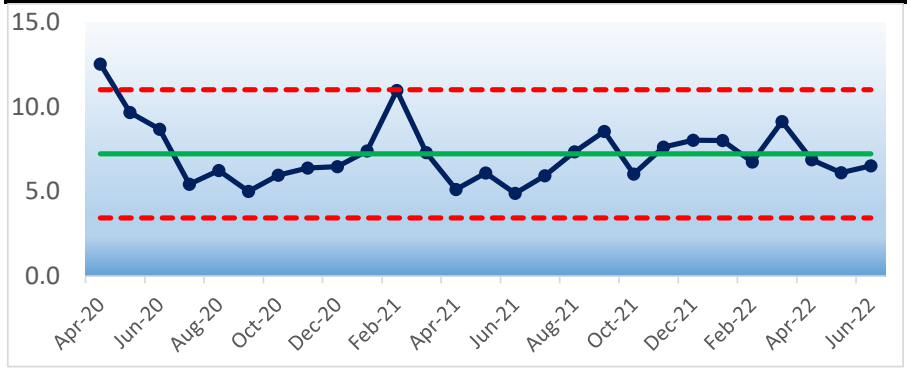
Increase in community acquired pressure ulcers. Likely due to challenges of patients not always being able to receive the desired frequency of repositioning due to gaps in social care provision (ie; home care). Adult community services have recently declared OPEL 4 and have been required to prioritise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

Indicator	**1.3 - Inpatient falls per 1,000 bed days**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Jun-22
Value / RAG rating	6.5

Indicator description

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

SPC chart



Narrative

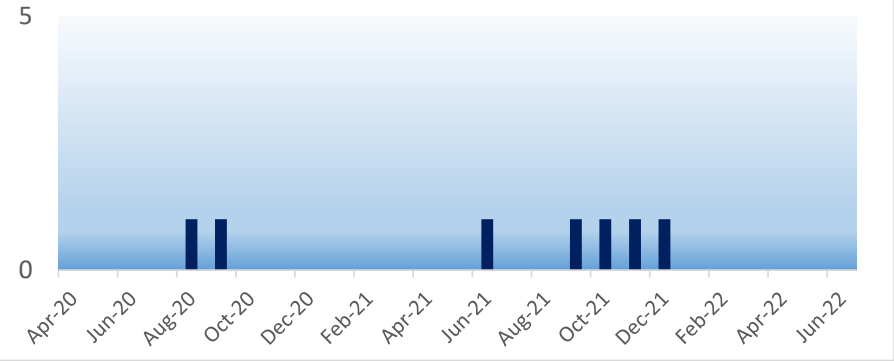
Slight increase in inpatient falls per 1,000 bed days. All escalation beds open and staffing challenges remain. Length of stay remains longer than necessary due to gaps in social care provision and therefore patients in ward areas for longer. Lack of falls nurse at present - returning from maternity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

Indicator	**1.4 - Infection control - Hospital acquired C.difficile cases, lapse in care identified**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Jun-22
Value / RAG rating	0

Indicator description

The number of hospital acquired C.difficile cases where root cause analysis has identified a lapse in care. HDFT's C. difficile trajectory for 2022/23 is a maximum of 40 hospital acquired cases - including avoidable, unavoidable and indeterminable causes.

Trend chart



Narrative

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

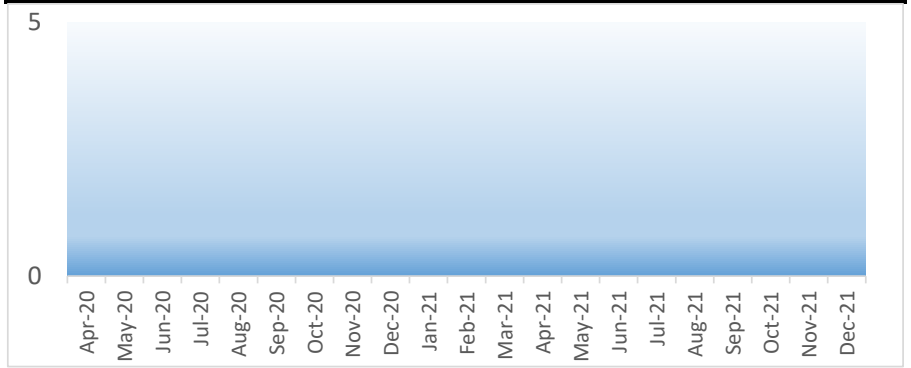
The Trust has now received confirmation from NHS England that its C. difficile trajectory for 2022/23 is a maximum of 40 hospital acquired cases - including avoidable, unavoidable and indeterminable causes.

Indicator	**1.5 - Infection control - Hospital acquired MRSA cases, lapse in care identified**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Jun-22
Value / RAG rating	0

Indicator description

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

Trend chart



Narrative

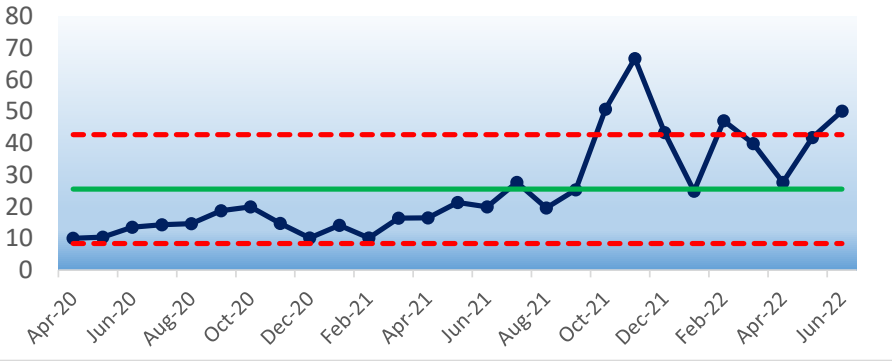
No hospital acquired MRSA cases where lapses in care identified for June.

Indicator	**1.6 - Incidents - ratio of low harm incidents**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Jun-22
Value / RAG rating	50.1

Indicator description

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

SPC chart



Narrative

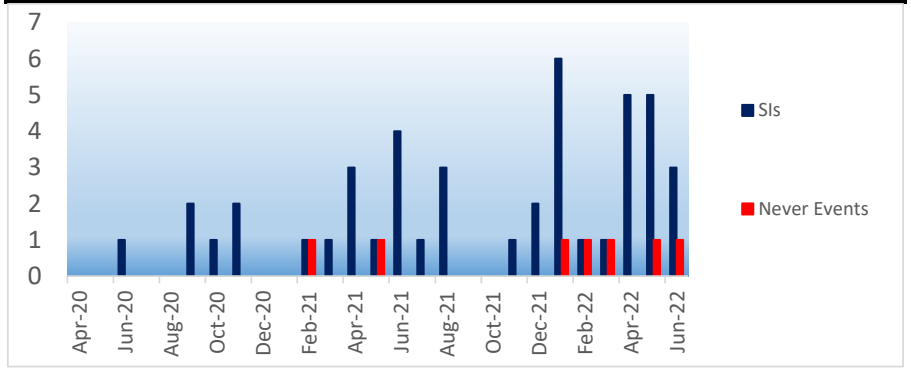
The number of low harm incidents reported in June has increased resulting in a level of reporting that positively exceeds the upper control limit of the SPC chart. In June 2022, the top 5 categories of incidents reported were:
Pressure Ulcers & Other Skin Damage (29%)
Records & Consent (10%)
Appointments,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

Indicator	**1.7 - Incidents - comprehensive serious incidents (SI) and Never Events**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Jun-22
Value / RAG rating	3 (SI), 1 (Never Events)

Indicator description

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

Trend chart



Narrative

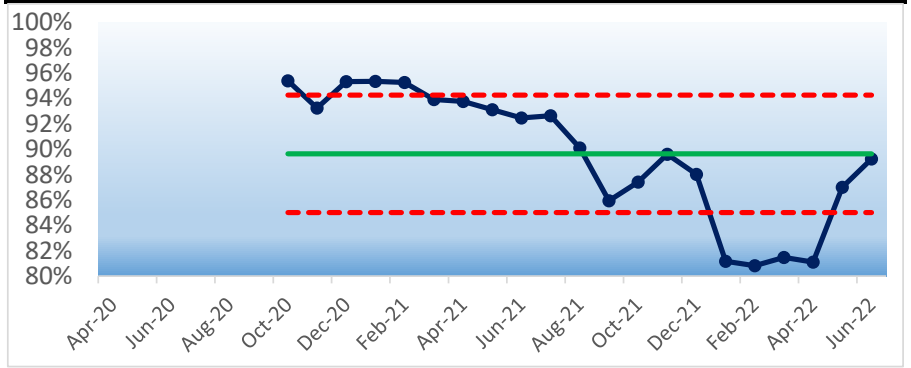
In June 2022, three serious incidents were declared, including one Never Event.
The SI Committee has strong oversight of current SI investigations with closure reports being produced and shared into Learning Summit.

Indicator	**1.8.1 - Safer staffing - fill rate**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Jun-22
Value / RAG rating	89.2%

Indicator description

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

SPC chart



Narrative

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

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

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

1) Recruitment
2) Retention
3) International Recruitment

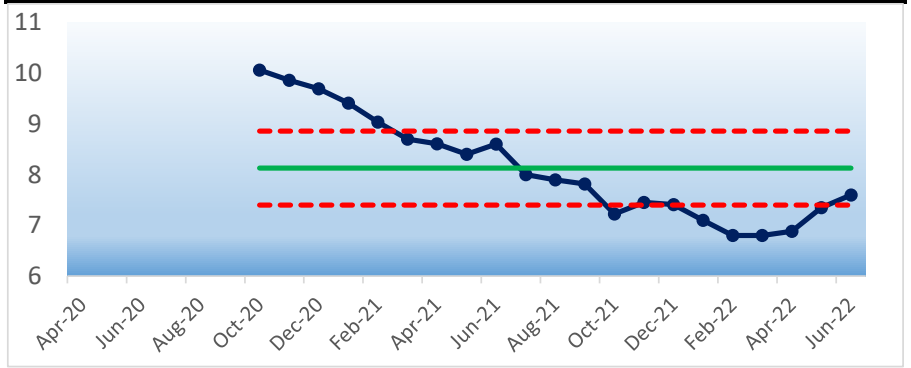
Recruitment and Retention groups have now been introduced feeding in to the Nursing, Midwifery and AHP Workforce Governance meetings.

Indicator	**1.8.2 - Safer staffing - care hours per patient per day (CHPPPD)**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Jun-22
Value / RAG rating	7.6

Indicator description

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

SPC chart



Narrative

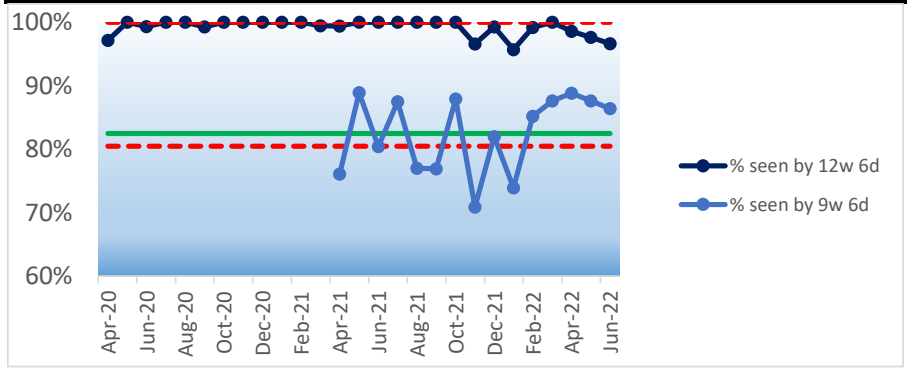
CHPPPD has increased over the last few months. However CHPPPD is not in line with fill rate. To note, calculations of nurse fill from Fountains are being based on 28 beds when they are mostly 15. Data is being reviewed to ensure accuracy of reporting staffing fill rates against changing operational position.

Indicator	**1.9 - Maternity - % women seen by a midwife (or healthcare professional) by 12w 6d**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Jun-22
Value / RAG rating	96.6%

Indicator description

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

SPC chart



Narrative

Performance against this standard remains good.

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

Indicator description

This indicator is under development.

SPC chart

Narrative

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

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

Indicator	**1.11 - Maternity - % women smoking at time of delivery**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Jun-22
Value / RAG rating	3.7%

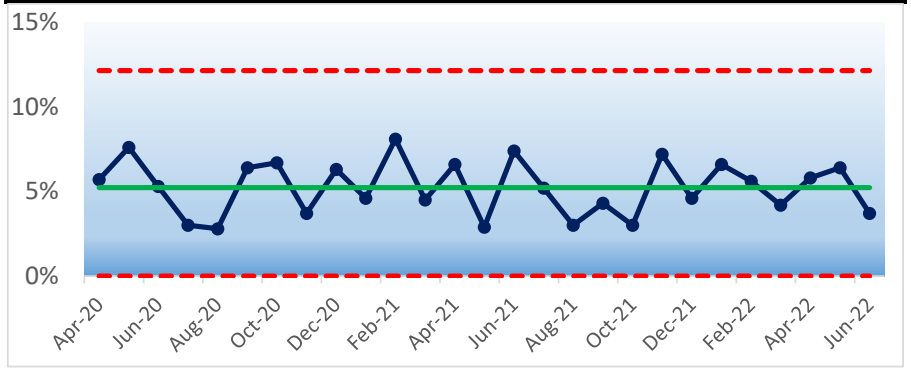
Indicator description

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

Narrative

Performance against this standard remains good.

SPC chart



Indicator	**1.12 - Maternity - % women initiating breastfeeding**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Jun-22
Value / RAG rating	81.8%

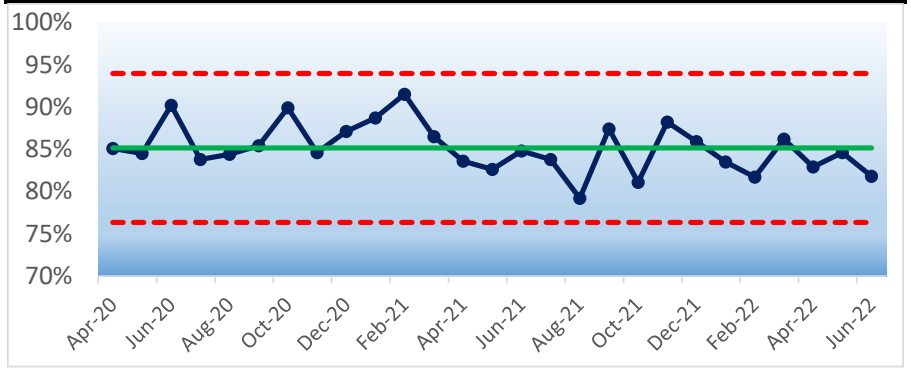
Indicator description

The % of women initiating breastfeeding

Narrative

Performance against this standard remains good

SPC chart

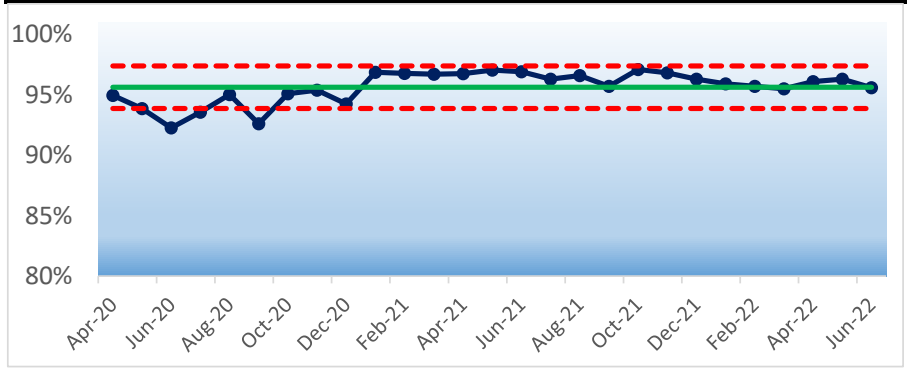


Indicator	**1.13 - VTE risk assessment - inpatients**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Jun-22
Value / RAG rating	95.6%

Indicator description

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

SPC chart



Narrative

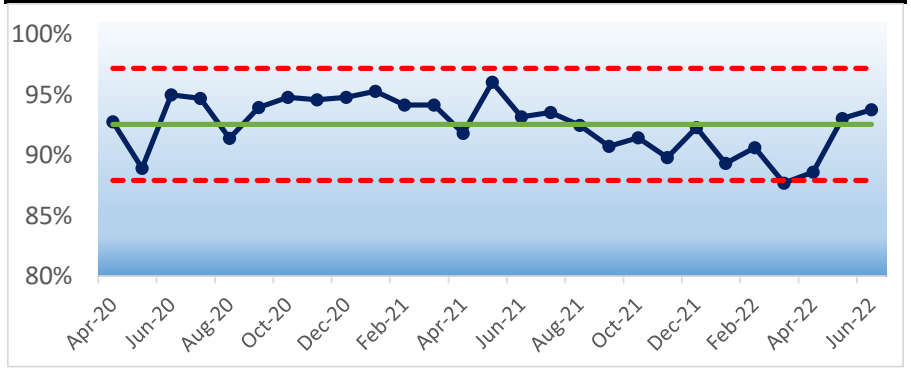
VTE risk assessment compliance continues to slowly improve, wards are reminded of the monitoring of this, remaining above the 95% standard.

Indicator	**1.14 - Sepsis screening - inpatient wards**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Jun-22
Value / RAG rating	93.8%

Indicator description

The percentage of eligible inpatients who were screened for sepsis.

SPC chart



Narrative

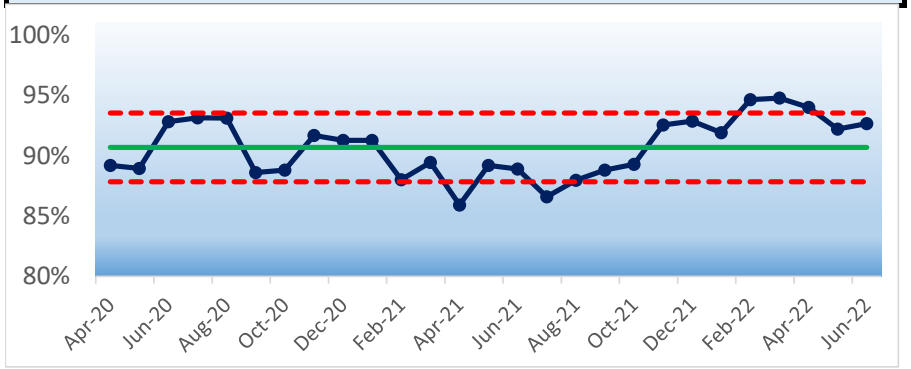
Improvement noted due to systems in place and monitoring from matrons.

Indicator	**1.15 - Sepsis screening - Emergency department**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Jun-22
Value / RAG rating	92.6%

Indicator description

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

SPC chart



Narrative

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

Integrated Board Report - June 2022

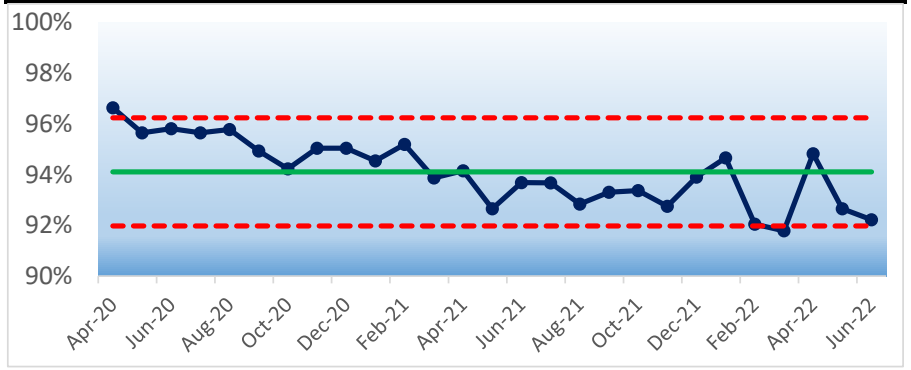
Domain 2 - Caring

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

Indicator description

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

SPC chart



Narrative

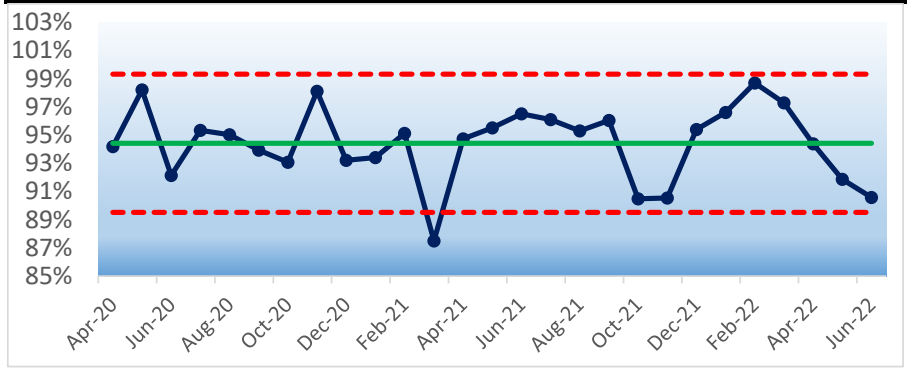
Performance against this standard continues to fluctuate but overall remains over 90% which is positive.

Indicator	**2.1.2 - Friends & Family Test (FFT) - Adult Community Services**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Jun-22
Value / RAG rating	90.6%

Indicator description

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

SPC chart



Narrative

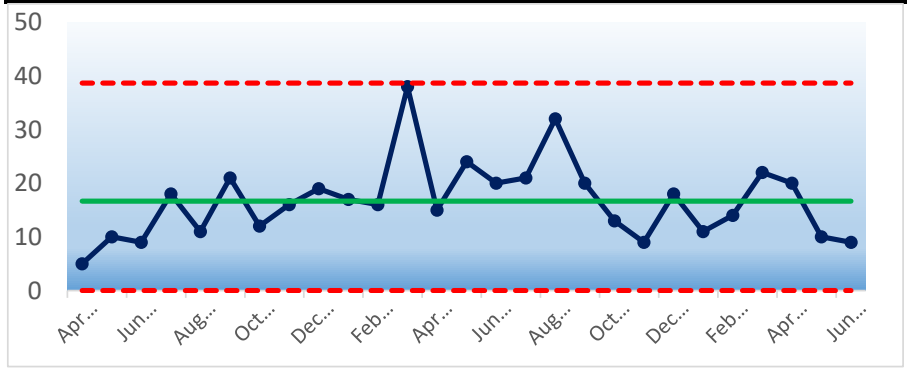
Performance against this standard continues to fluctuate but overall remains over 90% which is positive.

Indicator	**2.2.1 Complaints - numbers received**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Jun-22
Value / RAG rating	9

Indicator description

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

SPC chart



Narrative

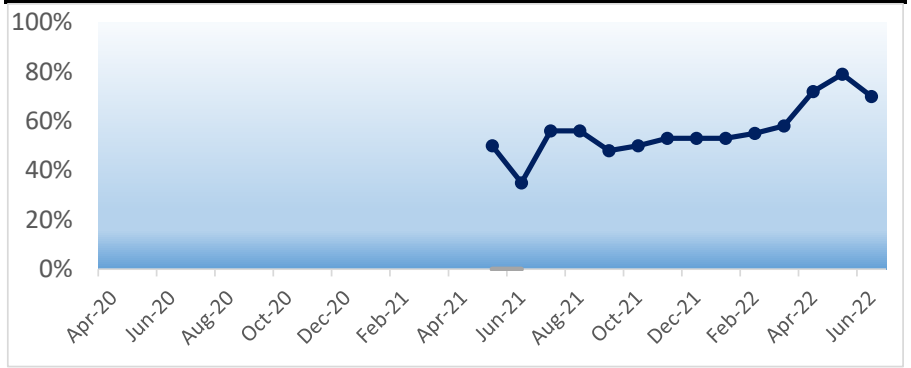
In June, there were 9 standard complaints received into the organisation that required a response within the 25 working day KPI. There were a further 2 multiagency complaints. There were 6 standard complaints in PSC, 1 in LTUC and 2 in Children's and Community. Some themes noted for complaints during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

Indicator	**2.2.2 Complaints - % responded to within time**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Jun-22
Value / RAG rating	70%

Indicator description

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

Trend chart



Narrative

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

Integrated Board Report - Juney 2022

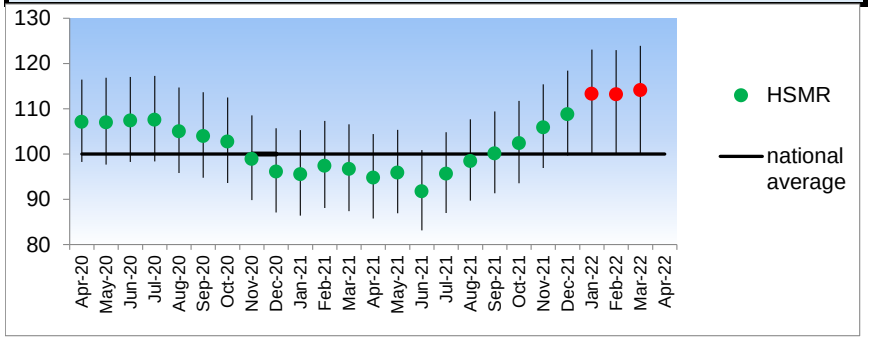
Domain 3 - Effective

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

Indicator description

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

Trend chart



Narrative

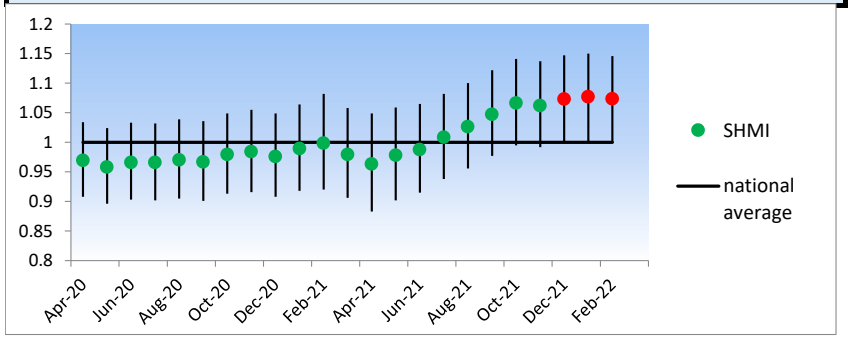
National average is 100. HDFT remains above the expected range. The funnel plot below shows HDFT as the diamond compared to similar Trusts (shown as a cross) and all other Trusts. The Deputy Medical Director (Quality and Safety) has performed a deep dive into the rise in our mortality indicators, details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

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

Indicator description

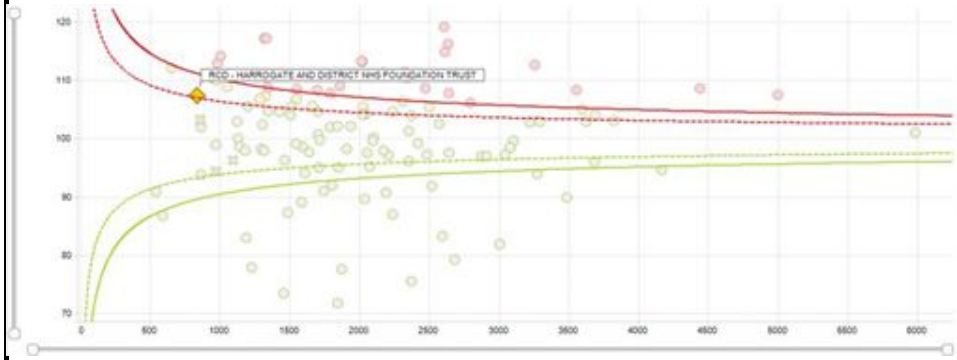
The SHMI looks at the mortality rates for all diagnoses and standardises against various criteria including age, sex and comorbidities. The measure does not make an adjustment for palliative care.

Trend chart



Narrative

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

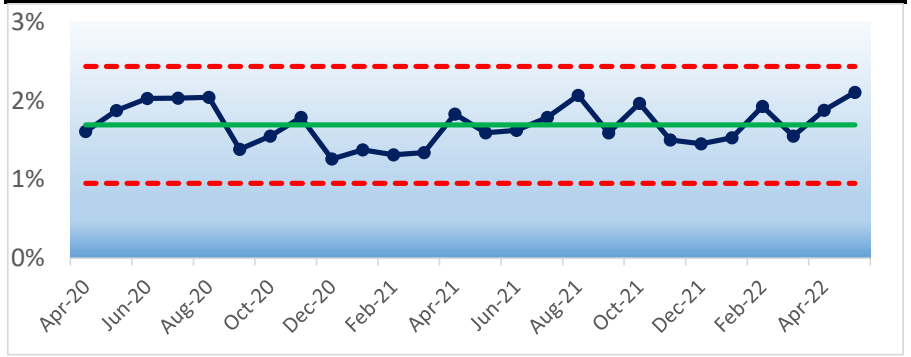


Indicator	**3.3.1 - Readmissions to the same specialty within 30 days - following elective admission**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	May-22
Value / RAG rating	2.1%

Indicator description

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

SPC chart



Narrative

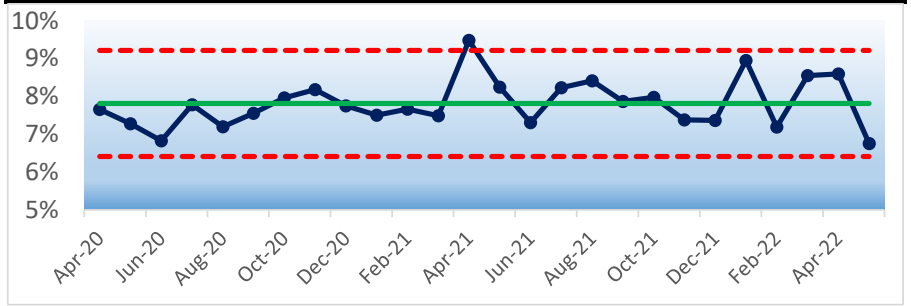
Readmissions following an elective admission increased to 2.1% in May but remain within control limits and less than national average.

Indicator	**3.3.2 Readmissions to the same specialty within 30 days - following non-elective admission**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	May-22
Value / RAG rating	6.8%

Indicator description

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

SPC chart



Narrative

Readmissions following a non-elective admission decreased to 6.8% in May, remaining within the control limits.

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

Indicator description
This indicator is under development.

SPC chart

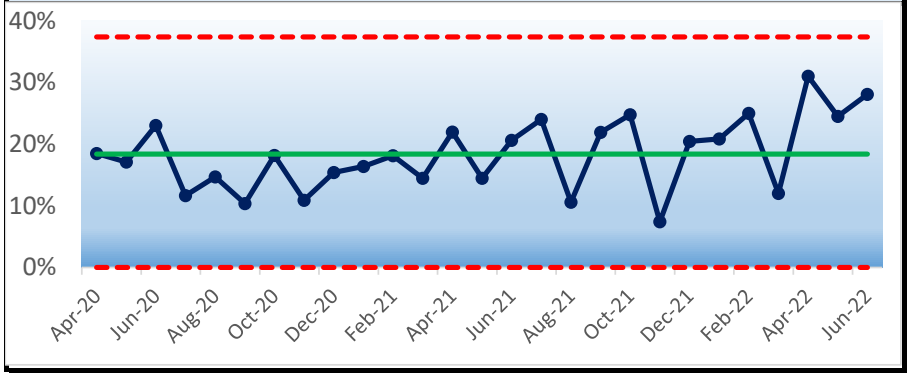
Narrative

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

Indicator description

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

SPC chart



Narrative

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

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

Integrated Board Report - June 2022

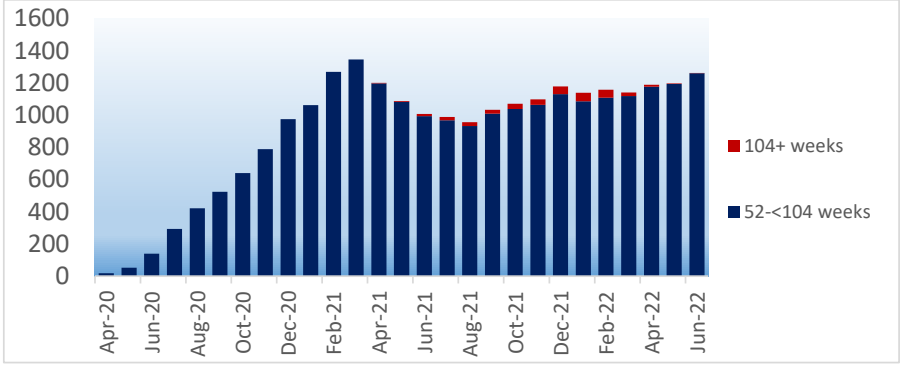
Domain 5 - Responsive

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

Indicator description

The number of incomplete pathways waiting over 52 weeks.

Trend chart



Narrative

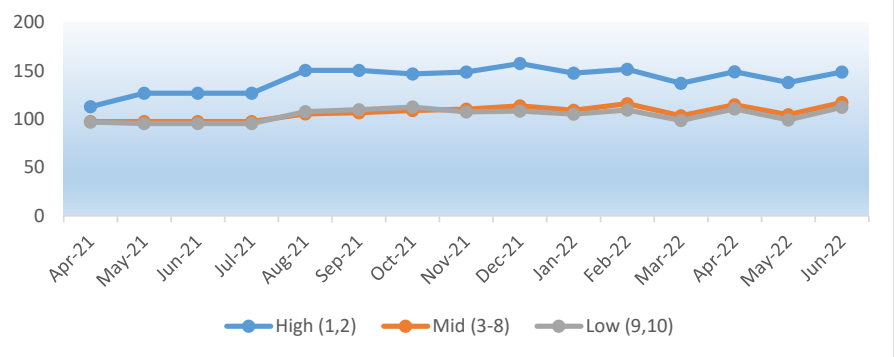
Due to the Covid-19 pandemic and the ceasing of elective work, waiting times have risen significantly. The over 52 weeks waiters peaked in March 2021. Risks remain in two main specialties of T&O and Community Dental (which together account for 78% of the over 52 week waiters). Plans in place to reduce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

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

Indicator description

The average RTT waiting time by level of deprivation.

Trend chart



Narrative

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

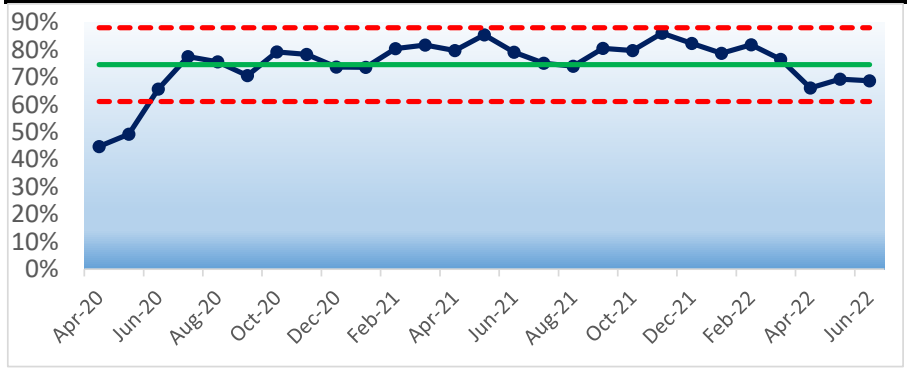
Work also continues in improving the recording of ethnicity and use of the learning disabilities flag across our clinical systems.

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

Indicator description

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

SPC chart



Narrative

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

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

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

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

Indicator description
This indicator is under development.

SPC chart

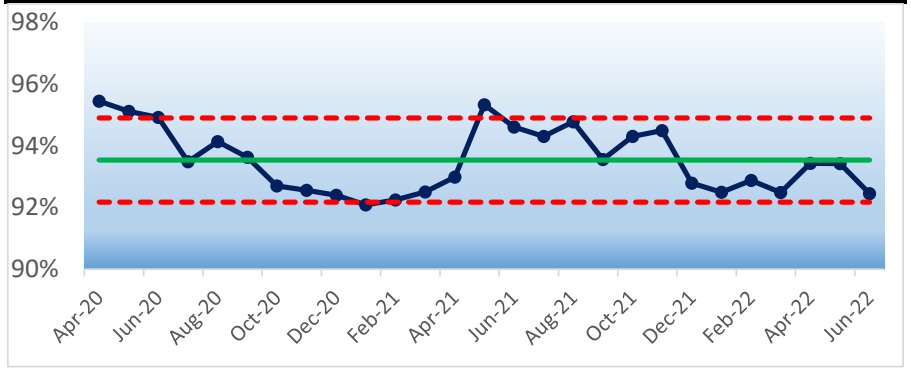
Narrative

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

Indicator description

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

SPC chart



Narrative

The Trust remains below the required standard of 97%. A revised focus on ethnicity data collection is underway, this measure is monitored at Trust weekly access meetings.

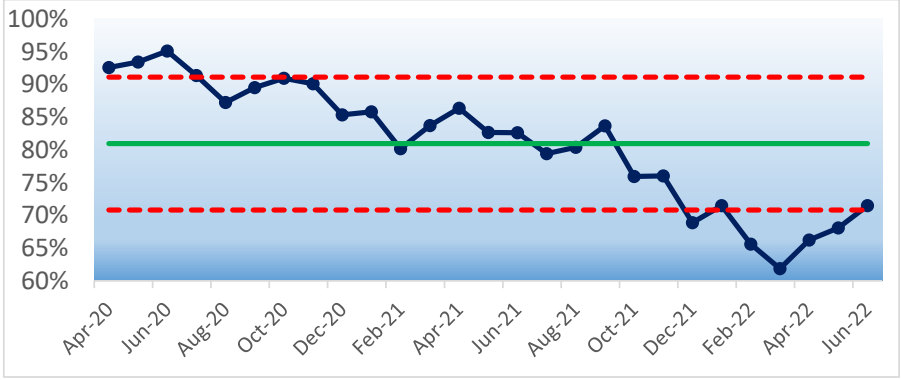
- Made contact with the lead at Central London Community NHS Trust (CLCH) who have improved their ethnicity recording rates on their patient records – they are organising a webinar to talk through their actions
- Reminded staff of the process regarding the collection of this data including reception staff aware that they should be collecting ethnic category, if not already there, as part of the demographic check.
- Progress of new Kiosks – previously electronic check in kiosks included a step to complete / update ethnic category. Removed as a result of COVID, awaiting new kiosks to re-introduce process.
- Exploring option of sending electronic forms to patients for completion and return.

Indicator	**5.6 - A&E 4 hour standard**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Jun-22
Value / RAG rating	71.5%

Indicator description

Percentage of patients spending less than 4 hours in Accident & Emergency (A&E). The data includes all A&E Departments, including Minor Injury Units (MIUs). The operational standard is 95%.

SPC chart



Narrative

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

Current work underway to improve this position includes:

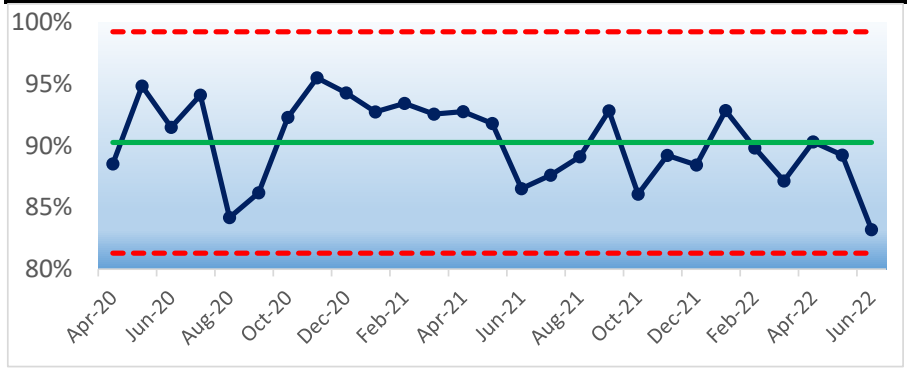
- delivering 7 day SDEC service and a direct to SDEC pathway with YAS;
- streaming of minors at the front door;
- utilising Criteria to Reside flow software to identify patients no longer requiring hospital care;
- developing a 2 hour crisis response service, expanding ARCH in-reach to ED and maximising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

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

Indicator description

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

SPC chart



Narrative

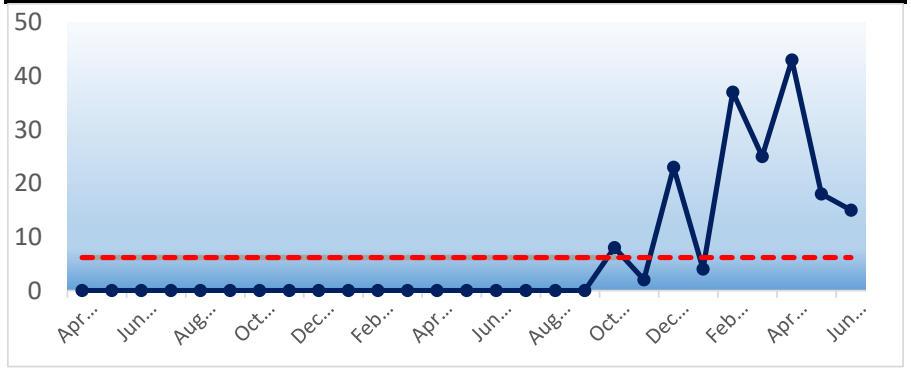
83% of ambulance handovers took place within 15 minutes in June. There were 32 over 30-minute handover breaches with 2 over 60-minutes in June. Prevention of ambulance handover delays continues to be a focus with the Trust operational processes being shared across the region by NHSE/I. Despite the high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

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

Indicator description

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

SPC chart



Narrative

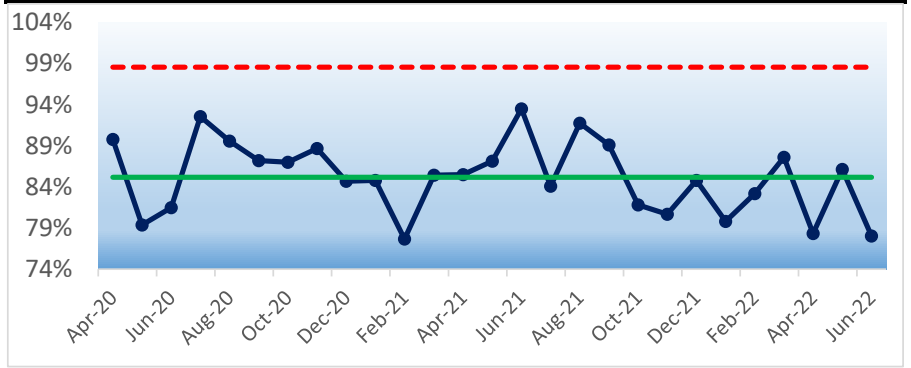
15 over 12 hour trolley waits were reported in June, a second month of improvement. As it stands, RCAs have been completed and reviewed at internal quality and performance meetings for 14 of the 15 reported cases. None of the 14 patients reviewed so far were harmed as a result of their wait in the Emergency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

Indicator	**5.9.1 - Cancer - 62 day wait for first treatment from urgent GP referral to treatment**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Jun-22
Value / RAG rating	78.0%

Indicator description

Percentage of cancer patients starting first treatment within 62 days of urgent GP referral. The operational standard is 85%.

SPC chart



Narrative

Provisional data indicates that the 62 day standard was not delivered in June (78.0%). There were 66.0 accountable treatments (76 patients) in June with 14.5 treated outside 62 days. Of the 11 tumour sites treated in June, performance was below 85% for 7 (Colorectal, Gynaecology, Lung, Other, Sarcoma, Upper GI,Urology). All pathway delays will be reviewed by the breach panel at the end of July.

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

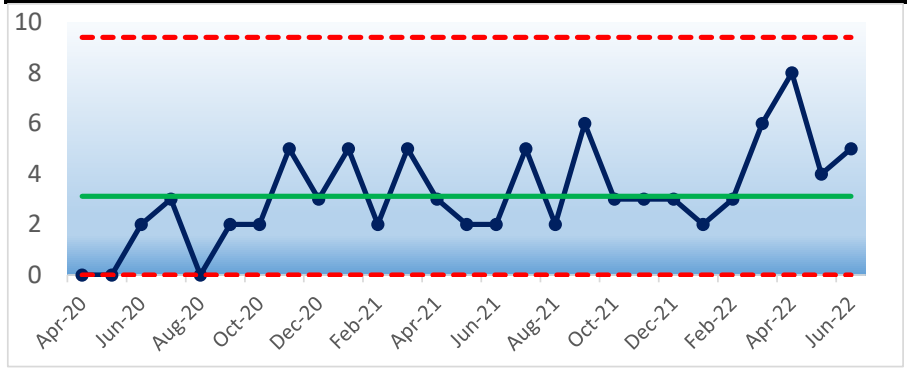
There are currently challenges with Colorectal elective capacity, and also Colorectal oncology capacity is severely limited. There are also continuing challenges in Urology outpatients for both new and follow-up appointments.

Indicator	**5.9.2 - Cancer - 62 day standard - number of 104 days waiters**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Jun-22
Value / RAG rating	5

Indicator description

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

SPC chart



Narrative

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

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

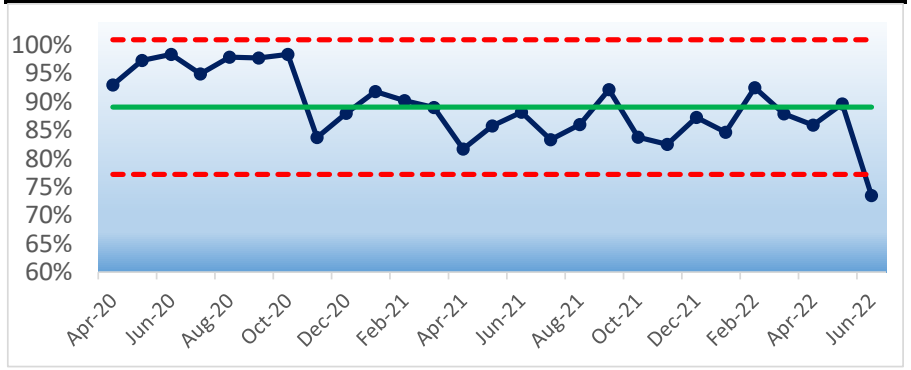
All patients have now received treatment and their pathways will be reviewed by the breach panel at the end of July.

Indicator	**5.10 - Cancer - 14 days maximum wait from urgent GP referral for all urgent suspect cancer referrals**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Jun-22
Value / RAG rating	73.5%

Indicator description

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

SPC chart



Narrative

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

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

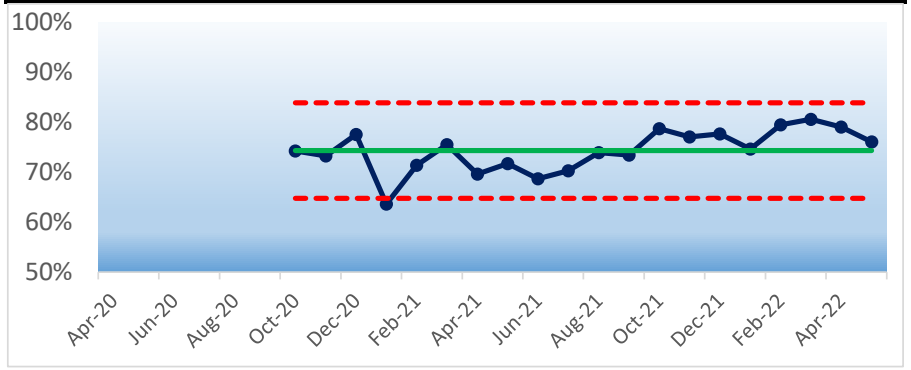
Performance for the breast 2WW standard was at 73.3% in June which is below the operational standard and a deterioration on the previous month. Performance for all 2WW breast attendances in June was at 74.5% compared to 96% in May.

Indicator	**5.11 - Cancer - 28 days faster diagnosis standard (suspected cancer referrals)**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Jun-22
Value / RAG rating	80.4%

Indicator description

From October 2021, Trusts are required to deliver the new 28 days faster diagnosis standard for all suspected cancer referrals. The proposed operational standard is 75%.

SPC chart



Narrative

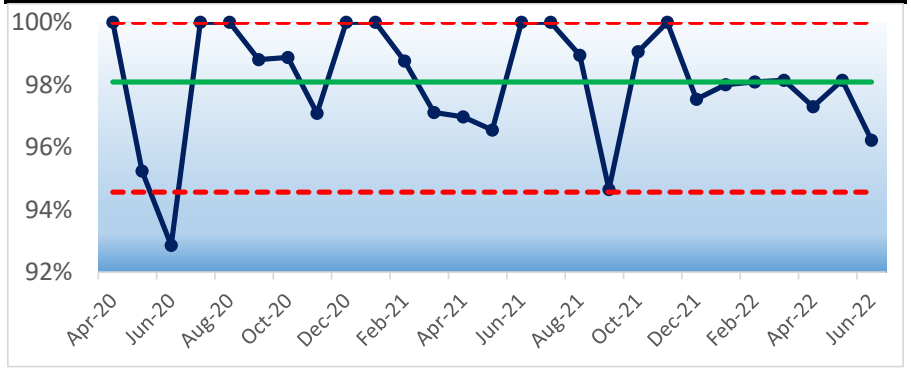
Provisional data indicates that in June combined performance for the three 28 days standards (2WW suspected cancer, 2WW non-cancer breast symptoms, Screening) has remained above the proposed operational standard of 75% (2WW cancer - 84.1%; 2WW Breast Symptoms - 100%; Screening - 43%).

Indicator	**5.12 - Cancer - 31 days maximum wait from diagnosis to treatment for all cancers**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Jun-22
Value / RAG rating	96.2%

Indicator description

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

SPC chart



Narrative

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

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

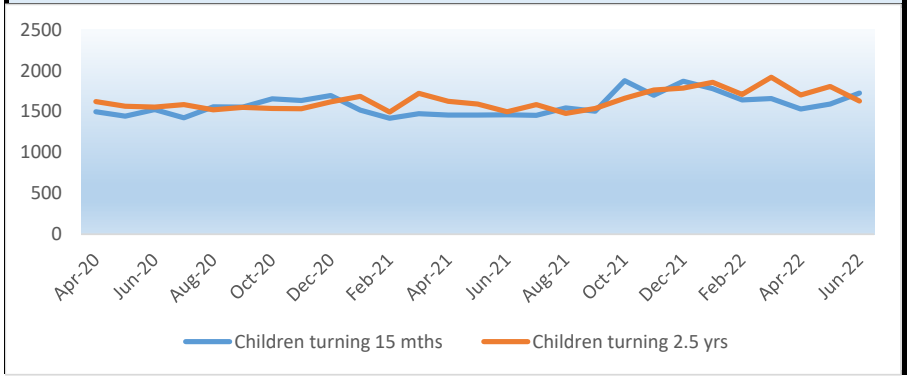
Overall peformance was above the expected standard of 96%.

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

Indicator description

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

SPC chart



Narrative

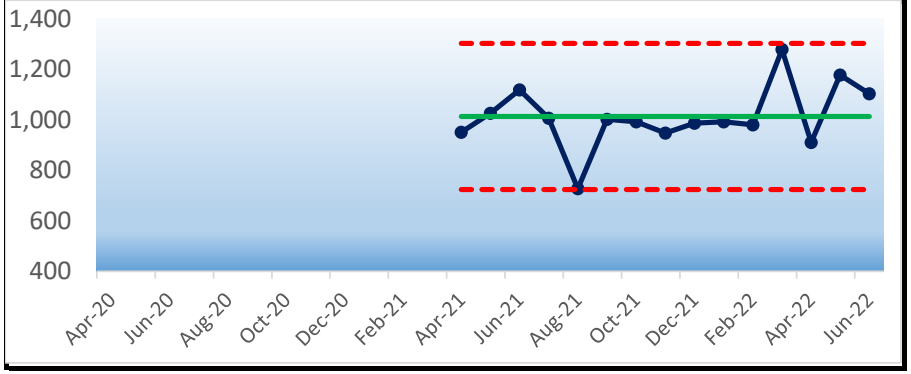
The 15 month old caseload increased in June, whilst the 2.5 year old caseload decreased.

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

Indicator description

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

SPC chart



Narrative

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

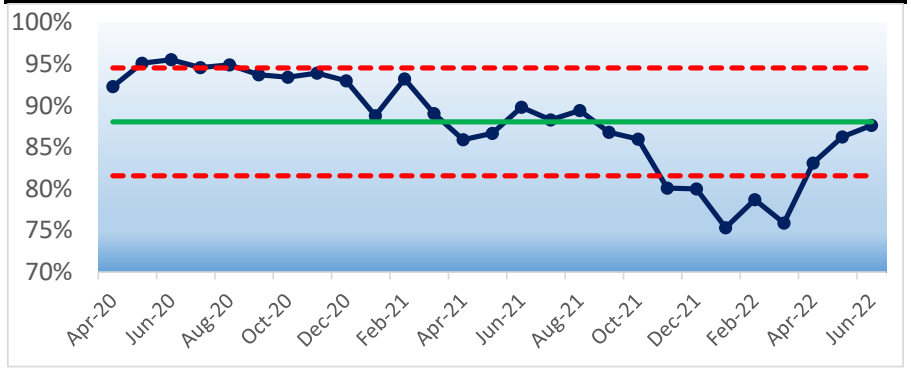
We continue to see very high levels of Safeguarding across our 0-19 Contact Areas which is in excess of the levels seen over the last three years. Additional resource has been added to the Safeguarding team to support these levels of activity.

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

Indicator description

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

SPC chart



Narrative

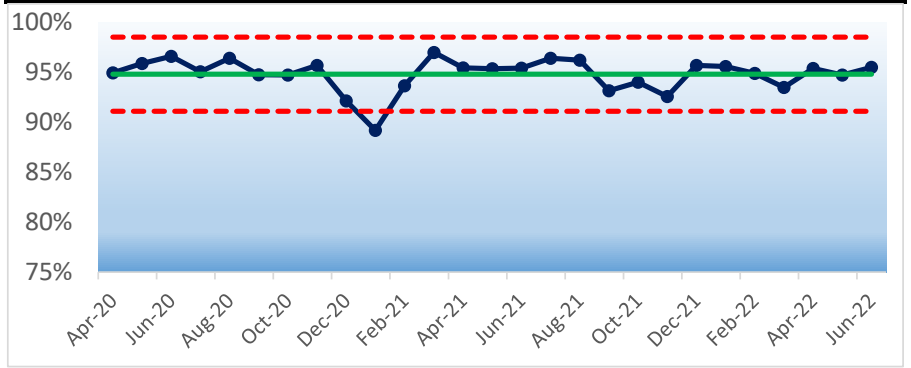
88% of eligible pregnant women received an initial antenatal visit in June, a further improvement on recent months. Middlesbrough performance (which was the main reason for the deterioration seen in recent months) improved to 83%, a significant improvement.

Indicator	**5.16 - Children's Services - 10-14 day new birth visit**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Jun-22
Value / RAG rating	95.5%

Indicator description

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

SPC chart



Narrative

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

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

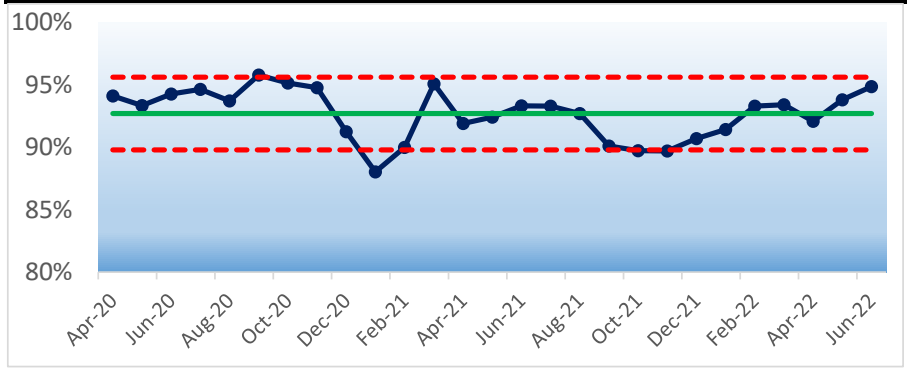
Indicator description

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

Narrative

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

SPC chart



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

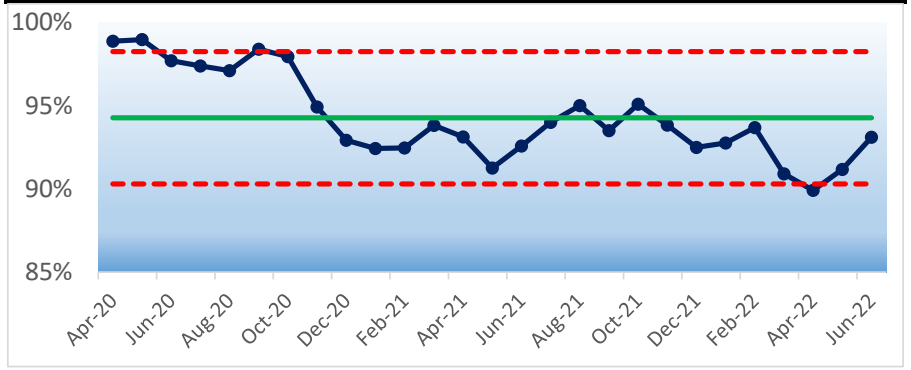
Indicator description

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

Narrative

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

SPC chart

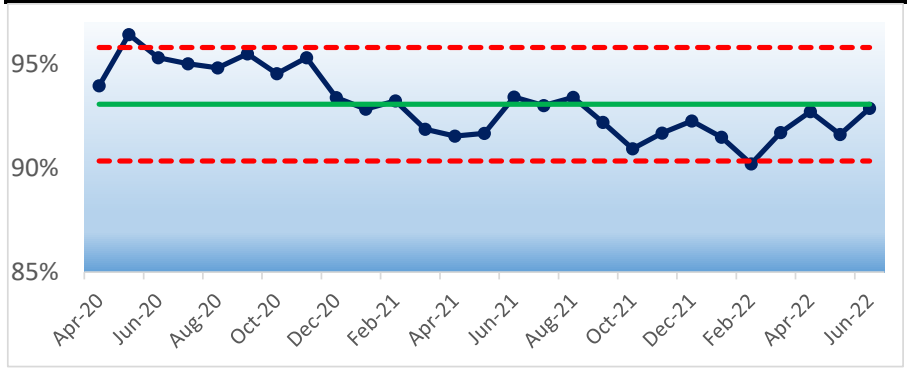


Indicator	**5.19 - Children's Services - 2.5 year review**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Jun-22
Value / RAG rating	92.9%

Indicator description

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

SPC chart



Narrative

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

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

Indicator description

This indicator is under development.

SPC chart

Narrative

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

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

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

Indicator description
This indicator is under development.

SPC chart

Narrative

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

Indicator description

This indicator is under development.

SPC chart

Narrative

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

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

Indicator description

This indicator is under development.

SPC chart

Narrative

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

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

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

Indicator description
This indicator is under development.

SPC chart

Narrative

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

Indicator description
This indicator is under development.

SPC chart

Narrative

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

Indicator description
This indicator is under development.

SPC chart

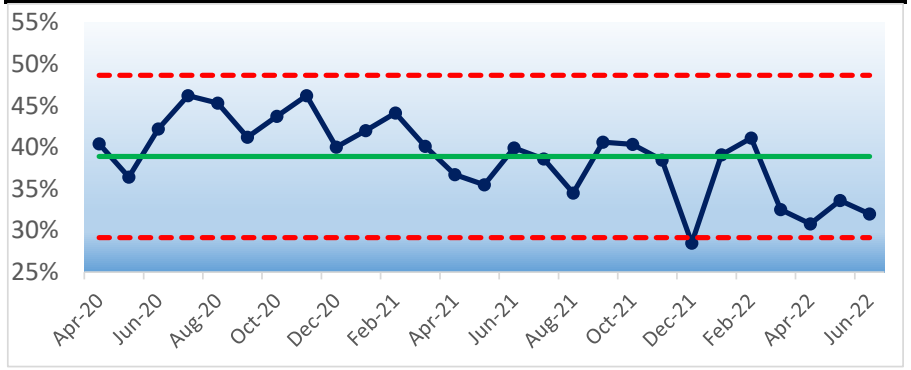
Narrative
CC Directorate have started to discuss and record OPEL levels for Adult Community Services at their Safety and Governance huddles. The overall position for June remained at level 3.

Indicator	**5.27 - GPOOH - telephone clinical assessment for URGENT cases within 20 minutes of call prioritisation**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Jun-22
Value / RAG rating	32.0%

Indicator description

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

SPC chart



Narrative

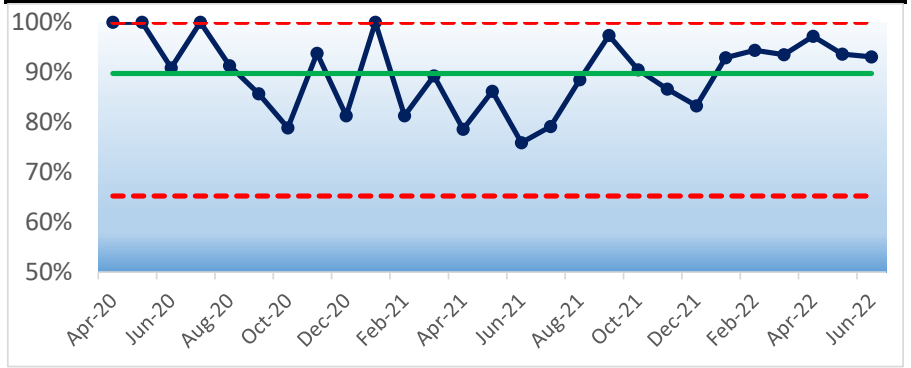
In June, 32% of urgent GPOOH cases received a telephone clinical assessment within 20 minutes of call prioritisation, remaining below the 95% target. The COO has requested an immediate deep dive into the GPOOH service to understand the demand and capacity gap that is being ancedotally mentioned at operational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

Indicator	**5.28 - GPOOH - Home visit: Face to face consultations started for URGENT cases within 2 hrs**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Jun-22
Value / RAG rating	93.1%

Indicator description

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

SPC chart



Narrative

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

Integrated Board Report - June 2022

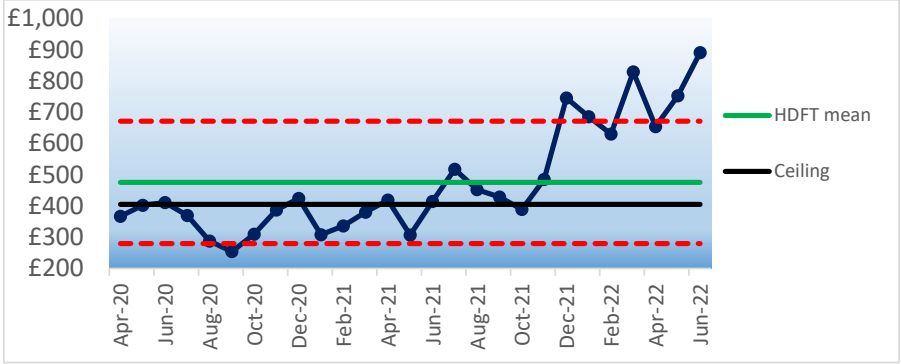
Domain 6 - Efficiency and Finance

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

Indicator description

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

SPC chart



Narrative

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

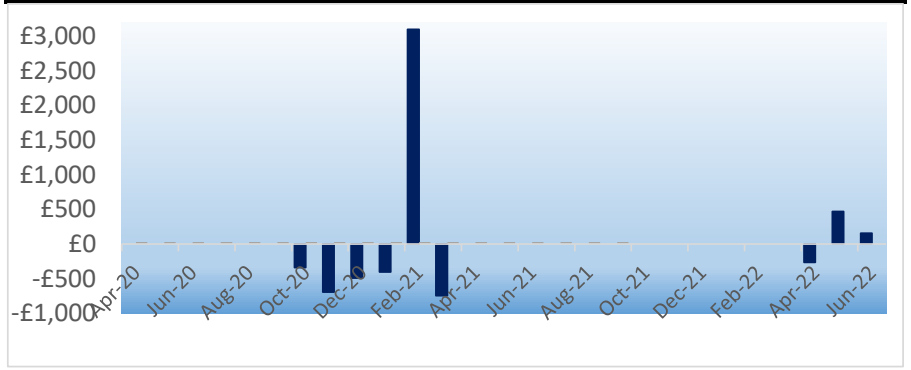
Further information is included within the Committee reports on this.

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

Indicator description

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

Trend chart



Narrative

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

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

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

Indicator description

Cumulative Capital Expenditure by month (£'000s)

Narrative

The Trust continues to implement this year's programme.

Trend chart

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

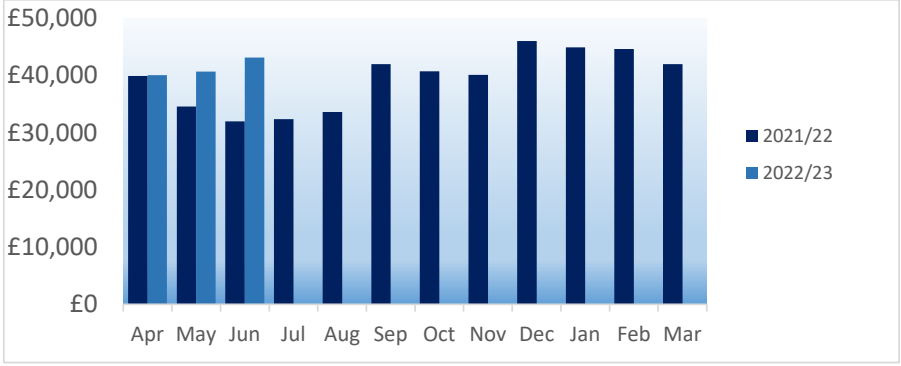
Indicator description

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

Narrative

The Trust cash balance remains positive.

Trend chart

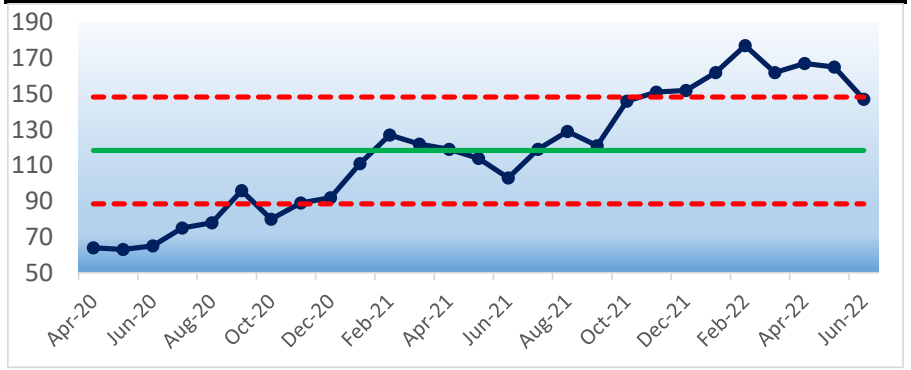


Indicator	**6.5.1 - Long stay patients - stranded (>7 days LOS)**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Jun-22
Value / RAG rating	147

Indicator description

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

SPC chart



Narrative

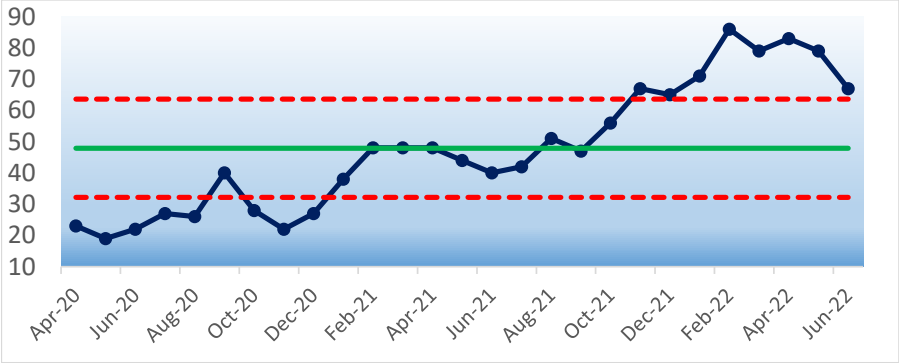
The number of long stay patients (> 7 days) was 147 in June, a reduction on recent months but remaining high. This is being driven by the increase in COVID patients, COVID 'pop ups' at day 7 and patients requiring observation as COVID contacts alongside the impact of COVID on POC, residential and nursing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

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

Indicator description

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

SPC chart



Narrative

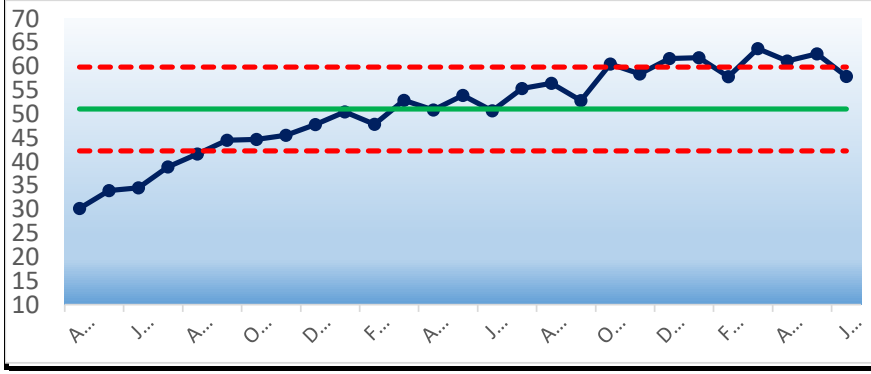
The number of long stay patients (> 21 days) was 67 in June, a reduction on recent months but remaining high. This is being driven by the increase in COVID patients, COVID 'pop ups' at day 7 and patients requiring observation as COVID contacts alongside the impact of COVID on POC, residential and nursing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

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

Indicator description

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

SPC chart



Narrative

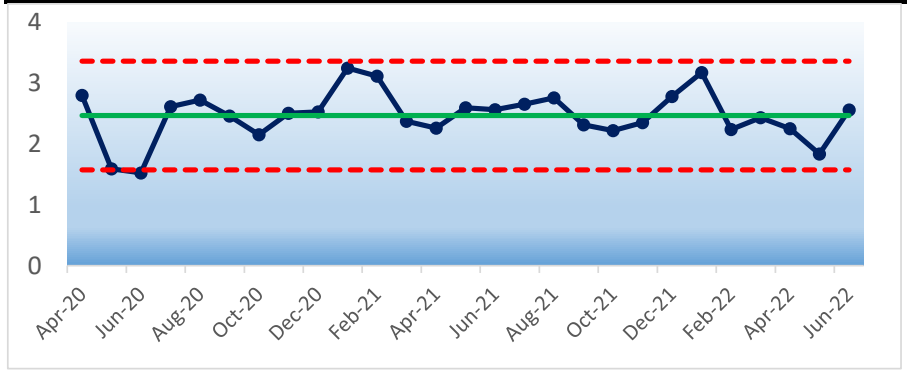
Occupied bed days decreased to 57.9 in June. In the 2 years prior to the pandemic, occupied bed days per 1,000 population averaged 57.8, below the current level.

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

Indicator description

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

SPC chart



Narrative

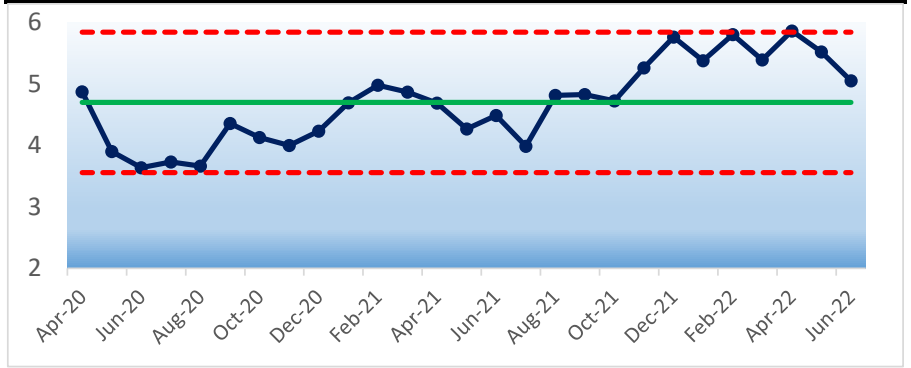
Elective length of stay increased in June and is now above our local stretch target of 2.5 days.

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

Indicator description

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

SPC chart



Narrative

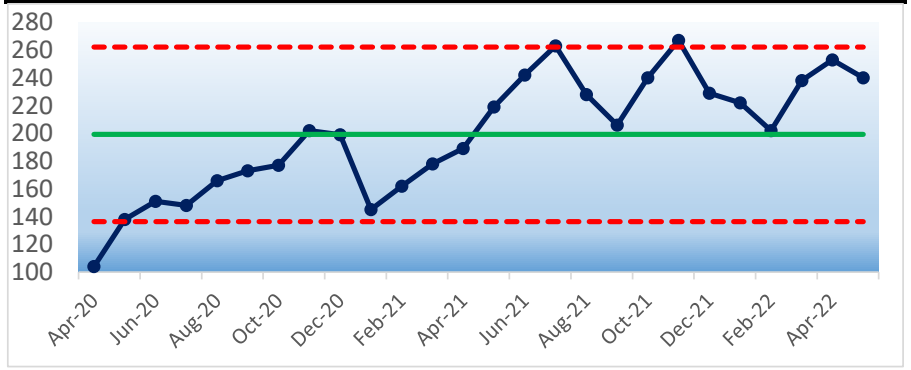
Non-Elective length of stay decreased in June but remains above our local stretch target. There is a combination of factors affecting patient flow, as described in indicators 6.5.1 - 6.7.1.

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

Indicator description

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

SPC chart



Narrative

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

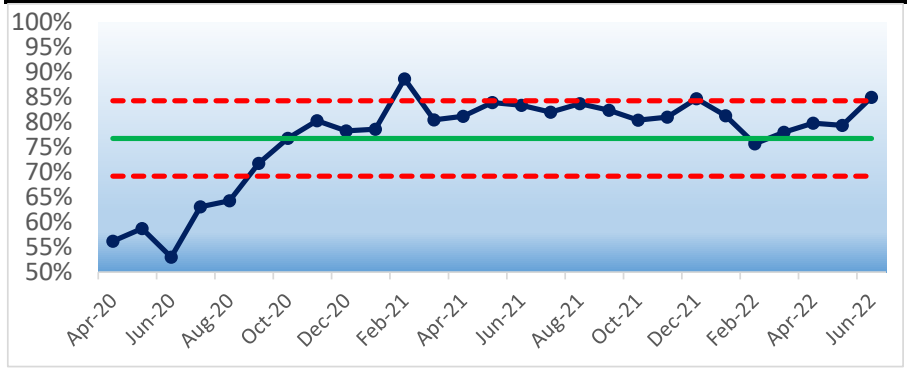
This is below pre-Covid levels - the average per month in 2018/19 was 270.

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

Indicator description

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

SPC chart



Narrative

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

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

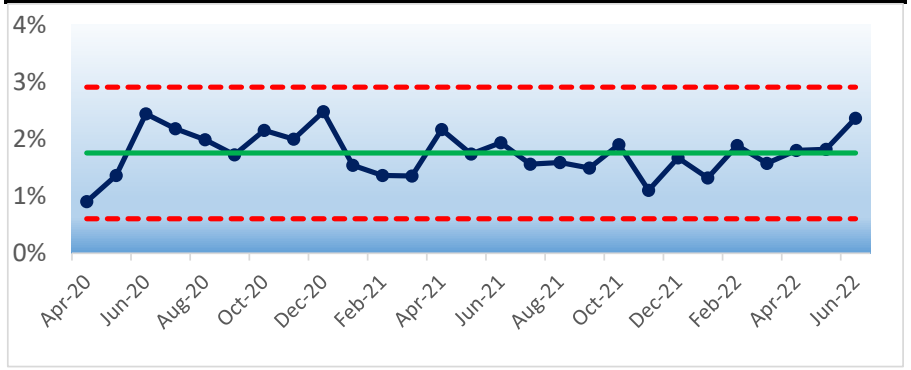
Indicator description

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

Narrative

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

SPC chart



Integrated Board Report - June 2022

Domain 7 - Activity

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

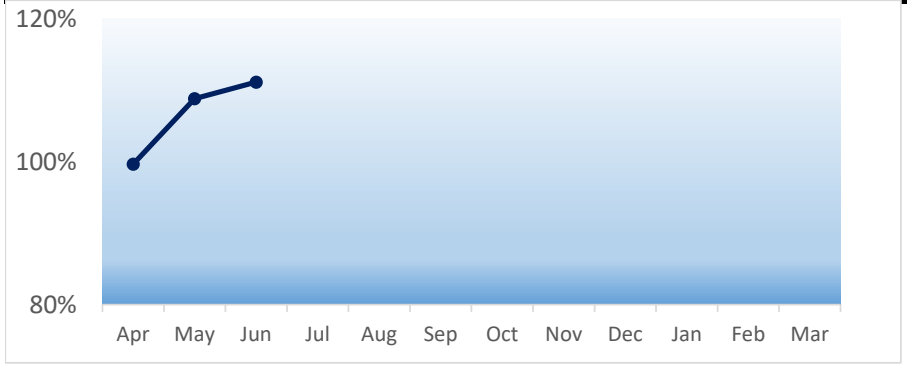
Indicator description

GP referrals against 2019/20 baseline.

Narrative

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

SPC chart

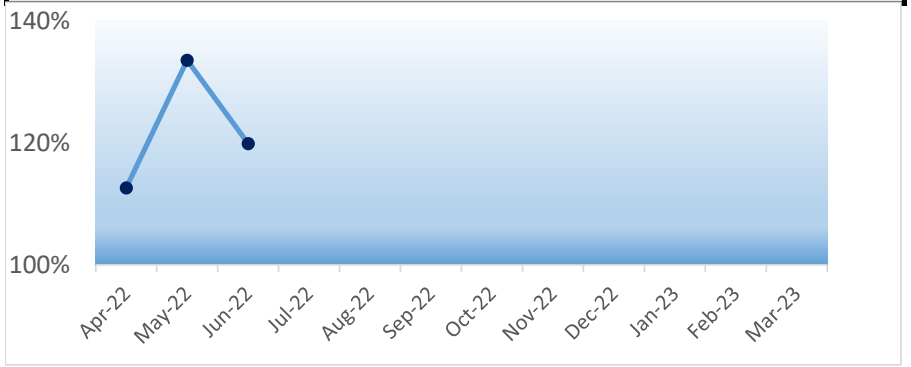


Indicator	**7.2 - Outpatient activity (consultant led) against plan**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Jun-22
Value / RAG rating	119.9%

Indicator description

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

Trend chart



Narrative

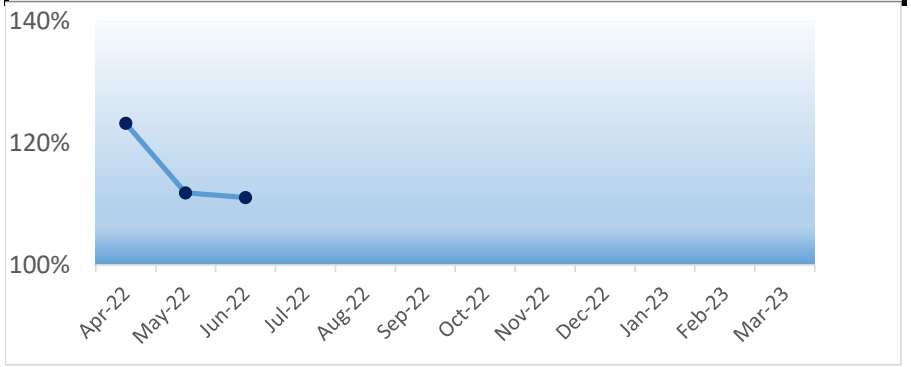
Outpatient activity was 20% above plan in June. New outpatient attendances were 7% below plan, whilst follow up attendances were significantly over plan (38%).

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

Indicator description

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

Trend chart



Narrative

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

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

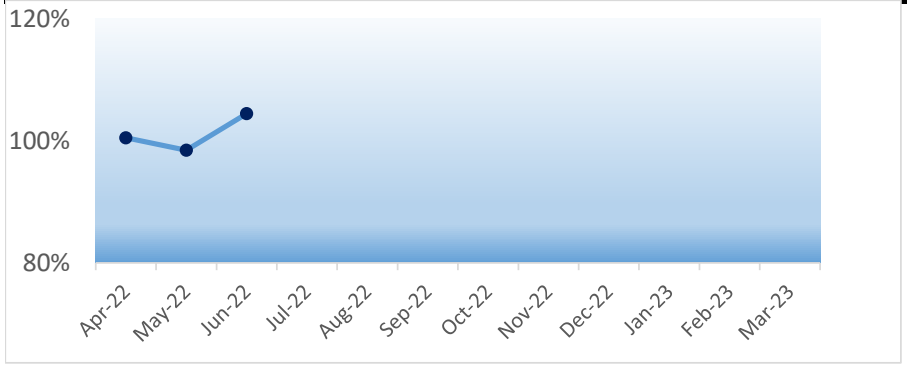
Indicator description

Non-elective activity against plan.

Narrative

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

Trend chart



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

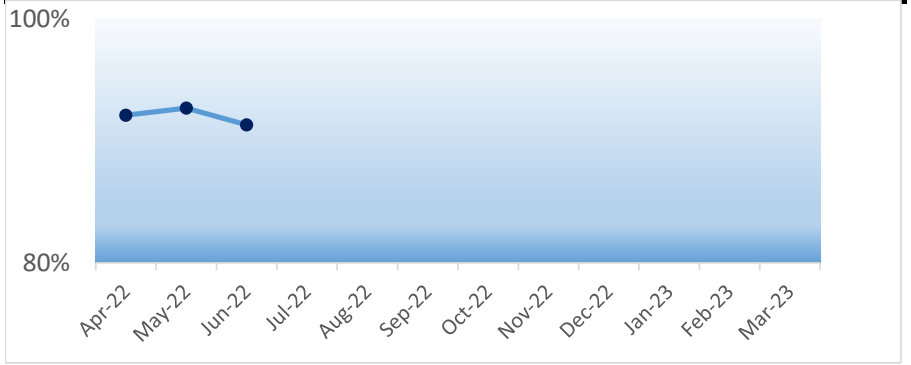
Indicator description

Emergency Department attendances against plan.

Narrative

Emergency Department attendances were 9% below plan in June.

Trend chart



Integrated Board Report - June 2022

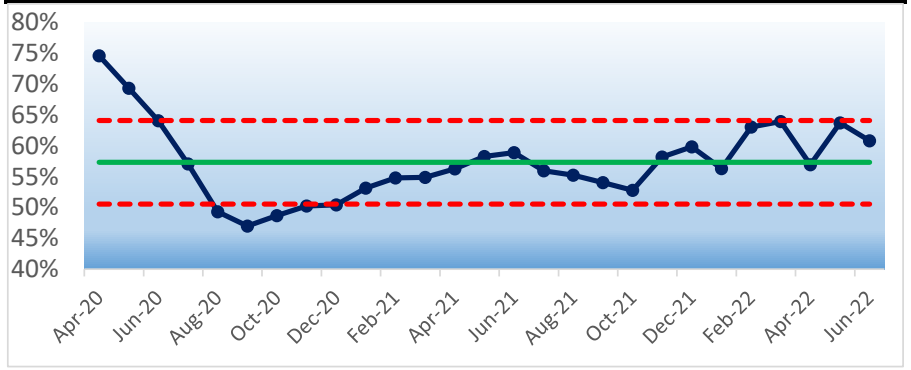
Domain 4 - Workforce

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

Indicator description

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

SPC chart



Narrative

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

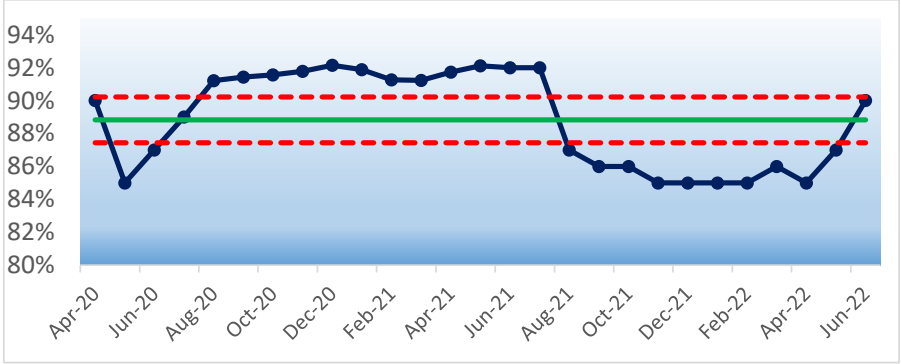
- Non-Medical appraisal % = 59.8% (previous month 63.2%)
- Medical appraisal % has increased to 73.3% (previous month 69.1%)

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

Indicator description

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

SPC chart



Narrative

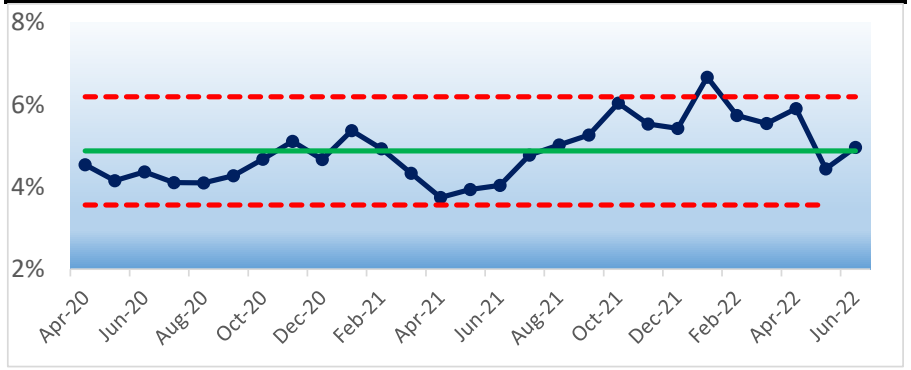
The data shown is for the end of June for the Mandatory Core elements of training. The overall compliance rate for substantive Trust staff is 90% and has increased by 3% since the previous month. The overall compliance for Mandatory core and role based training for Trust substantive staff is currently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

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

Indicator description

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

SPC chart



Narrative

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

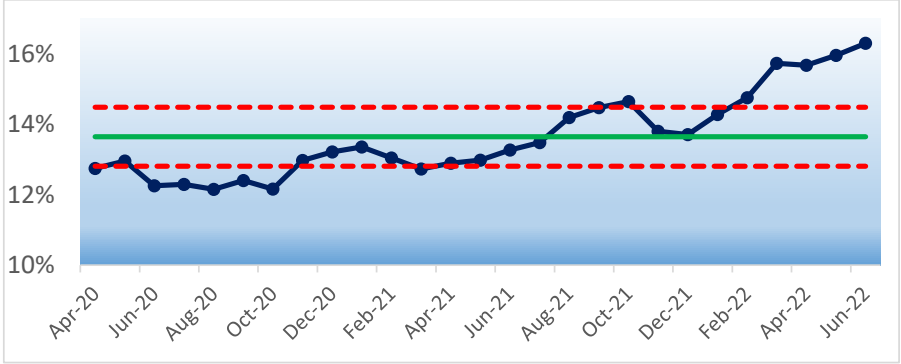
Long term sickness has remained at a similar level this month (2.5%), however short term sickness has increased from 2.0% to 2.5%. "S15 Chest & respiratory problems", which is the sickness reason used for recording Covid related sickness, is the top reason for sickness this month and contributes to 25.4%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

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

Indicator description

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

SPC chart



Narrative

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

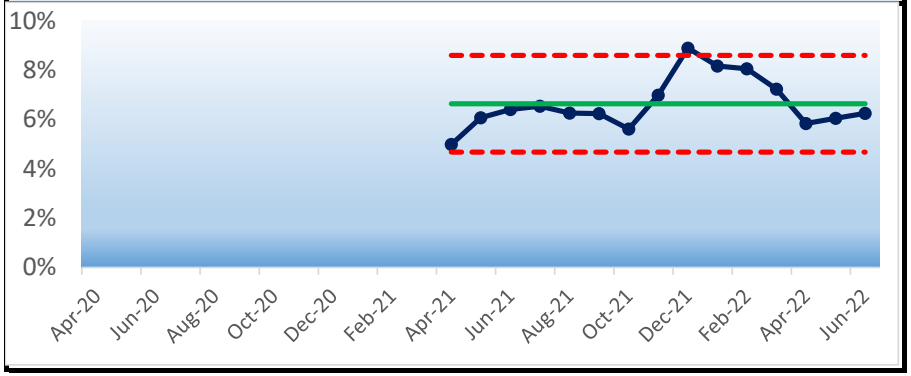
PSC and CC Directorates have seen increases to turnover this month and have turnover rates of 18.5% and 15.5% respectively. In PSC Directorate, there has been high turnover in June within Critical Care and also within the surgical wards. The turnover rates within these areas are now at 25.8% and 29.1%.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

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

Indicator description

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

SPC chart



Narrative

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

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

Harrogate and District NHS Foundation Trust

Trust Board (Public)

27th July 2022

Title:	Use of Trust Seal
Responsible Director:	Associate Director Quality & Corporate Affairs
Author:	Associate Director Quality & Corporate Affairs

Purpose of the report and summary of key issues:	The Trust Board is asked to note the items contained within this report.	
BAF Risk:	AIM 1: To be an outstanding place to work	
	BAF1.1 to be an outstanding place to work	✓
	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	✓
Corporate Risks	No Change	
Report History:	Board of Directors	
Recommendation:	The Board is asked to note and discuss the contents of this report	

HARROGATE AND DISTRICT NHS FOUNDATION TRUST
STANDING ORDERS
July 2022

1.0 PURPOSE

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

2.0 APPROVAL OF SIGNING AND SEALING OF DOCUMENTS

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

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

3.0 RECOMMENDATIONS

The Trust Board is requested to:

- Authorise the use of the Trust's seal

Kate Southgate
Associate Director of Quality and Corporate Affairs
July 2022