Corporate Risk Register Overview

Corporate Risk ID	Principle Risk	Current Risk Rating
CRR5: Nursing Shortages	Risk to service delivery and patient care due to failure to fill registered nurse vacancies due to the national labour market shortage.	**(4X4) - 16**
CRR73 – Insufficient staffing for special care baby unit	Insufficient capacity to meet the key national safety standard of a Qualified in Specialty (QIS) staff member on every shift and 70% of the establishment (8.3wte) qualified on Special Care Baby Unit (SCBU).	**(3x4) - 12**
CRR6: The impact of Covid and Operational Pressures on Workforce Wellbeing	Risk to patient care and safety due to current staffing levels and poor morale due to increased workload, post pandemic burn-out and poor working environment. Risk of: - both short and long term mental health impacts on staff	**(4x4) - 16**
CRR34: Autism Assessment	Risk to quality of care by not meeting NICE guidance in relation to the commencement of autism assessment within 3 months of referral. Risk that children may not get access to the right level of support without a formal diagnosis and that this could lead to deterioration in condition.	**(3X4) - 12**
CRR41: RTT	Risk to patient safety, performance, financial performance, and reputation due to increasing waiting times across a number of specialties, including as a result of the impact of Covid 19 (added 13/03/2020)	**(3x4) - 12**
CRR61: ED 4-hour Standard	Risk of increased morbidity/ mortality for patients due to failure to meet the 4 hour standard.	**(3x5) – 15**
CRR 71: Agency Usage	The Trust is currently in breach of regulatory obligation regarding agency price caps, is incurring premium costs for staffing where vacancies exist, and in some circumstances this results in an adverse impact to quality and safety. Breach of IR35 regulations and potential fine from HRMC.	**(3X5) - 15**
CRR 72: Operational Financial Position	Risk to financial sustainability and regulatory impacts as a result of not achieving breakeven. Risk of providing value for money to taxpayer.	**(4x3) - 12**

CORPORATE RISK REGISTER

CQC SAFE DOMAIN

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

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

Lead Committee	Quality Committee	**Risk Type**	Clinical	Workforce	**Risk Appetite**	Averse	
Executive Committee	Quality Management Group (QGMG)	**Summary in Month:** This area of the Corporate Risk Register is linked to Safe Domain. Currently there are 3 Corporate Risks within this Domain, the Health & Safety Risk has been appropriately mitigated to reduce the risk, and this will now be taken forward at local level. The risk has now reached its target score of 9. Nursing Shortages (CRR5) remains a High Level risk, however mitigation is in place. A new risk has been included around insufficient staffing for the special care baby unit, this is scored at a High Level risk of 12.					
Initial Date of Assessment	1st July 2022						
Last Reviewed	17th November 2022						

Strategic Ambition	Corporate Risk ID	Principle Risk	Key Targets	Current Position (October 2022)	Plans to Improve Control and Risks to Delivery	Risk Rating Target (CvL)	Risk Rating Current (CvL)
Best Quality, Safest Care	CRR5: Nursing Shortages	Risk to service delivery and patient care due to failure to fill registered nurse vacancies due to the national labour market shortage.	Vacancy Rate Turnover Sickness Covid absences Maternity Leave – including currently commencement at 28 weeks gestation	Successful bid (87k) to NHSE/I to recruit additional CSWs to bring to zero vacancy (inpatient units). Additional focused HCSW recruitment day 26/5/22 and ongoing HCSW recruitment and resulted in 40 offers of posts to HCSWs – on boarding now taking place with total of 36 new recruits remaining in the process. Redefining of CSW Development Programme to support new recruits, programme has commenced and evaluating well. Clarity of career progression from CSW to RN and points between Agreed 'Home Trust' status with York St John University, have 100% clinical placement capacity at HDFT to support 'growing our own' Additional placement capacity agreed to accommodate additional student numbers. Which would increase the student intake from 186 currently, to 222 in September '22 and a predicted 237 by 2023 International Recruitment and associated funding to increase capacity, continue to review opportunities to increase IR intakes. Expecting 26 new arrivals between June '22 and January '23. There has been a development of 'bootcamp' style courses in preparation for OSCES Refreshed recruitment and retention operational group recommenced in June with two focused task and finish groups established – one for recruitment and one for retention.	Focus on recruitment and retention and effective roster practice ***ACTION: Review to be undertaken on development of a wider corporate risk regarding clinical workforce.*** ***Action: Emma Nunez to discuss with jenny Nolan regarding changing the target risk and date***	**(4x2) - 8**	**(4X4) - 16**

				Working with Directorates re bed bases / establishments and staffing models including principles for changing WFM's to provide additional support to the ward/ departments Focused work on HealthRoster KPIs and performance of effective rostering practice Focused work on additional roles to support nursing, business case being produced Preceptorship programmes to retain newly qualified and new starters refreshed Bid for 2 x 0.5 wte Legacy Mentor to support retention from NYE			
An Environment that promotes wellbeing	CRR70: Health and Safety	Organisational Risk to compliance with legislative Health and Safety requirements impacting on employees, patients and contractors to HDFT sites due to an absence of infrastructure and associated governance, systems and processes	Datix reported Health and Safety Incidents HSE/RIDDOR reporting	Notification to organisation to cease using the Goods Yard access with immediate effect – reduction in some footfall but not all. Further work required as continued use of this as a cut through has been noted Work ongoing with plans to section off the yard so access is not possible. Recruitment: One x Band 8b – Head of Health and Safety in post, 2 x Band 7 Health and Safety Managers (one Acute and one Community) both in post in September 2022. Revisions to ToR for Health and Safety Committee Procurement of Datix to support wider risk register roll out, including H&S Health and Safety walk around due to take place in September 2022 to provide further benchmarking of the acute site. Currently no uniformed approach to managing contractors accessing Trust premises. Trust and HIF have taken on the role of Principal Designer (CDM 2015), and do not have the appropriate competencies to comply with the legal duties this entails. This is particularly relevant to the 3 major CDM projects on site (SALIX, Plant rooms and ED refurbishment). Currently breaching H&S law both as client and Principal Designer. In addition the inadequate early planning of the CDM projects has resulted in increased workplace transport / pedestrian risk, due to the loss of previous walkways. Patient Falls is currently the most significant incident report (DATIX). Resource for addressing this issue from both clinical and non-clinical is insufficient. High level of patient falls in turn this increases the exposure of staff to risks associated with patient handling. Lack of resources, both persons able to train staff and lack of basic training facilities, means there is a significant backlog both in basic induction training, refresher (3 year mandatory) and task specific. This includes training in the safe use of the varied lifting aids used across the Trust, putting both staff and patients at risk.	Exploration of Tendable as a mechanism for audit programme Review of contract with SALUS and proposal for alternative provision being drawn up Contractor meetings with HIF to ensure that H&S requirements of external contractors are adhered to TNA/GAP Analysis to be commenced to understand training needs and gaps for managers re: H&S responsibilities Action plan drawn up following external review of H&S compliance, this will be exception reported to revised Health and Safety Committee to capture and monitor ongoing risks Review and updating of the Ligature Risk procedure Review of Fire Door compliance across the site Full site survey for all access control/lockdown to report back on position for improvement H&S team carrying out urgent review of fire assessments for all areas of the Acute setting. H&S team carrying out urgent review of current manual handling provision / risk assessment / training Occupational Health have obtained approval for 6 month secondment to assist with MH training provision ***To note: All risks are now discussed at the health and safety committee. Risks will be highlighted to exec risk from this committee. Risk score has reduced to 9.***	**(3x3) - 9**	**(3x3) – 9**
Best Quality, Safest Care	CRR73 – Insufficient staffing for	Insufficient capacity to meet the key national safety standard of a		<table><tr><th>Establishment</th><td>Oct</td><td>Nov Plan</td><td>Dec Plan</td><td>Jan Plan</td><td>Feb Plan</td><td>Mar Plan</td></tr></table>	Increase in % of substantive establishment with QIS or on development pathway to obtain QIS	**(2x4) – 8**	**(3x4) - 12**

	special care baby unit	Qualified in Specialty (QIS) staff member on every shift and 70% of the establishment (8.3wte) qualified on Special Care Baby Unit (SCBU).		<table><tr><th></th><th>Budget</th><th>Amended plan</th><th>QIS available</th><th>QIS</th><th>QIS</th><th>QIS</th><th>QIS</th><th>QIS</th><th>Minimum QIS Target</th></tr><tr><td>B5</td><td>8.81</td><td>6.20</td><td>2.45</td><td>2.45</td><td>2.45</td><td>3.22</td><td>4.14</td><td>4.14</td><td>2.75</td></tr><tr><td>B6</td><td>3.01</td><td>5.62</td><td>2.91</td><td>2.91</td><td>2.91</td><td>2.91</td><td>4.29</td><td>5.29</td><td>5.52</td></tr><tr><td>Total</td><td>11.82</td><td>11.82</td><td>5.36</td><td>5.36</td><td>5.36</td><td>6.13</td><td>8.43</td><td>9.43</td><td>8.27</td></tr></table> There is planned ward QIS cover on each shift but very limited ability to react to short-notice sickness/absence, even with the shift incentive. Colleagues with QIS across wider HDFT team are being proactively contacted to identify if they would be willing to support and their training/familiarisation needs to enable increase in bank availability, including offer to cover travel expenses and travel time where contracted bases are not in Harrogate e.g. for Safeguarding nurse with QIS from Middlesbrough. 3 B5 posts (2.3wte) have been recruited to – 1 of which has QIS (0.77wte), the other two are newly qualified so will commence their training when in post – they will need to complete foundation level first so development will take approx. 2years. In addition, supporting existing substantive B5 through their QIS (foundation level completed). Recent retiree with QIS has returned on zero hours contract for 12months to support – is currently working 0.61wte. Remaining 2.6wte B5 vacancy has been converted to B6 and advertised with 1.38wte now successfully recruited to from the first round of interviews. The posts are back out to advert. SOP for QIS gap ratified at OMG 14/10/22 following input by Maternity services and clinical input from Paediatrics & CC Directorate clinical leadership and available to on call managers/directors Fostered solid relationships with current staff therefore staff have willingly regularly worked NHSP shifts as well as being flexible with their substantive shifts to maintain the QIS cover.	Increase of available bank/agency QIS nurses to support SCBU B6 recruitment		

CQC EFFECTIVE DOMAIN

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

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

Lead Committee	Quality Committee	**Risk Type**	Clinical	Workforce	Operational	**Risk Appetite**	Cautious
Executive Committee	Quality Management Group (QGMG)	**Summary in Month:** This area of the Corporate Risk Register is linked to the Effective Domain. Currently there are no Corporate Risks that link to this domain.					
Initial Date of Assessment	1st July 2022						
Last Reviewed	17th November 2022						

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

CQC CARING DOMAIN

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

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

Lead Committee	Quality Committee (Clinical Risk) People and Culture (Workforce Risk)	**Risk Type**	**Clinical**	**Workforce**		**Risk Appetite**	Minimal
Executive Committee	Quality Management Group (QGMG) (Clinical) Workforce Committee (Workforce)	**Summary in Month:** This area of the Corporate Risk Register is linked to the Caring Domain. Currently there is 1 Corporate Risks within this Domain. The impact of COVID and Operational Pressures on workforce wellbeing (previously wellbeing of staff) (CRR6) remains a High Level risk at 16. Mitigation is in place to reduce this risk and a range of wellbeing packages are in place with further being developed.					
Initial Date of Assessment	1st July 2022						
Last Reviewed	17th November 2022						

Strategic Ambition	Corporate Risk ID	Principle Risk	Key Targets	Current Position (October 2022)	Plans to Improve Control and Risks to Delivery	Risk Rating Target (CvL)	Risk Rating Current (CvL)
At Our Best – Making HDFT the Best Place to Work	CRR6: The impact of Covid and Operational Pressures on Workforce Wellbeing	Risk to patient care and safety due to current staffing levels and poor morale due to increased workload, post pandemic burn-out and poor working environment. Risk of: - both short and long term mental health impacts on staff	Inpulse engagement scores National Staff survey scores: Engagement, morale, Sickness absence levels Turnover Vacancy rate	• **Staff Engagement** Our staff engagement scores are reasonably healthy: - Engagement within the Trust has increased 23% from 53% in January 2022 to 65% - 54% increase in the number of employees feeling completely positive about their work. - More people feel they can be themselves at work (an increase from 66% to 77%) - More people are advocates of the organisation (an increase from 47% to 57%). • **Turnover** Turnover is high for HDFT, at 15.76% against a target of 12% - but relative to private sector organisations low – work on retention to stem the flow of colleagues leaving the organisation is a priority • **Sickness Absence** At 4.84% Sickness absence is has increased slightly from the previous month's figure of 4.59% This is due to an increase in short term non-Covid related sickness. Long term sickness has however decreased this month and accounts to 46% of the	A number of Financial supports are in place to assist colleagues with escalating cost of living. These include some of the following welfare fund, additional 10p per mile (fuel costs), free car parking. A wide range of Financial Wellbeing resources available on Living at Our Best pages of the Internet. Flu and Covid Vaccines available for all colleagues since September 2022 until January 2023. Current vaccination levels 47.58% for Covid and 46.46 for Flu. Recruitment and Retention groups underway. Wellbeing fund of 0.5 million provided to upgrade working environment.	**(3x4) - 12**	**(4x4) - 16**

				overall sickness absence, which is down from 57% from the previous month. • **Vacancy Rate** Vacancy rate of 5.8% has dropped from previous month's figure of 5.97% and Agency usage has reduced slightly this month.	New clinical leadership model in place from December 2022. Inpulse survey feedback to be handled locally by line managers to support increased engagement and morale ***Action: Angela Wilkinson to update engagement stats within the trust, as the figure of increase is not accurate.***		

CQC RESPONSIVE DOMAIN

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

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

Lead Committee	Resource Committee	**Risk Type**	**Clinical**	**Operational**		**Risk Appetite** Cautious
Executive Committee	Operational Management Group (OMG)	**Summary in Month:** This area of the Corporate Risk Register is linked to the Responsive Domain. Currently there are 3 Corporate Risks within this Domain. Autism Assessment (CRR34) remains a High Level risk at 12 and working is ongoing to determine future needs of the service. Numbers on the waiting list has increased from 676, last month to 713. Longest wait has also increased from 53 to 58. RTT (CRR41) remains a High Level risk at 12 due to performance against the national standards. However, a wide range of mitigation in place and zero 104 week waits are noted. Finally ED 4 hour standards also remains a High Level risk at 15 due to the continued failure to meet the target. A wide range of mitigation is in place including a pilot of new streaming pathways.				
Initial Date of Assessment	1st July 2022					
Last Reviewed	17th November 2022					

Strategic Ambition	Corporate Risk ID	Principle Risk	Key Targets	Current Position (October 2022)	Plans to Improve Control and Risks to Delivery	Risk Rating Target (CvL)	Risk Rating Current (CvL)
Great Start in Life	CRR34: Autism Assessment	Risk to quality of care by not meeting NICE guidance in relation to the commencement of autism assessment within 3 months of referral. Risk that children may not get access to the right level of support without a formal diagnosis and that this could lead to deterioration in condition.	Need to reduce the backlog of referrals back to the NICE standard of 3 months (reduce the waiting list to approximately 120)	Due to continuing higher referral numbers & assessment model (which is in line with NICE recommendations) we are predicting we would end the year with a waiting list of 933 children with a 23 month wait to commence assessment. The Service is working with commissioners on a transformation model approach using evaluation data from two pilots that have been running in Selby & Scarborough. These utilise SENCO referrals with local authority engagement and an early help/SEND hub offer. Unfortunately the evaluation information was only been made available 3.10.22 and has raised significant concern from the local authority around SENCO capacity. It was agreed with commissioners that HDFT would have an autism pathway review day (3/11/22) to agree a proposal which improves pathway and access but also includes waiting list stabilisation/reduction options. A further meeting with commissioners to discuss this proposal is scheduled 14/11/22. • Numbers on the waiting list: 713 • Longest wait: 58 weeks (excluding exceptions) • Financial year to date delivery 346 completed assessments against a plan of 340	Autism pathway review pay to agree proposal.	**(3X2) - 6**	**(3X4) - 12**
Person Centred, Integrated	CRR41: RTT	Risk to patient safety, performance, financial performance, and	92% 18 week incomplete performance standard		**Additional theatre lists at a weekend** Clinicians continue to undertake additional work on a weekend, with lists now being	**(3x2) -6**	**(3x4) - 12**

Care, Strong Partnerships		reputation due to increasing waiting times across a number of specialties, including as a result of the impact of Covid 19 (added 13/03/2020)	52+ Waits 78+ Waits (zero by March 23) 104+ Waits (zero by July 22)	<table><tr><th></th><th>Apr-22</th><th>May-22</th><th>Jun-22</th><th>Jul-22</th><th>Aug-22</th><th>Sept-22</th><th>Oct-22 (provisional</th></tr><tr><td>Total incomplete RTT pathways</td><td>24,714</td><td>25,384</td><td>25,134</td><td>25,629</td><td>25,564</td><td>25,490</td><td>26,860</td></tr><tr><td>> 52 weeks</td><td>1,187</td><td>1,196</td><td>1,261</td><td>1,297</td><td>1,297</td><td>1,350</td><td>1,334</td></tr><tr><td>> 78 weeks</td><td>205</td><td>184</td><td>169</td><td>155</td><td>144</td><td>133</td><td>123</td></tr><tr><td>> 104 weeks</td><td>11</td><td>3</td><td>1</td><td>0</td><td>0</td><td>0</td><td>0</td></tr><tr><td>RTT new clock starts</td><td>6,403</td><td>7,219</td><td>6,382</td><td>6,817</td><td>6,917</td><td>6,669</td><td>6,138</td></tr><tr><td>RTT clock stops</td><td>4,290</td><td>5,136</td><td>5,119</td><td>5,244</td><td>5,515</td><td>5,291</td><td>3,988</td></tr></table> Elective recovery work continues to be a major focus, and the Trust continues to, where possible, increase elective admissions to reduce the gap to pre-COVID levels. The trust have implemented and resourced dedicated project support in theatres that commenced in October 2021 to aid elective recovery. To mitigate the WLI changes and annual leave rollover dynamic, clinical sessions are in place to ensure most clinically pressured activity is covered. Ring fencing of orthopaedic elective capacity is underway alongside a pilot of an LLP model to re-engage weekend and evening lists (commenced 11th June 2022 with lists alternate weekends since) 34 patients have had their care delivered through this mechanism. The 5th room to support capsule endoscopy remains operational and Endoscopy lists are available seven days per week Clinical prioritisation and review continue for elective patients with 99% of patients waiting having been allocated a P1-6 national classification. The majority of those yet to be classified have been waiting <=2 weeks and work is progressing to ensure these are rapidly coded. **104+ week waiters** Ongoing mutual aid across WYATT and more latterly HNY is used to support system clearance of long waiting patients. HDFT have supported both systems. 104 week waiting patients were cleared in advance of the July 2022 deadline. The community dental over 104 weeks is also now zero. All patients over 88 weeks have a date for surgery. Some of these treatment dates deliver surgery at 99-102 weeks. **78 week waiters (clearance target March 2023**) Internally the Trust continue to review all patients on the Admitted pathway over 60 weeks and have initiated a weekly PTL meeting. With the service manager, admissions manager and 18-week lead each patient is reviewed to ensure that there are clear plans in place. Trajectories by speciality are produced on a weekly basis for achievement of over 78 week waiters.	booked for Community Dentistry Paediatric sessions, General Surgery , Ophthalmology and Urology. Staffing in theatres continues to be challenging with vacancies gaps and covid related sickness but there is now a greater up take for covering additional theatre lists in the evening and at weekends and there are currently 22 new starters in the workforce pipeline. Additional capacity will become available for treating patients through the Wharefdale theatres (TIF1 Scheme)- however the timelines for this opening have slipped into 23-24 Limited access to an interim solution through a vanguard theatre at Wharfedale is being progressed to impact quarter 3 2022/3. The independent sector support is being increased with circa 500 cases being delivered in this way. None treatment RTT waiting over 52 weeks is minimal currently with only Gastroenterology, Neurology and specialist gender endocrinology-having patients waiting this long. Recovery plans in gastroenterology and neurology are currently in development. **Validation and real-time updating of RTT waiting lists** The following actions are underway/ completed to improve accuracy of waiting list, which will further reduce the numbers allowing closer scrutiny of genuine waiting patients. • Standardised Reporting Dashboard : piloted & in place • Elective recovery meeting: weekly in place, using new data/ format. Directorates implementing equivalent at service level. • 6:4:2 – booking levels and utilisation improving (confounded by covid absence to some degree)		

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- RTT out coming: business case and funding are approved and moving forward procurement.
- RTT team – move to embedding in directorates. Final model agreed, consultation with affected staff to commence in next 4 weeks.

To Note: Risk to remain as now, but may need further review when information regarding strike action emerges.
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<td>Best Quality, Safest Care</td>
<td>CRR61: ED 4-hour Standard</td>
<td>Risk of increased morbidity/ mortality for patients due to failure to meet the 4 hour standard.</td>
<td>A&E 4 hour standard (below 95% in August 2022)

12 hour DTA breaches (82 in August 2022)

Ambulance Handovers (15 over 30 minute handover breaches and 2 over 60 minute in August 2022)</td>
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Performance against the A&E 4-hour standard is improving but remains below the 95% standard. The position has deteriorated over the past 2 months and is now the second lowest position after March 2022.

5% improvement in 4 hour standard as compared with September

Supporting system pressures with diverts from York.

Swaledale/ Harlow ward closure to facilitate Estates work has reduced acute bed base by 25. Flipping of Wensleydale onto Swaledale has reduced the bed base by a further 6 but Winter Plan to reopen both wards still in places for mid Dec

Reduced flow secondary to 45+ patients not meeting right to reside waiting for NH/RH/POC. System partners (York and Scarborough) at Opel 4 most days

Reduction in covid patient numbers by 1/3 (11 on 11/11 compared with 33 as at 17/10) improving flow

Ambulance handover delays (HO) have significantly increased. To note there have been data quality issues relating to the accurate recording of clock start times in some instances in previous months. This is now rectified but the correction will has (accurately) inflated the Sept/ Oct position compared to previous months.

Build work commenced in on Tuesday 20th Sept with the interim loss of fit to sit capacity, which was introduced in recent months to support flow. Building delays mean that the Fit to Sit area will be ready for use from Mon 12th Dec with the net increase of 6 spaces in the ED.

<table>
<tr><th></th><th>12 Hour DTA</th><th>12 Hour total wait</th><th>30 Min HO</th><th>60 Min HO</th></tr>
<tr><td>June 22</td><td>15</td><td></td><td>30</td><td>1</td></tr>
<tr><td>July 22</td><td>37</td><td>219</td><td>14</td><td>2</td></tr>
<tr><td>August 22</td><td>82</td><td>346</td><td>16</td><td>2</td></tr>
<tr><td>September 22</td><td>60</td><td>286</td><td>77</td><td>25</td></tr>
<tr><td>October 22</td><td>45</td><td>247</td><td>42</td><td>41</td></tr>
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Streaming launch 4 January 2023.

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

2nd wk Dec (delayed 3 weeks), phase 1 of the works will be complete with the opening of the new fit to sit space with the net increase of 6 spaces in the ED.

1 Nov pilot of SDEC opened for additional 2 hours every weekday evening to support flow out of the ED. To run until end March 23 or earlier if pilot determines unsuccessful. Analysis of first 2 weeks underway.

W/C 19th Dec (at the latest) AFU will relocate to Swaledale with the net increase of 8 patient spaces including frailty SDEC further enhancing flow out of the ED

Community 2 hour response to reduce admissions/attendances over next 6 months.
The plans for improvement in performance are likely to take 3-6 months to address the different elements contributing to poor performance.

ACTION: Review wider mitigation and key risks for Acute Care Pathways.

Action: Risk rating to remain the same, but the target date is to change to June 2023. Russell Nightingale to speak to Directorate regarding this.
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<td>(3x2) - 6</td>
<td>(3x5) – 15</td>
</tr>
</table>

CQC WELL-LED DOMAIN

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

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

Lead Committee	Trust Board	**Risk Type**	**Clinical**	**Workforce**	**Operational**	**Risk Type**	Cautious
Executive Committee	Senior Management Committee (SMT)	**Summary in Month:** This area of the Corporate Risk Register is linked to the Well-Led Domain. Currently there are no Corporate Risks that link to this domain.					
Initial Date of Assessment	1st July 2022						
Last Reviewed	17th November 2022						

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

USE OF RESOURCES

Use of resources area Key lines of enquiry (KLOEs)

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

Lead Committee	Resource Committee	**Risk Type**	Financial	Workforce	Operational	**Risk Appetite**	Minimal
Executive Committee	Operational Management Committee (OMG)	**Summary in Month:** This area of the Corporate Risk Register is linked to the Use of Resources Domain. Currently there are 2 Corporate Risks that are link to this domain. Agency Usage (CRR71) remains a High Level risk at 15, however it is noted that this risk is being used to off set CRR5 Nursing Shortages and CRR6 Staff Wellbeing. In addition the Operational Financial Position (CRR72) also remains a High Level risk at 12.					
Initial Date of Assessment	1st July 2022						
Last Reviewed	17th November 2022						

Strategic Ambition	Corporate Risk ID	Principle Risk	Key Targets	Current Position (August 2022)	Plans to Improve Control and Risks to Delivery	Risk Rating Target (CvL)	Risk Rating Current (CvL)
Overarching	CRR 71: Agency Usage	The Trust is currently in breach of regulatory obligation regarding agency price caps, is incurring premium costs for staffing where vacancies exist, and in some circumstances this results in an adverse impact to quality and safety. Breach of IR35 regulations and potential fine from HRMC.	Monthly financial performance Performance against indicative agency ceiling Weekly reporting regarding cap compliance	The Trust is current spending in excess of the agency ceiling. The Trust breaches the agency cap for a number of roles. No agency medical staff are engaged below agency cap rates. It should be noted that this risk is mitigating some of the other risks currently raised on the Trust risk register. In particular nurse staffing, work around ED/flow and elective recovery. This clearly is not ideal but is accepted whilst those other risks persist.	Substantive recruitment and retention schemes Clear escalation on cascades where appropriate and available ***ACTION: Review wording regarding the principle risk*** ***Action: Jordon Mckie to review risk target.***	**(3X3) - 9**	**(3X5) - 15**
Overarching	CRR 72: Operational Financial Position	Risk to financial sustainability and regulatory impacts as a result of not achieving breakeven. Risk of providing value for money to taxpayer.	Monthly financial performance Savings programme performance Various procurement indicators Monthly budgetary reporting at directorate level Various benchmarking information – eg Model Hospital	The Trust is currently at risk of managing within resources available. There were two factors contributing to this – 1. Performance in relation to Savings Programme As reported in June, £5.2m has been actioned in month 3 against the £8.3m target required to achieve this year's plan. Risk adjusted forecasts still outline a £1m risk to the programme and the Trust position. 2. Inflation As can be seen in the wider economy there are a number of material impacts in relation to inflation. The two most notable for the Trust relate to Cost of Capital and Energy prices, which impact the Trust by £1.7m and £1.6m respectively. Previously we were awaiting guidance on these elements, which has now been received. The Trust has received funding to support this non recurrently.	Delivery of directorate savings programme Management of monthly budget position across all areas, from cost centre to trustwide Clear link between business planning, prioritisation and strategy Strong local vacancy control processes Maximising procurement savings through consolidation and collaboration Negotiation with wider system	**(4x1)- 4**	**(4x3) - 12**

				Following the support received for funding inflation from NHS England, the HNY ICS had a residual financial issue. To support the ICS the Trust is in a position where we are being asked to support the ICS by £3.5m, £2.2m of which is already in the previous planning assumptions. There are currently no plans on achieving the £1.3m but it has been agreed in principle with some wider incentives being discussed.	Potential non recurrent support would be adjusting annual leave process to pre pandemic policy. ***ACTION: Jordan Mckie to review wording around this risk to include why the risk moves to the next financial year, and further specify exactly what the risk includes.***		

Directorate risks for discussion (scoring 12+)

CC

Speech and language risk discussed, currently scoring a 12 – appropriate mitigation in place, so not required to go onto the corporate risk reg. Russell to feedback to directorate.

Maternity safeguarding (new risk) – Emma Nunez to be exec sponser. This risk will be included onto the corporate risk register for discussion in the December meeting. This risk will be added under the Well-Led Domain.

PSC

Agency risk – there was a query regarding the need for this risk, given this is on the corporate risk register.

Maternity patient record – this risk is to be removed from risks to escalate as this is currently scoring a 9. To be managed at a local level.

Bowel cancer risk to be reviewed by James Wright (Operational Director - PSC)

FY1 cover in SDEC – to be reviewed by James Wright (Operational Director – PSC)

Harrogate and District NHS Foundation Trust

Board Committee Report to the Board of Directors

Committee Name:	Quality Committee
Committee Chair:	Laura Robson, Non-executive Director.
Date of meeting:	24th October 2022
Date of Board meeting this report is to be presented	30th November 2022

- The quality committee met via Teams. Sue Eddleston observed the meeting on behalf of the Governors
- We had a number of deputies presenting papers, due to school holidays.
- The meeting began with a presentation on the new Patient Safety Incident Response Framework (PSIRF), The framework provides the opportunity for Trusts to respond to incidents in a way which enables organisational learning, focusses on improvement and avoids blame. A detailed explanation and discussion took place. It demonstrated that this process is a move away from the current incident investigation and requires a cultural change. The Quality Committee will ensure that it is kept informed of progress, learning takes place from untoward events and is embedded in the organisation.
- The Quality report was presented. It has developed further since the last meeting. A number of items were discussed these include NICE guidance compliance and update of policies and procedures, falls and pressure ulcers, infection prevention control monitoring and changes since the COVID pandemic began, mortality reporting and the actions taken to investigate our elevated HSMR and SHIMI and complaints response times that have deteriorated in recent month.
- Directorate update from 2Cs was discussed although there was no Directorate representative the DON, Midwifery and AHPs answered the questions raised. Of concern is the vaccination uptake for Meningitis and Diphtheria in Middlesbrough that is 28%. A multiagency response to this is being formulated. Further Guidance from the Arthur and Star investigation review is awaited.
- Long Term Unscheduled Care update highlighted delay in transferring stroke patients to the Stroke unit for urgent treatment. This is a networked service it requires beds to be available in Leeds or York for our urgent patients. Ambulance availability for the transfer also presents challenges at present. A network meeting is planned to review the situation and ensure safe and immediate transfer. There is also a public health issue enabling people to recognise a stroke and

ensure that patients get to the right place as soon as possible.

- Cohorting of NIV patients was also discussed. During the pandemic the plan to create a unit for NIV patients was planned but it is now delayed until the formation of a medical HDU on the current Wendsleydale ward.
- Radiology has been the subject of a RPIW. Any relevant outcome will be presented to a future Quality Committee.
- An update on the ED cultural work and current performance was provided. The main risk remains the result of medically optimised patients remaining in the hospital, preventing optimal flow through ED. Colleague wellbeing remains a concern although we were pleased to learn of the success of the enhanced security measures. The building work going on within the department also creates a challenge to colleagues working in the department.
- Planned and surgical directorate update focussed on Theatres and the cultural improvement programme. We were assured of the action taken to address the second never event related to wrong side nerve block. Recruitment has significantly improved and a number of initiatives are in place to train more of our own staff. Again, current building work is providing a challenge to the teams. Good progress against the theatre action plan was reported.
- The committee received a Health and Safety update for the first time from the newly appointed Head of Health and Safety. A number of issues have been identified and action to bring about improvement is in place. These include comprehensive review of ligature points, improved availability of moving and handling training. Replacement of the SALUS system that is no longer fit for purpose. The Head of Health and Safety has specific expertise in construction. He will attend all construction planning meetings, ensuring appropriate safety precautions are in place.
- Maternity Services report on Strengthening Maternity and Neonatal services was received. The East Kent enquiry was discussed and the potential for more scrutiny and demands on the service arising from the report. Potentially another report from Nottingham may lead to further actions. There is potential for more pressure on Obstetric and midwifery colleagues resulting from these enquiries. The Trust continues to actively monitor the culture of services and colleague wellbeing.

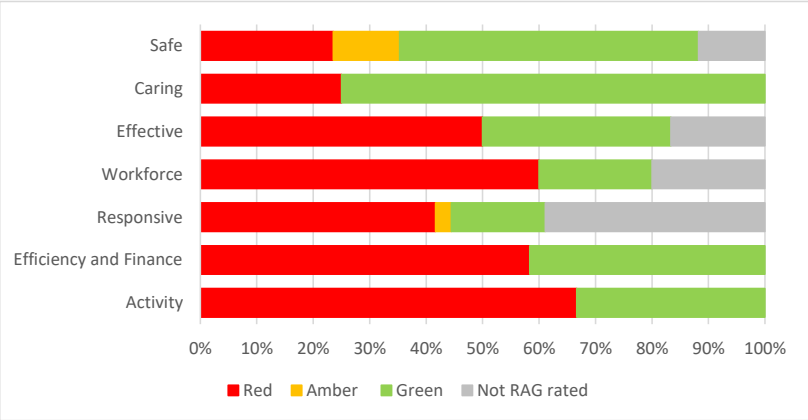
Any significant risks for noting by Board? (list if appropriate)
No additional risks for the Board to note
Any matters of escalation to Board for decision or noting (list if appropriate)
Ongoing pressure caused by medically optimised patients not being discharged

from the hospital and the safety concerns arising. Potential delay of transfer of stroke patients to the Stroke services in Leeds or York

Integrated Board Report - Summary of indicators - October 2022

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

		RAG ratings			
Domain	**Total indicators**	**Red**	**Amber**	**Green**	**Not RAG rated**
Safe	17	4	2	9	2
Caring	4	1	0	3	0
Effective	6	3	0	2	1
Workforce	5	3	0	1	1
Responsive	36	15	1	6	14
Efficiency and Finance	12	7	0	5	0
Activity	9	6	0	3	0
Total	**89**	**39**	**3**	**29**	**18**



Integrated Board Report - Summary of October 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	0.20
Safe	1.2	Pressure ulcers - community acquired - cat 3 or above - per 1,000 patient contacts	0.99
Safe	1.3	Inpatient falls per 1,000 bed days	7.0
Safe	1.4	Infection control - C.diff hospital acquired cases due to a lapse in care	0
Safe	1.5	Infection control - MRSA hospital acquired cases due to a lapse in care	0
Safe	1.6	Incidents - ratio of low harm incidents	39.54
Safe	1.7.1	Incidents - comprehensive serious incidents (SI)	1
Safe	1.7.2	Incidents - Never events	0
Safe	1.8.1	Safer staffing levels - fill rate	88.0%
Safe	1.8.2	Safer staffing levels - CHPPD	7.3
Safe	1.9	Maternity - % women seen by a midwife (or healthcare professional) by 12w 6d	93.1%
Safe	1.10	Maternity - % women with Continuity of Care pathway	
Safe	1.11	Infant health - % women smoking at time of delivery	7.4%
Safe	1.12	Infant health - % women initiating breastfeeding	82.5%
Safe	1.13	VTE risk assessment - inpatients	95.9%
Safe	1.14.1	Sepsis screening - inpatient wards	94.0%
Safe	1.14.2	Sepsis screening - Emergency department	90.6%

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	95.7%
Caring	2.2.1	Complaints - numbers received	9
Caring	2.2.2	Complaints - % responded to within time	80%
Effective	3.1	Mortality - HSMR	114.71
Effective	3.2	Mortality - SHMI	1.085
Effective	3.3.1	Readmissions to the same specialty within 30 days - following elective admission	2.0%
Effective	3.3.2	Readmissions to the same specialty within 30 days - following non-elective admission	7.4%
Effective	3.4	Returns to theatre	
Effective	3.5	Delayed Transfer of Care	29.4%
Workforce	4.1	Staff appraisal rate	63.3%
Workforce	4.2	Mandatory training rate	90.0%
Workforce	4.3	Staff sickness rate	4.88%
Workforce	4.4	Staff turnover rate	15.9%
Workforce	4.5	Vacancies	6.66%

Domain	Indicator number	Indicator name	Latest position
Responsive	5.1.1	RTT Incomplete pathways performance - median	12
Responsive	5.1.2	RTT Incomplete pathways performance - 92nd centile	44
Responsive	5.1.3	RTT Incomplete pathways - total	25437
Responsive	5.1.4	RTT Incomplete pathways - 52-<104 weeks	1285
Responsive	5.1.5	RTT Incomplete pathways - 104+ weeks	0
Responsive	5.2.1	RTT waiting times - by ethnicity	
Responsive	5.2.2	RTT waiting times - by level of deprivation	
Responsive	5.2.3	RTT waiting times - learning disabilities	
Responsive	5.3	Diagnostic waiting times - 6-week standard	62.0%
Responsive	5.4	Outpatient follow-up waiting list - number of follow up patients past due date	
Responsive	5.5	Data quality on ethnic group - inpatients	91.4%
Responsive	5.6	A&E 4 hour standard	68.0%
Responsive	5.7	Ambulance handovers - % within 15 mins	67.0%
Responsive	5.8	A&E - number of 12 hour trolley waits	72
Responsive	5.9.1	Cancer - 62 day wait for first treatment from urgent GP referral to treatment	79.6%
Responsive	5.9.2	Cancer - 62 day wait for first treatment from urgent GP referral to treatment - number of 104 days waiters	8
Responsive	5.10	Cancer - 14 days maximum wait from urgent GP referral for all urgent suspect cancer referrals	47.3%
Responsive	5.11	Cancer - 28 days faster diagnosis standard (suspected cancer referrals)	62.3%
Responsive	5.12	Cancer - 31 days maximum wait from diagnosis to treatment for all cancers	99.0%

Domain	Indicator number	Indicator name	Latest position
Responsive	5.13.1	Children's Services - 0-12 months caseload	1852
Responsive	5.13.2	Children's Services - 2-3 years caseload	1663
Responsive	5.14	Children's Services - Safeguarding caseload	875
Responsive	5.15	Children's Services - Ante-natal visits	89.9%
Responsive	5.16	Children's Services - 10-14 day new birth visit	95.9%
Responsive	5.17	Children's Services - 6-8 week visit	94.5%
Responsive	5.18	Children's Services - 12 month review	95.5%
Responsive	5.19	Children's Services - 2.5 year review	95.7%
Responsive	5.20	Children's Services - % children with all 5 mandated contacts	
Responsive	5.21	Children's Services - Delivery of Immunisation trajectory	
Responsive	5.22	Children's Services - OPEL level	1/2/3
Responsive	5.23	Community Care Adult Teams - performance against new timeliness standards	
Responsive	5.24	Community Care Adult Teams - Number of virtual beds delivered in Supported Discharge Service	
Responsive	5.25	Community Care Adult Teams - Number of cancelled routine visits	
Responsive	5.26	Community Care Adult Teams - OPEL level	3
Responsive	5.27	Out of hours - telephone clinical assessment for URGENT cases within 20 minutes of call prioritisation	32.5%
Responsive	5.28	Home visit: Face to face consultations started for URGENT cases within 2 hrs	81.5%

Domain	Indicator number	Indicator name	Latest position
Efficiency and Finance	6.1	Agency spend	£ 934
Efficiency and Finance	6.2	Surplus / deficit and variance to plan	-£ 732
Efficiency and Finance	6.3	Capital spend	£ 2,974
Efficiency and Finance	6.4	Cash balance	£ 37,476
Efficiency and Finance	6.5.1	Long stay patients - stranded (>7 days LOS)	155
Efficiency and Finance	6.5.2	Long stay patients - superstranded (>21 days LOS)	69
Efficiency and Finance	6.6	Occupied bed days per 1,000 population	62.2
Efficiency and Finance	6.7.1	Length of stay - elective	2.49
Efficiency and Finance	6.7.2	Length of stay - non-elective	5.33
Efficiency and Finance	6.8	Avoidable admissions	211
Efficiency and Finance	6.9	Theatre utilisation (elective sessions)	80.0%
Efficiency and Finance	6.10	Day case conversion rate	1.5%

Domain	Indicator number	Indicator name	Latest position
Activity	7.1	GP Referrals against 2019/20 baseline	101.5%
Activity	7.2.1	Outpatient activity (consultant led) against plan (new and follow up)	77.7%
Activity	7.2.2	Outpatient activity (consultant led) against 2019/20 baseline (new and follow up)	80.7%
Activity	7.3.1	Elective activity against plan	72.3%
Activity	7.3.2	Elective activity against 2019/20 baseline	75.9%
Activity	7.4.1	Non-elective activity against plan	97.2%
Activity	7.4.2	Non-elective activity against 2019/20 baseline	92.8%
Activity	7.5.1	Emergency Department attendances against plan	90.9%
Activity	7.5.2	Emergency Department attendances against plan, 2019/20 baseline	101.6%

Integrated Board Report - List of indicators

Domain	Indicator number	Indicator name	Clinical Directorate(s) metric is applicable to	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Exec Lead	Committee reported to:	Monthly RAG thresholds: Red	Amber	Green
Safe	1.1	Pressure ulcers - hospital acquired - cat 3 or above - per 1,000 bed days	PSC, LTUC	0.37	0.00	0.61	0.34	0.55	1.06	0.61	0.74	0.80	0.50	0.75	0.58	1.11	1.08	0.32	0.90	0.82	0.93	0.20	EN	Quality	>0		0
Safe	1.2	Pressure ulcers - community acquired - cat 3 or above - per 1,000 patient contacts	LTUC	1.38	1.36	0.61	1.01	1.25	0.66	0.56	0.89	1.51	0.88	1.24	0.74	1.11	0.56	1.24	1.38	1.20	1.08	0.99	EN	Quality	>0		0
Safe	1.3	Inpatient falls per 1,000 bed days	PSC, LTUC	5.1	6.1	4.9	5.9	7.4	8.6	6.0	7.6	8.0	8.0	6.7	9.1	6.9	6.1	6.5	6.1	8.7	7.1	7.0	EN	Quality	above HDFT average for 2021/22 (7.0)	0-20% below HDFT average for 2021/22	>20% below HDFT average for 2020/21 (5.6)
Safe	1.4	Infection control - Hospital acquired C.difficile cases, lapse in care identified	All	0	0	1	0	0	1	1	1	1	0	0	0	0	0	0	0	0	0	0	EN	Quality	>40 YTD (total cases)		<=40 YTD (total cases)
Safe	1.5	Infection control - Hospital acquired MRSA cases, lapse in care identified	All	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	EN	Quality	>0 YTD		0 YTD
Safe	1.6	Incidents - ratio of low harm incidents	All	16.49	21.29	19.98	27.63	19.58	25.29	50.76	66.71	43.38	37.50	56.65	39.91	48.71	51.63	74.38	43.52	44.91	42.77	39.54	EN	Quality	HDFT in bottom 25% of Acute Trusts	HDFT in middle 50% of Acute Trusts	HDFT in top 25% of Acute Trusts
Safe	1.7.1	Incidents - comprehensive serious incidents (SI)	All	3	1	4	1	3	0	0	1	2	6	1	1	5	5	3	3	1	4	1	EN	Quality	>0		0
Safe	1.7.2	Incidents - Never events	All	0	1	0	0	0	0	0	0	0	1	1	1	0	1	1	0	0	1	0	EN	Quality			
Safe	1.8.1	Safer staffing levels - fill rate	All	93.8%	93.1%	92.5%	92.6%	90.1%	85.9%	86.2%	89.6%	88.0%	81.2%	80.8%	81.5%	81.1%	87.0%	89.2%	85.8%	89.1%	88.4%	88.0%	EN	Quality	<80%	80% - 95%	>=95%
Safe	1.8.2	Safer staffing levels - CHPPD	All	8.6	8.4	8.6	8.0	7.9	7.8	7.2	7.5	7.4	7.1	6.8	6.8	6.9	7.4	7.6	7.1	7.2	6.3	7.3	EN	Quality	tbc		
Safe	1.9	Maternity - % women seen by a midwife (or healthcare professional) by 12w 6d	PSC	99.4%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	96.6%	99.3%	95.7%	99.2%	100.0%	98.6%	97.6%	96.6%	95.4%	96.2%	96.0%	93.1%	EN	Quality	<90%		>=90%
Safe	1.10	Maternity - % women with Continuity of Care pathway	PSC																				EN	Quality			
Safe	1.11	Infant health - % women smoking at time of delivery	PSC	6.6%	2.9%	7.4%	5.2%	3.0%	4.3%	3.0%	7.2%	4.6%	6.6%	5.6%	4.2%	5.8%	6.4%	3.7%	3.5%	2.3%	3.9%	7.4%	EN	Quality	>15%		<=15%
Safe	1.12	Infant health - % women initiating breastfeeding	PSC	83.6%	82.6%	84.8%	83.8%	79.2%	87.4%	81.1%	88.2%	85.9%	83.5%	81.7%	86.2%	82.9%	84.6%	81.8%	75.2%	81.8%	84.0%	82.5%	EN	Quality	<75%		>=75%
Safe	1.13	VTE risk assessment - inpatients	PSC, LTUC	96.7%	97.1%	96.9%	96.3%	96.6%	95.7%	97.1%	96.8%	96.3%	95.9%	95.7%	95.5%	96.1%	96.3%	95.6%	95.1%	96.2%	96.0%	95.9%	EN	Quality	<95%		>=95%
Safe	1.14.1	Sepsis screening - inpatient wards	All	91.8%	96.1%	93.2%	93.5%	92.5%	90.8%	91.5%	89.8%	92.3%	89.3%	90.6%	87.7%	88.6%	93.0%	93.8%	89.8%	88.2%	95.4%	94.0%	EN	Quality	<90%		>=90%
Safe	1.14.2	Sepsis screening - Emergency department	LTUC	85.9%	89.2%	88.9%	86.6%	88.0%	88.8%	89.3%	92.5%	92.9%	91.9%	94.6%	94.8%	94.0%	92.2%	92.6%	95.6%	92.3%	93.4%	90.6%	EN	Quality	<90%		>=90%
Caring	2.1.1	Friends & Family Test (FFT) - All Patients	All	94.2%	92.7%	93.7%	93.7%	92.8%	93.3%	93.4%	92.7%	93.9%	94.7%	92.0%	91.8%	94.1%	92.7%	92.2%	92.3%	79.5%	80.9%	92.2%	EN	Quality	<90%		>=90%
Caring	2.1.2	Friends & Family Test (FFT) - Adult Community Services	CC	94.7%	95.5%	96.5%	96.1%	95.3%	96.0%	90.5%	90.5%	95.4%	96.6%	98.7%	97.3%	94.4%	91.9%	90.6%	93.9%	95.9%	90.9%	95.7%	EN	Quality	<90%		>=90%
Caring	2.2.1	Complaints - numbers received	All	14	24	18	20	31	19	13	9	18	11	14	22	17	10	9	12	10	13	9	EN	Quality	above HDFT average for 2021/22 (18)		On or below HDFT average for 2021/22 (18)
Caring	2.2.2	Complaints - % responded to within time	All		50%	35%	56%	56%	48%	50%	53%	53%	53%	55%	58%	72%	79%	70%	50%	45%	58%	80%	EN	Quality	<95%		>=95%
Effective	3.1	Mortality - HSMR	All	94.45	95.61	91.58	95.56	98.45	99.68	102.34	105.86	108.72	113.26	113.15	114.09	118.15	117.26	117.4	113.81	114.71			JA	Quality	Higher than expected		Within expected range or below expected
Effective	3.2	Mortality - SHMI	All	0.964	0.978	0.988	1.008	1.021	1.047	1.066	1.062	1.073	1.077	1.074	1.093	1.097	1.103	1.085	1.085				JA	Quality	Higher than expected		Within expected range or below expected
Effective	3.3.1	Readmissions to the same specialty within 30 days - following elective admission - as % of all elective admissions	All	1.8%	1.6%	1.6%	1.8%	2.1%	1.6%	2.0%	1.5%	1.5%	1.5%	1.9%	1.5%	1.8%	2.1%	2.0%	1.5%	1.6%	2.0%		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%	8.4%	6.6%	7.7%	7.1%	6.7%	7.4%		RN	Resources	> 10%	8% - 10%	<= 8%
Effective	3.4	Returns to theatre	PSC																				RN	Resources	tbc		
Effective	3.5	Delayed Transfer of Care - % inpatients not meeting the criteria to reside	LTUC	22.0%	14.5%	20.6%	24.0%	10.6%	21.9%	24.7%	7.4%	20.4%	20.8%	25.0%	12.0%	30.9%	24.5%	28.1%	38.3%	36.9%	37.5%	29.4%	RN	Resources	> 17.5%	15% - 17.5%	<= 15%
Workforce	4.1	Staff appraisal rate	All	56.3%	58.3%	58.9%	55.9%	55.2%	54.0%	52.8%	58.2%	59.8%	56.3%	63.0%	63.9%	56.9%	63.7%	60.8%	61.6%	61.7%	61.6%	63.3%	AW	People and Culture	<70%	70% - 90%	>=90%
Workforce	4.2	Mandatory training rate	All	91.7%	92.1%	92.0%	92.0%	87.0%	86.0%	86.0%	85.0%	85.0%	85.0%	85.0%	86.0%	85.0%	87.0%	90.0%	90.0%	89.0%	89.0%	90.0%	AW	People and Culture	<50%	50% - 75%	>=75%
Workforce	4.3	Staff sickness rate	All	3.74%	3.94%	4.04%	4.77%	5.02%	5.26%	6.04%	5.53%	5.42%	6.67%	5.74%	5.54%	5.90%	4.44%	4.96%	5.32%	4.59%	4.84%	4.88%	AW	People and Culture	>3.9%		<=3.9%
Workforce	4.4	Staff turnover rate	All	12.9%	13.0%	13.3%	13.5%	14.2%	14.5%	14.6%	13.8%	13.7%	14.3%	14.8%	15.7%	15.7%	16.0%	16.3%	16.4%	15.9%	15.8%	15.9%	AW	People and Culture	>15%		<=15%
Workforce	4.5	Vacancies	CC	4.98%	6.06%	6.40%	6.53%	6.25%	6.23%	5.61%	6.98%	8.89%	8.16%	8.05%	7.22%	5.84%	6.04%	6.25%	6.55%	5.97%	5.80%	6.66%	AW	People and Culture	tbc		
Responsive	5.1.1	RTT Incomplete pathways performance - median	All	8	8	8	9	9	10	10	9	10	10	10	9	10	10	11	11	11	12	12	RN	Resources	>10	08 - 10	<=8
Responsive	5.1.2	RTT Incomplete pathways performance - 92nd centile	All	44	43	41	40	40	41	41	41	42	43	43	43	44	43	44	44	44	45	44	RN	Resources	>24	18 - 24	<=18
Responsive	5.1.3	RTT Incomplete pathways - total	All	18156	19476	20631	21785	22168	22648	22423	22714	23464	23323	23900	23931	24714	25384	25134	25629	25564	25490	25437	RN	Resources	>15,000	14,000 - 15,000	<=14,000
Responsive	5.1.4	RTT Incomplete pathways - 52-<104 weeks	All	1196	1082	993	968	932	1008	1037	1063	1130	1086	1107	1118	1176	1193	1260	1297	1297	1350	1285	RN	Resources	>0		0
Responsive	5.1.5	RTT Incomplete pathways - 104+ weeks	All	3	5	13	20	23	24	33	34	47	52	50	22	11	3	1	0	0	0	0	RN	Resources	>0		0
Responsive	5.2.1	RTT waiting times - by ethnicity	All																				RN	Resources			
Responsive	5.2.2	RTT waiting times - by level of deprivation	All																				RN	Resources			
Responsive	5.2.3	RTT waiting times - learning disabilities	All																				RN	Resources			
Responsive	5.3	Diagnostic waiting times - 6-week standard	All	79.7%	85.4%	79.2%	75.1%	74.0%	80.5%	79.7%	86.1%	82.4%	78.7%	81.9%	76.5%	66.0%	69.2%	59.8%	58.9%	55.3%	50.4%	62.0%	RN	Resources	<99%		>=99%
Responsive	5.4	Outpatient follow-up waiting list - number of follow up patients past due date	All																				RN	Resources			
Responsive	5.5	Data quality on ethnic group - inpatients	All	93.0%	95.3%	94.6%	94.3%	94.8%	93.6%	94.3%	94.5%	92.8%	92.5%	92.9%	92.5%	93.7%	93.4%	92.5%	92.1%	92.3%	91.5%	91.4%	RN	Resources	<97%		>=97%
Responsive	5.6	A&E 4 hour standard	LTUC	86.3%	82.7%	82.6%	79.4%	80.6%	83.7%	75.9%	76.0%	68.9%	71.5%	65.6%	61.9%	66.2%	68.1%	71.5%	71.4%	66.7%	63.9%	68.0%	RN	Resources	<90%	90-95%	>=95%

Domain	Indicator number	Indicator name	Clinical Directorate(s) metric is applicable to	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Exec Lead	Committee reported to:	Monthly RAG thresholds: Red	Amber	Green
Responsive	5.7	Ambulance handovers - % within 15 mins	LTUC	92.8%	91.8%	86.5%	87.6%	89.1%	92.8%	86.1%	89.2%	88.4%	92.9%	89.8%	87.2%	90.3%	89.2%	83.2%	89.0%	88.6%	78.9%	67.0%	RN	Resources	<90%	90-95%	>=95%
Responsive	5.8	A&E - number of 12 hour trolley waits	LTUC	0	0	0	0	0	0	8	2	23	4	37	25	43	18	15	37	82	60	72	RN	Resources	>0		0
Responsive	5.9.1	Cancer - 62 day wait for first treatment from urgent GP referral to treatment	LTUC	85.5%	87.1%	93.5%	84.1%	91.7%	89.1%	81.8%	80.7%	84.8%	79.8%	83.2%	87.6%	78.3%	86.3%	80.9%	78.3%	82.2%	70.6%	79.6%	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	4	3	5	8	RN	Resources	>0		0
Responsive	5.10	Cancer - 14 days maximum wait from urgent GP referral for all urgent suspect cancer referrals	LTUC	81.7%	85.8%	88.2%	83.4%	86.0%	92.2%	83.8%	82.5%	87.3%	84.6%	92.5%	87.9%	85.9%	89.6%	73.6%	70.4%	47.3%	47.7%	47.3%	RN	Resources	<93%		>=93%
Responsive	5.11	Cancer - 28 days faster diagnosis standard (suspected cancer referrals)	LTUC	69.6%	71.7%	68.7%	70.3%	73.9%	73.4%	78.7%	77.0%	77.7%	74.6%	79.5%	80.6%	79.4%	76.1%	79.7%	74.6%	68.0%	54.6%	62.3%	RN	Resources	<70%	70-75%	>= 75%
Responsive	5.12	Cancer - 31 days maximum wait from diagnosis to treatment for all cancers	LTUC	97.0%	96.6%	100.0%	100.0%	98.9%	94.6%	99.1%	100.0%	97.5%	98.0%	98.1%	98.1%	97.3%	98.2%	97.4%	98.9%	98.9%	96.6%	99.0%	RN	Resources	<96%		>=96%
Responsive	5.13.1	Children's Services - 0-12 months caseload	CC	1457	1455	1459	1453	1545	1503	1876	1698	1871	1779	1642	1658	1531	1591	1726	1684	1728	1787	1852	RN	Resources	tbc		
Responsive	5.13.2	Children's Services - 2-3 years caseload	CC	1625	1591	1496	1583	1476	1536	1662	1762	1784	1857	1708	1918	1701	1806	1628	1788	1606	1703	1663	RN	Resources	tbc		
Responsive	5.14	Children's Services - Safeguarding caseload	CC	951	1026	1118	1006	727	1002	992	947	986	992	980	1278	910	1177	1103	1094	938	988	875	RN	Resources	tbc		
Responsive	5.15	Children's Services - Ante-natal visits	CC	85.9%	86.7%	89.8%	88.3%	89.4%	86.8%	86.0%	80.1%	80.0%	75.3%	78.7%	75.9%	83.1%	86.2%	87.9%	90.9%	90.9%	89.5%	89.9%	RN	Resources	<75%	75% - 90%	>=90%
Responsive	5.16	Children's Services - 10-14 day new birth visit	CC	95.4%	95.4%	95.4%	95.7%	95.4%	93.2%	94.0%	92.6%	95.7%	95.6%	95.4%	93.5%	95.4%	94.7%	95.7%	97.3%	96.8%	96.4%	95.9%	RN	Resources	<75%	75% - 90%	>=90%
Responsive	5.17	Children's Services - 6-8 week visit	CC	91.9%	92.4%	93.3%	93.3%	92.7%	90.1%	89.7%	89.7%	90.7%	91.4%	93.3%	93.4%	92.1%	93.8%	94.9%	95.2%	95.0%	93.6%	94.5%	RN	Resources	<75%	75% - 90%	>=90%
Responsive	5.18	Children's Services - 12 month review	CC	93.1%	91.2%	92.6%	94.0%	95.0%	93.5%	95.1%	93.8%	92.5%	92.8%	93.7%	90.9%	89.9%	91.2%	91.7%	93.2%	92.7%	94.6%	95.5%	RN	Resources	<75%	75% - 90%	>=90%
Responsive	5.19	Children's Services - 2.5 year review	CC	91.5%	91.7%	93.4%	92.3%	92.8%	92.2%	90.9%	91.7%	92.3%	91.5%	92.0%	91.7%	92.7%	91.6%	93.9%	95.6%	94.2%	94.1%	95.7%	RN	Resources	<75%	75% - 90%	>=90%
Responsive	5.20	Children's Services - % children with all 5 mandated contacts	CC																				RN	Resources	<75%	75% - 90%	>=90%
Responsive	5.21	Children's Services - Delivery of Immunisation trajectory	CC																				RN	Resources			
Responsive	5.22	Children's Services - OPEL level	CC									2/3	2/3	1/2/3	2/3	1/2/3	1/2/3	1/2/3	1/2/3	1/2/3	1/2/3	1/2/3	RN	Resources	tbc		
Responsive	5.23	Community Care Adult Teams - performance against new timeliness standards	CC																				RN	Resources	tbc		
Responsive	5.24	Community Care Adult Teams - Number of virtual beds delivered in Supported Discharge Service	CC																				RN	Resources			
Responsive	5.25	Community Care Adult Teams - Number of cancelled routine visits	CC																				RN	Resources			
Responsive	5.26	Community Care Adult Teams - OPEL level	CC									3	3	3	3	3	3	3	3	3	3	3	RN	Resources			
Responsive	5.27	Out of hours - telephone clinical assessment for URGENT cases within 20 minutes of call prioritisation	LTUC	36.7%	35.5%	39.9%	38.6%	34.5%	40.6%	40.3%	38.5%	28.5%	39.1%	41.1%	32.5%	30.8%	33.6%	32.0%	36.0%		32.7%	32.5%	RN	Resources	<95%		>=95%
Responsive	5.28	Home visit: Face to face consultations started for URGENT cases within 2 hrs	LTUC	78.6%	86.2%	75.9%	79.2%	88.5%	97.4%	90.5%	86.7%	83.3%	92.9%	94.4%	93.5%	97.2%	93.6%	93.1%	85.7%		82.9%	81.5%	RN	Resources	<95%		>=95%
Efficiency and Finance	6.1	Agency spend	All	£ 419	£ 307	£ 414	£ 517	£ 453	£ 429	£ 389	£ 485	£ 745	£ 685	£ 630	£ 829	£ 654	£ 752	£ 890	£ 798	£ 980	£ 991	£ 934	JC	Resources	>3% of pay bill	1% - 3%	<= 1%
Efficiency and Finance	6.2	Surplus / deficit and variance to plan	All	£ -	£ -	£ -	-	-	-	-	-	-	-	-	-	-£ 265	-£ 471	£ 157	-£ 282	£ 6	-£ 916	-£ 732	JC	Resources	>1% behind plan	0 - 1% behind plan	On plan
Efficiency and Finance	6.3	Capital spend	All	£ 518	£ 834	£ 1,856	£ 2,330	£ 3,188	£ 4,274	£ 8,006	£ 10,861	£ 11,503	£ 14,559	£ 17,301	£ 29,657	£ 500	£ 905	£ 1,506	£ 1,915	£ 1,829	£ 2,244	£ 2,974	JC	Resources	>25% behind plan	10% - 25% behind plan	On plan or <10% behind plan
Efficiency and Finance	6.4	Cash balance	All	£ 39,900	£ 34,587	£ 32,007	£ 32,386	£ 33,600	£ 42,000	£ 40,738	£ 40,119	£ 46,027	£ 44,921	£ 44,615	£ 42,004	£ 40,077	£ 40,671	£ 43,156	£ 38,660	£ 35,921	£ 36,042	£ 37,476	JC	Resources	>10% behind plan	0 - 10% behind plan	On plan
Efficiency and Finance	6.5.1	Long stay patients - stranded (>7 days LOS)	All	119	114	103	119	129	121	146	151	152	162	177	162	167	165	147	164	158	158	155	RN	Resources	>90	70-90	<=70
Efficiency and Finance	6.5.2	Long stay patients - superstranded (>21 days LOS)	All	48	44	40	42	51	47	56	67	65	71	86	79	83	79	67	76	74	77	69	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	62.2	60.4	60.1	62.2	RN	Resources	>60	55-60	<=55
Efficiency and Finance	6.7.1	Length of stay - elective	All	2.26	2.60	2.57	2.66	2.76	2.31	2.22	2.35	2.78	3.17	2.24	2.43	2.25	1.84	2.56	2.41	2.94	2.85	2.49	RN	Resources	>2.75	2.5-2.75	<=2.5
Efficiency and Finance	6.7.2	Length of stay - non-elective	All	4.69	4.27	4.49	3.99	4.81	4.82	4.72	5.26	5.76	5.37	5.80	5.39	5.86	5.52	5.05	4.92	5.69	5.61	5.33	RN	Resources	>4.5	4-4.5	<=4.0
Efficiency and Finance	6.8	Avoidable admissions	All	189	219	242	263	228	206	240	267	229	222	202	238	261	256	261	208	212	211		RN	Resources	>270		<=270
Efficiency and Finance	6.9	Theatre utilisation (elective sessions)	PSC	81.2%	83.9%	83.4%	82.0%	83.7%	82.4%	80.4%	81.0%	84.7%	81.3%	75.7%	78.0%	79.8%	79.4%	85.0%	78.4%	79.4%	81.4%	80.0%	RN	Resources	<85%	85%-90%	>=90%
Efficiency and Finance	6.10	Day case conversion rate	PSC	2.2%	1.7%	1.9%	1.6%	1.6%	1.5%	1.9%	1.1%	1.7%	1.3%	1.9%	1.6%	1.8%	1.8%	2.4%	1.7%	1.9%	1.4%	1.5%	RN	Resources	>2%	1.5%-2%	<=1.5%
Activity	7.1	GP Referrals against 2019/20 baseline	All	95.4%	94.1%	113.1%	99.6%	101.1%	112.0%	97.1%	109.1%	111.5%	99.9%	109.7%	167.2%	99.6%	108.7%	110.9%	98.7%	115.3%	111.1%	101.5%	RN	Resources	<95%		>=95%
Activity	7.2.1	Outpatient activity (consultant led) against plan (new and follow up)	All	113.7%	106.9%	123.2%	84.2%	87.0%	93.3%	103.2%	111.6%	111.3%	96.1%	103.1%	110.9%	112.6%	133.5%	122.1%	76.3%	88.9%	89.5%	77.7%	RN	Resources	<95%		>=95%
Activity	7.2.2	Outpatient activity (consultant led) against 2019/20 baseline (new and follow up)	All	90.8%	86.5%	98.7%	85.3%	88.6%	95.2%	80.1%	100.6%	95.9%	84.7%	93.8%	117.7%	84.4%	115.1%	91.8%	84.0%	94.2%	90.9%	80.7%	RN	Resources	<95%		>=95%
Activity	7.3.1	Elective activity against plan	All	102.5%	97.3%	109.3%	77.4%	75.4%	84.9%	99.4%	104.1%	105.2%	95.8%	88.7%	101.6%	123.2%	111.8%	111.1%	70.5%	90.2%	102.8%	72.3%	RN	Resources	<95%		>=95%
Activity	7.3.2	Elective activity against 2019/20 baseline	All	74.8%	80.6%	90.4%	73.9%	69.6%	80.7%	72.9%	79.7%	84.9%	72.7%	73.3%	112.7%	76.1%	99.0%	78.5%	98.4%	75.4%	85.0%	75.9%	RN	Resources	<95%		>=95%
Activity	7.4.1	Non-elective activity against plan	All	96.5%	97.4%	105.2%	104.3%	94.5%	93.5%	95.2%	87.1%	89.4%	84.3%	85.2%	105.5%	100.5%	98.5%	104.3%	89.8%	95.9%	97.9%	97.2%	RN	Resources	<95%		>=95%
Activity	7.4.2	Non-elective activity against 2019/20 baseline	All	89.9%	98.6%	104.8%	98.3%	92.7%	90.6%	94.1%	84.1%	88.8%	84.7%	84.5%	119.1%	90.4%	97.8%	100.6%	88.3%	91.0%	91.8%	92.8%	RN	Resources	<95%		>=95%
Activity	7.5.1	Emergency Department attendances against plan	LTUC	98.9%	106.6%	111.2%	103.4%	104.0%	105.7%	101.5%	99.2%	91.9%	95.6%	94.4%	114.92%	92.1%	92.7%	91.3%	96.1%	91.0%	92.6%	90.9%	RN	Resources	<95%		>=95%

Domain	Indicator number	Indicator name	Clinical Directorate(s) metric is applicable to	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Exec Lead	Committee reported to:	Monthly RAG thresholds: Red	Amber	Green
Activity	7.5.2	Emergency Department attendances against plan, 2019/20 baseline	LTUC	98.9%	106.6%	110.8%	103.7%	104.1%	105.7%	106.5%	104.3%	96.6%	98.3%	97.6%	149.7%	99.6%	108.8%	110.9%	98.8%	99.5%	102.8%	101.6%	RN	Resources	<95%		>=95%

Integrated Board Report - October 2022

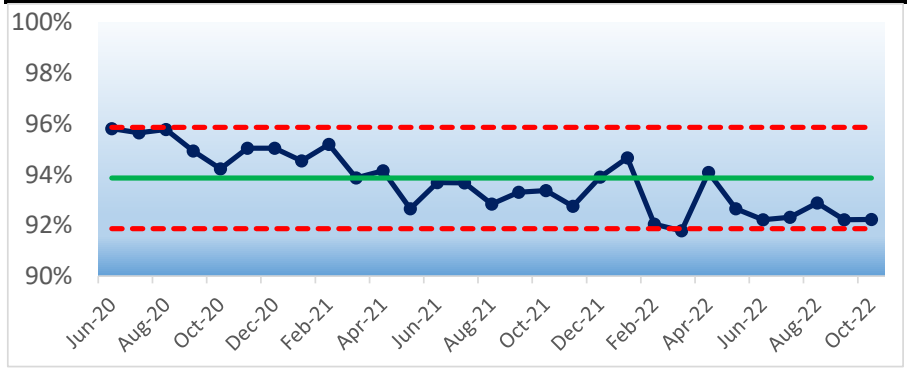
Domain 2 - Caring

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	Oct-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

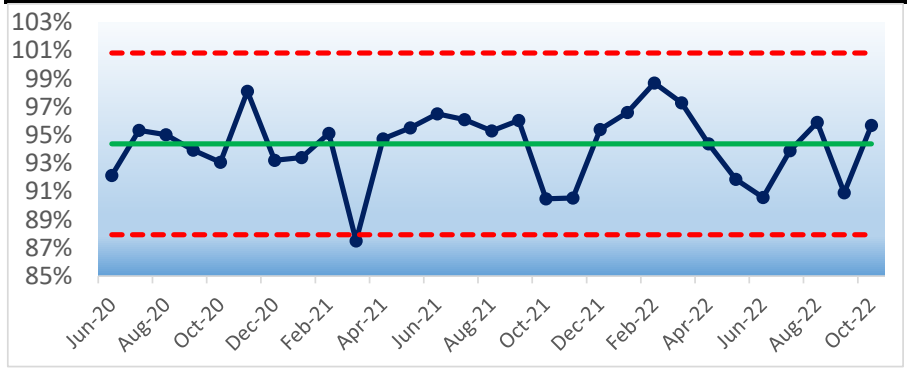
Performance against this standard continues to fluctuate but overall remains above 90% which is positive.

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	Oct-22
Value / RAG rating	95.7%

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

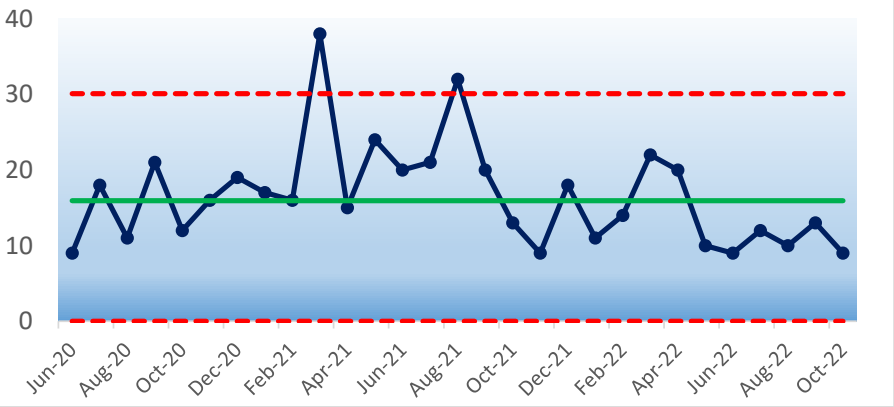
Performance against this standard continues to fluctuate but overall remains above 90% which is positive.

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	Oct-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 total, there were 9 standard complaints received in October (number and response rate for our KPI which is the standard complaints - 25 working days). 3 complaints came under CC Directorate, 2 complaints came under LTUC and 4 complaints came under PSC. Including Multi-agency and Complaints requiring a meeting, there were 11 complaints in total (2 multiagency).

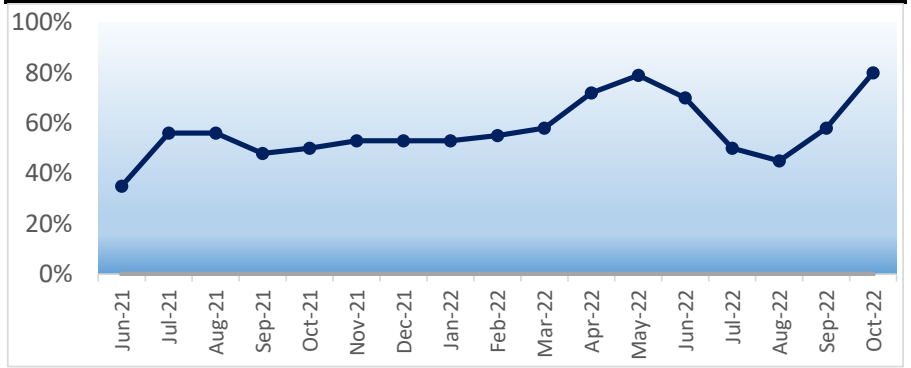
This is the 6th consecutive month that the number of complaints received by the Trust has fallen below the mean.

Indicator	**2.2.2 Complaints - % responded to within time**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Oct-22
Value / RAG rating	80%

Indicator description

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

Trend chart



Narrative

The response rate declined over the summer months (50% in July, 45% in August). This was closely monitored. The response rate for October is 80%.

This is the third consecutive month where an improvement has been observed. The aspiration remains for consistent delivery of the 95% standard.

Integrated Board Report -October 2022

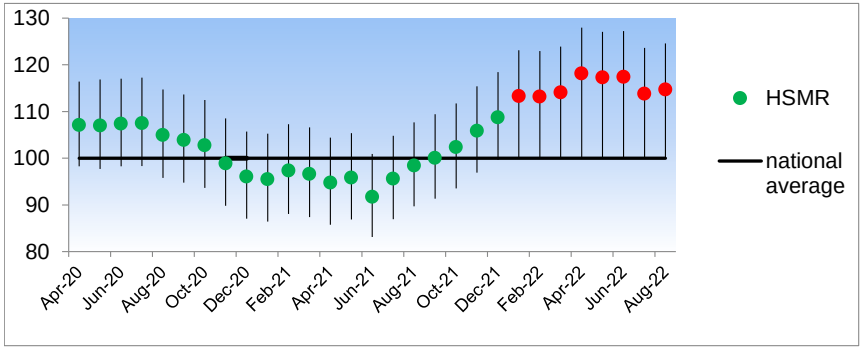
Domain 3 - Effective

Indicator	**3.1 - Hospital Standardised Mortality Ratio (HSMR)**
Executive lead	Jacqueline Andrews, Medical Director
Board Committee	Quality Committee
Reporting month	Aug-22
Value / RAG rating	114.71

Indicator description

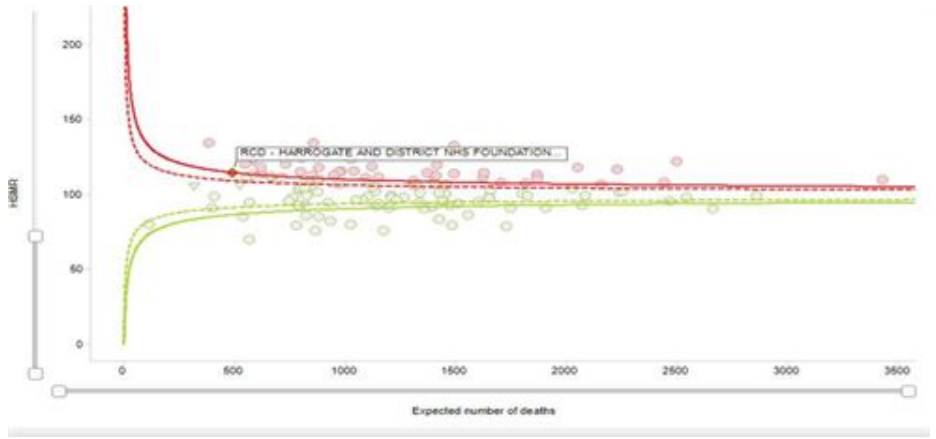
The HSMR looks at the mortality rates for 56 common diagnosis groups that account for around 80% of in-hospital deaths and standardises against various criteria including age, sex and comorbidities. The measure also makes an adjustment for palliative care.

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 triangle) and all other Trusts. Further work is ongoing to explore possible reasons for the rise.

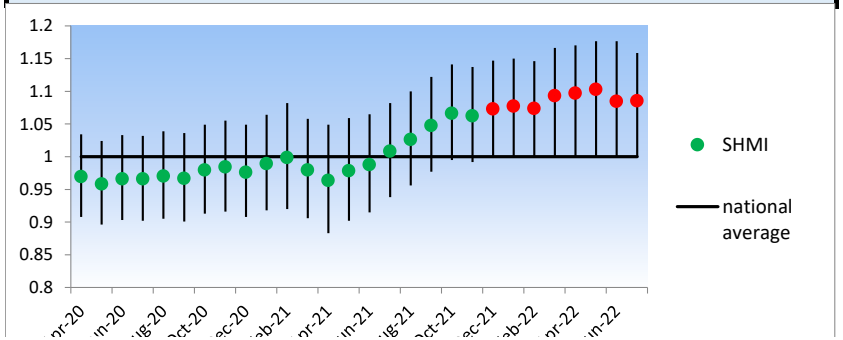


Indicator	**3.2 - Summary Hospital Mortality Index (SHMI)**
Executive lead	Jacqueline Andrews, Medical Director
Board Committee	Quality Committee
Reporting month	Jul-22
Value / RAG rating	1.085

Indicator description

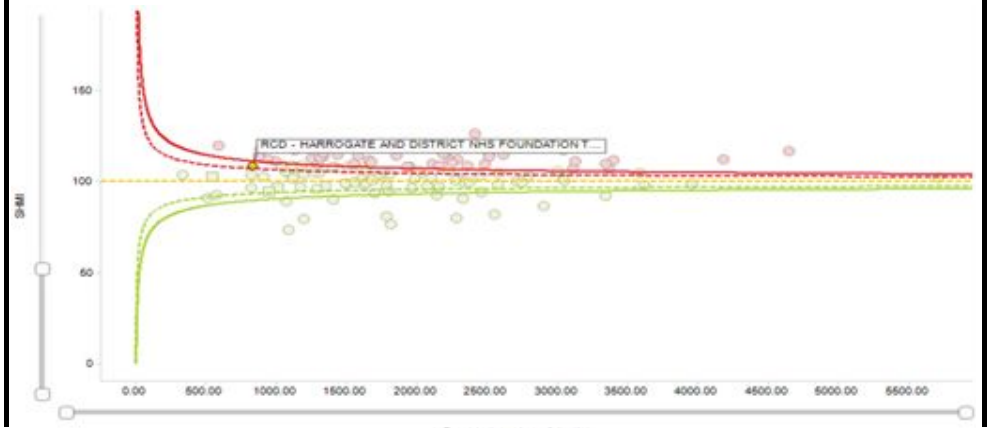
The SHMI looks at the mortality rates for all diagnoses and standardises against various criteria including age, sex and comorbidities. The measure does not make an adjustment for palliative care.

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 triangle) and all other Trusts. Note that although SHMI has risen, it is of a lower equivalent value than the HSMR.

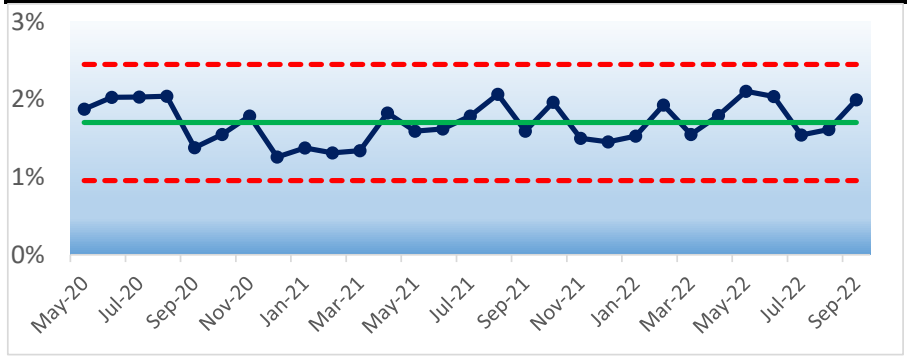


Indicator	**3.3.1 - Readmissions to the same specialty within 30 days - following elective admission**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Sep-22
Value / RAG rating	2.0%

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

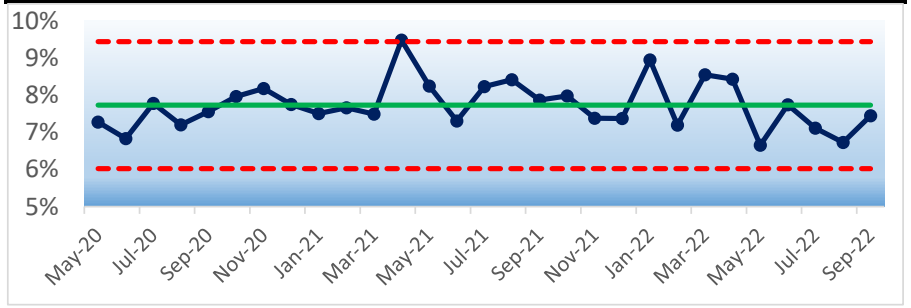
Readmissions following an elective admission increased to 2.0% in September but remain within control limits and less than national average.

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	Sep-22
Value / RAG rating	7.4%

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 increased to 7.4% in October but remain within the control limits.

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

Indicator description
This indicator is under development.

SPC chart

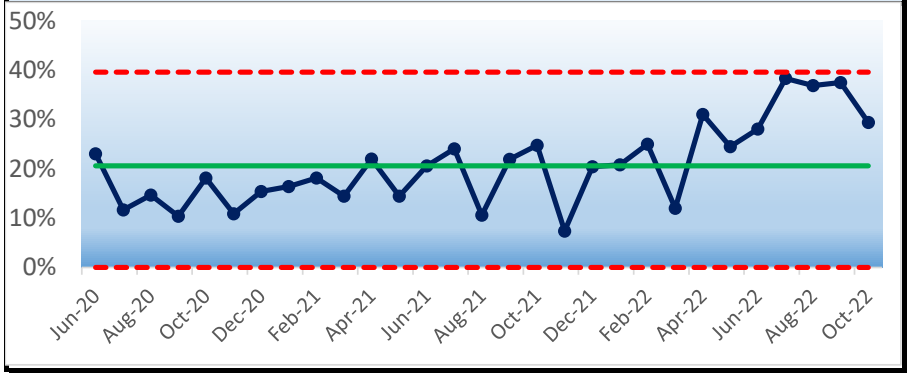
Narrative

Indicator	**3.5 - Delayed transfers of care**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Oct-22
Value / RAG rating	29.4%

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

29% of inpatients did not meet the criteria to reside when the snapshot was taken in October - a reduction on recent months but remaining high. The Trust have now purchased a system using funding from NHSE that allows the ward teams to electronically capture the criteria to reside of every patient. This is now rolled out across all adult wards and provides real-time information.

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

Integrated Board Report - October 2022

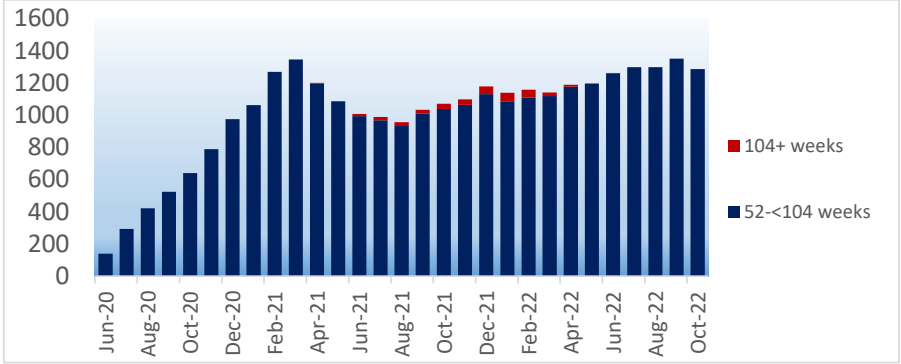
Domain 5 - Responsive

Indicator	**5.1 - RTT Incomplete pathways - 52+ weeks**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Oct-22
Value / RAG rating	1285

Indicator description

The number of incomplete pathways waiting over 52 weeks.

Trend chart



Narrative

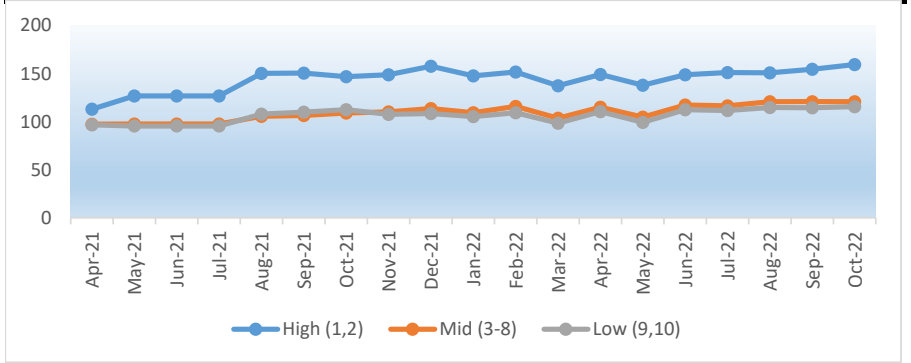
The Trust reported no patients waiting over 104 weeks at the end of October. The number of over 52 week waiters stands at 1,285, a reduction on last month. Risks remain in two main specialties of T&O and Community Dental (which together account for 59% of the over 52 week waiters). There are plans in place to reduce the number of over 52 week waiters to 750 by March 2023. 78 week waiting patients are on or close to trajectory for elimination by the end of March 2023. The most pressured specialties remain General Surgery and Urology.

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

Indicator description

The average RTT waiting time by level of deprivation.

Trend chart



Narrative

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

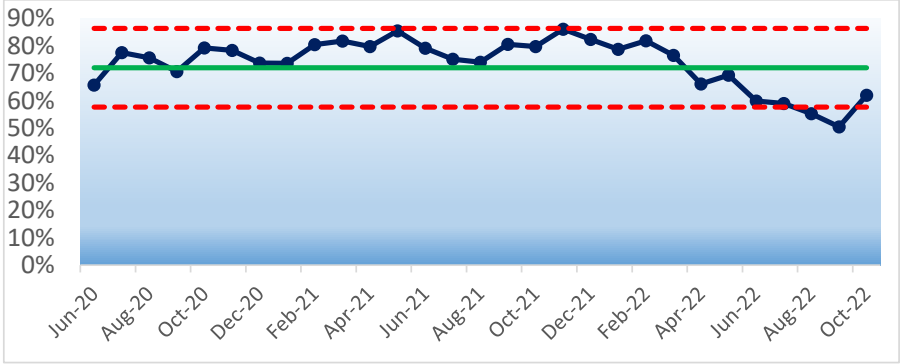
Work also continues in improving the recording of ethnicity and use of the learning disabilities flag across our clinical systems (this will improve further with the reinstatement of patient kiosks).

Indicator	**5.3 - Diagnostic waiting times - 6-week standard**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Oct-22
Value / RAG rating	62.0%

Indicator description

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

SPC chart



Narrative

Performance has improved this month as anticipated with 2,617 waiting over 6 weeks (3,298 last month). Of the 2,617 waiting over 6 weeks, this includes 1,001 Dexa, 801 ultrasound, 410 MRI and 281 audiology.

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

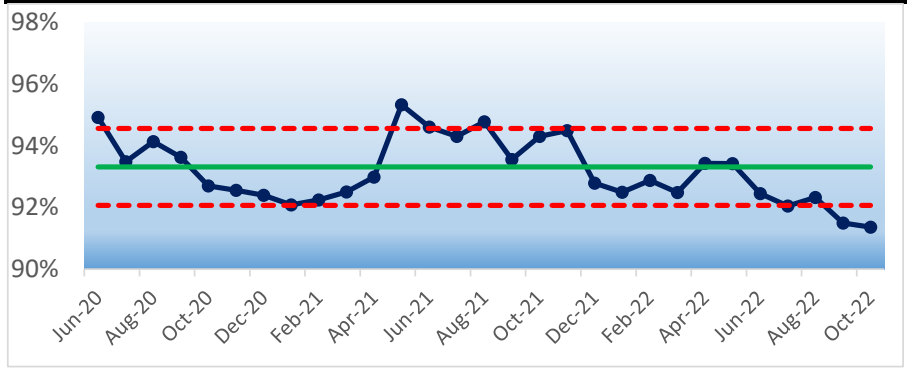
Narrative

Indicator	**5.5 - Data quality on ethnic group - inpatients**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Oct-22
Value / RAG rating	91.4%

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.

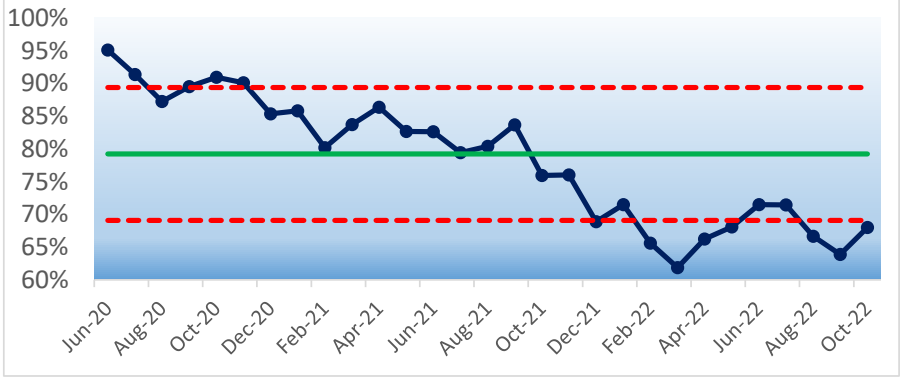
- Made contact with the lead at Central London Community NHS Trust (CLCH) who have improved their ethnicity recording rates on their patient records – they are organising a webinar to talk through their actions
- Reminded staff of the process regarding the collection of this data including reception 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	Oct-22
Value / RAG rating	68.0%

Indicator description

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

SPC chart



Narrative

Performance against the A&E 4-hour standard remains below the 95% standard. Performance reflects the continuing significant pressures with high bed occupancy relating to discharge challenges and staff absenses, coupled with the current buidling works which is impacting ED capacity. The Trust continue to support the HNY system which is significantly pressured (OPEL 4) with regular diverts of ambulance patients to Harrogate - 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:

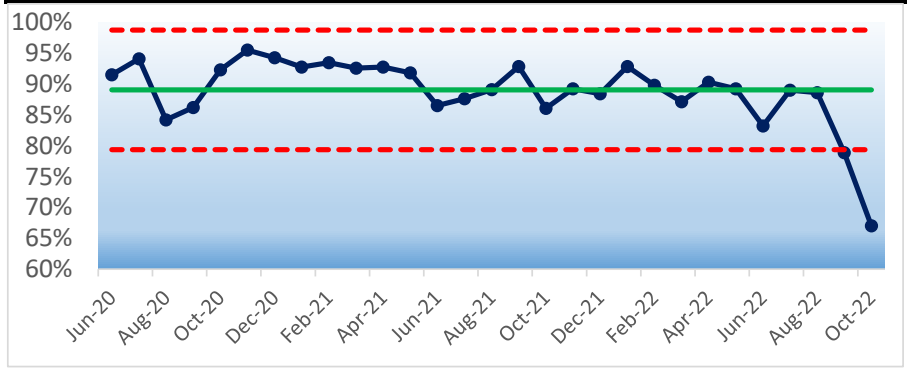
- delivering 7 day SDEC service and a direct to SDEC pathway with YAS;
- streaming of minors at the front door;
- utilising Criteria to Reside flow software to identify patients no longer requiring hospital care;
- developing a 2 hour crisis response service, expanding ARCH in-reach to ED and maximising 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	Oct-22
Value / RAG rating	67.0%

Indicator description

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

SPC chart



Narrative

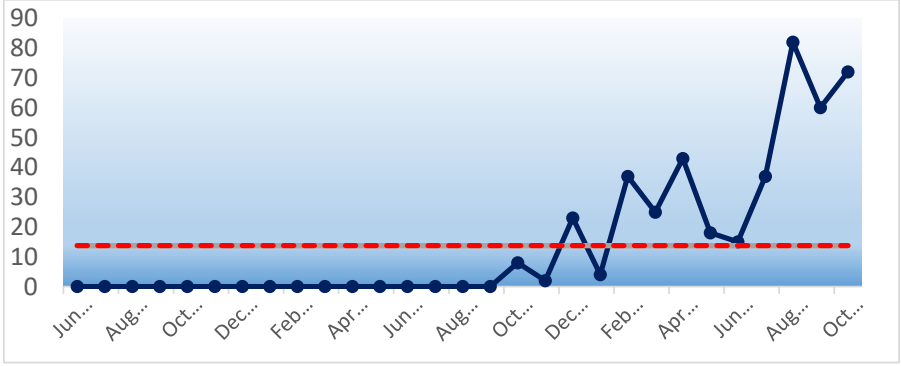
67% of ambulance handovers took place within 15 minutes in October, a deterioration on previuos months. There were 147 over 30-minute handover breaches with 64 over 60-minutes in October. Prevention of ambulance handover delays continues to be a focus with the Trust operational processes being shared 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	Oct-22
Value / RAG rating	72

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

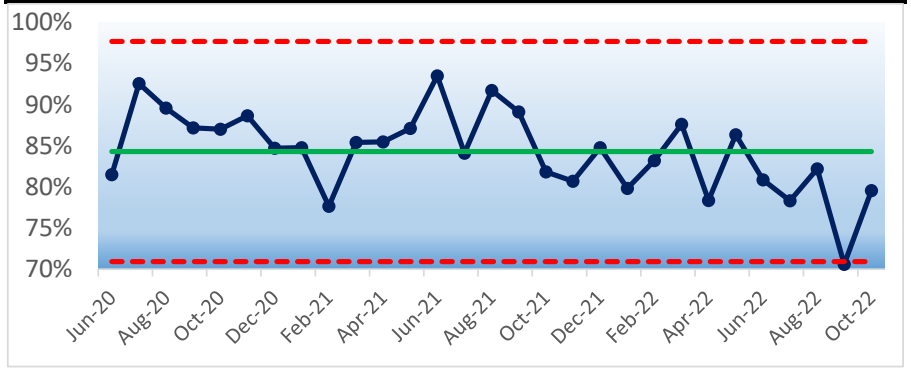
72 over 12 hour trolley waits were reported in October. RCAs have commenced and will be reviewed at internal quality and performance meetings. A preliminary review of the Datix reports submitted suggest no reports of patient harm.

Indicator	**5.9.1 - Cancer - 62 day wait for first treatment from urgent GP referral to treatment**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Oct-22
Value / RAG rating	79.6%

Indicator description

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

SPC chart



Narrative

Provisional data indicates that the 62 day standard was not delivered in October for the fifth consecutive month (79.6%). There were 68.5 accountable treatments (75 patients) in October with 14.0 treated outside 62 days. Of the 9 tumour sites treated in October, performance was below 85% for 5 (Colorectal, Gynaecology, Haematology, Head and Neck, and Lung).

Provisional data indicates that 54.5% (6/11) of patients treated at Tertiary centres in October were transferred for treatment by day 38, compared to 36.4% (8/22) last month.

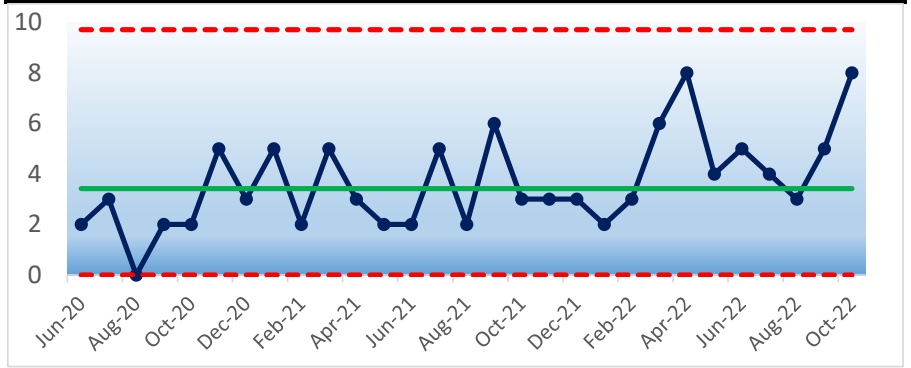
Deteriorating performance against the 14 day standard is having an impact on other targets, especially 62 days. Higher volumes of referrals in Lower GI, Skin and Breast are also impacting on delivery.

Indicator	**5.9.2 - Cancer - 62 day standard - number of 104 days waiters**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Oct-22
Value / RAG rating	8

Indicator description

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

SPC chart



Narrative

8 patients waited 104+ days for treatment in October (1 x Harrogate Gynae; 2 x Harrogate Skin; 1 x Upper GI treated at Hull; 4 x Urological treated at Leeds). The 2 skin delays were primarily due to lack of capacity in Dermatology outpatients, and the 4 Urology delays were due to a combination of diagnostic delays at Harrogate, elective capacity at Leeds, and patient medical fitness. The Gynaecology delay was a complex pathway, and the Upper GI patient was referred to Hull on day 36 so the critical delays occurred at the treating centre.

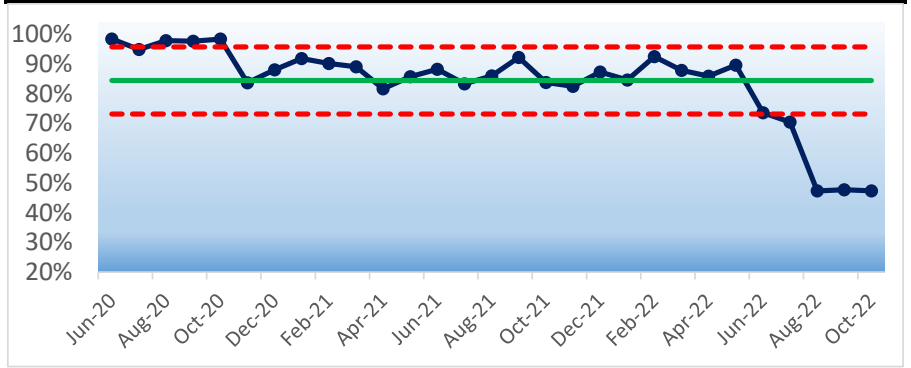
All patients have now received treatment and their pathways. Following the implementation of a new cancer system in October (Somerset Cancer Registry) and the time constraints on the tracking team, it has been agreeed to stand down the October, November and December breach panel meetings. This means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

Indicator	**5.10 - Cancer - 14 days maximum wait from urgent GP referral for all urgent suspect cancer referrals**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Oct-22
Value / RAG rating	47.3%

Indicator description

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

SPC chart



Narrative

1,094 patients attended their first appointment for suspected cancer in October which is the highest number ever seen in one month at HDFT. Of these, 576 were seen outside 14 days (47.3%).

14 day capacity continues to be challenging in October, particularly in Breast, Gynae, Colorectal, Dermatology, and Urology. There were a significant number of 2WW breaches in Breast, Gynaecology, and Dermatology in October with performance at 16.8%, 37.1%, and 10.7% respectively. The average wait for a Dermatology first appointment in October was 28 days and the longest 14 day wait was 71 days (Dermatology). This is continuing into November but there has been a moderate improvement in Dermatology.

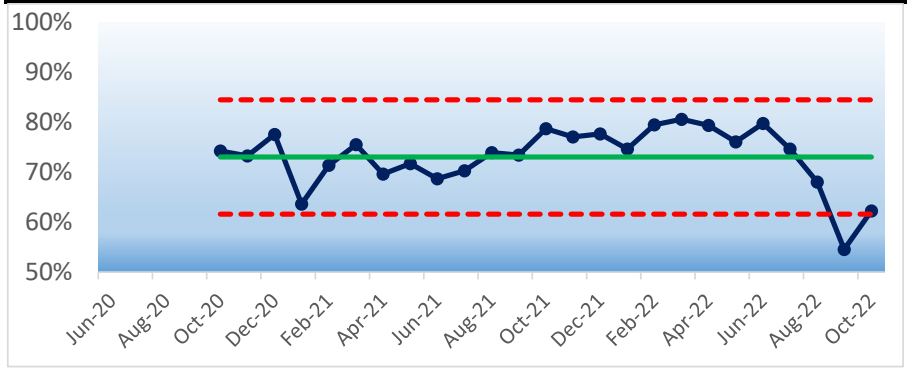
Poor performance for the breast 2WW standard continued in October with 8% patients seen within 14 days (4 out of 50).

Indicator	**5.11 - Cancer - 28 days faster diagnosis standard (suspected cancer referrals)**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Oct-22
Value / RAG rating	62.3%

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

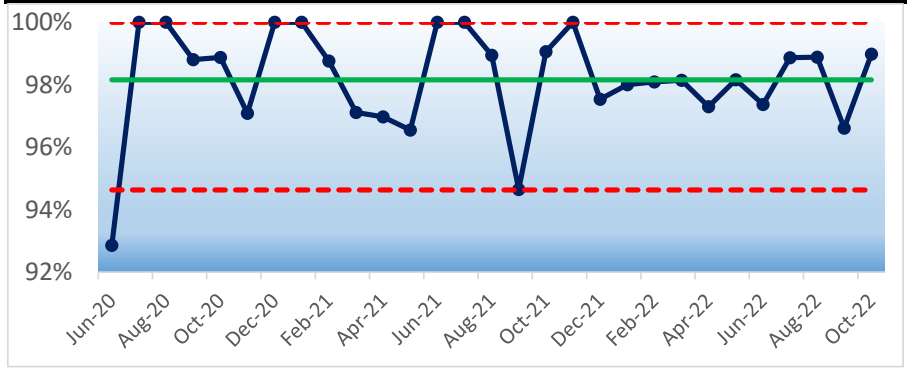
Provisional data indicates that in October combined performance for the three 28 days standards (2WW suspected cancer, 2WW non-cancer breast symptoms, Screening) continued to be below the proposed operational standard of 75% at 62.3%, although this is slight improvement on last month (2WW cancer – 64.6%; 2WW Breast Symptoms – 93.9%; Screening – 29.4%). This is mainly due to the deterioration in 14 day performance and the Screening performance which is consistently below 50%.

Indicator	**5.12 - Cancer - 31 days maximum wait from diagnosis to treatment for all cancers**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Oct-22
Value / RAG rating	99.0%

Indicator description

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

SPC chart



Narrative

Provisional data indicate that 98 patients received First Definitive Treatment for cancer at HDFT in October, with 1 patient (Colorectal) treated outside 31 days (99.0%) – the colorectal delay was due to elective capacity.

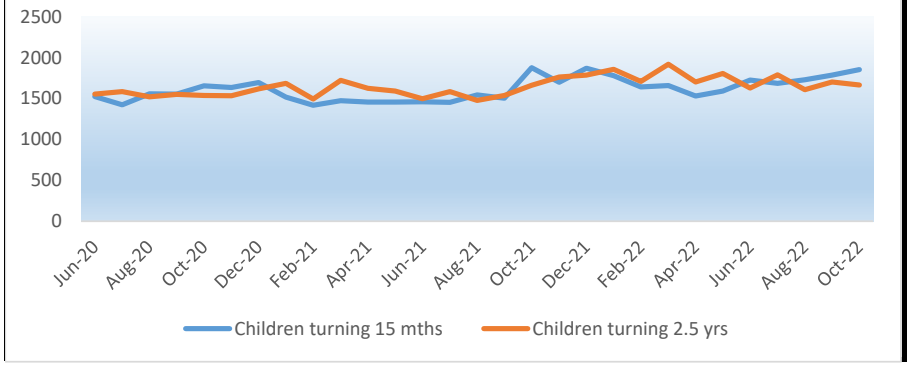
Overall performance was above the expected standard of 96%.

Indicator	**5.13 - Children's Services - 0-12 months and 2-3 years caseload**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Oct-22
Value / RAG rating	

Indicator description

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

SPC chart



Narrative

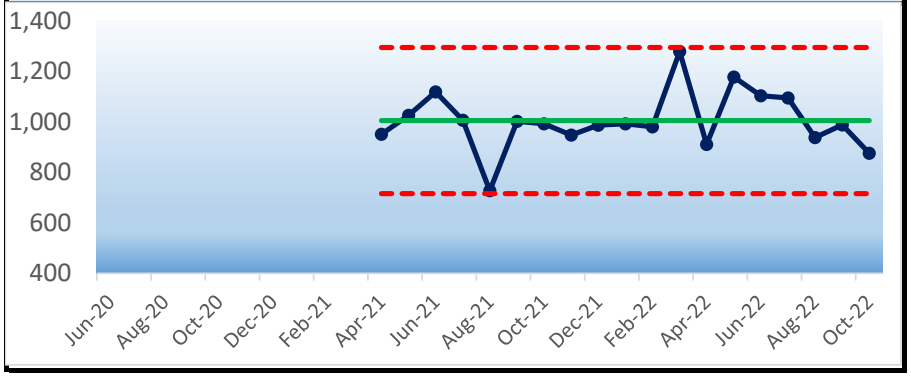
Both caseloads remain fairly static.

Indicator	**5.14 - Children's Services - Safeguarding caseload**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Oct-22
Value / RAG rating	875

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	Oct-22
Value / RAG rating	89.9%

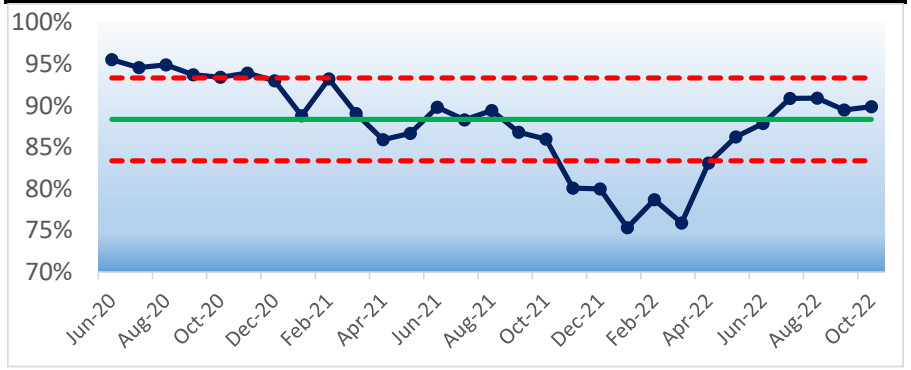
Indicator description

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

Narrative

Just less than 90% of eligible pregnant women received an initial antenatal visit in October. Middlesbrough performance (which was the main reason for the deterioration seen earlier in the year) is now in line with that of other localities and above 90%.

SPC chart

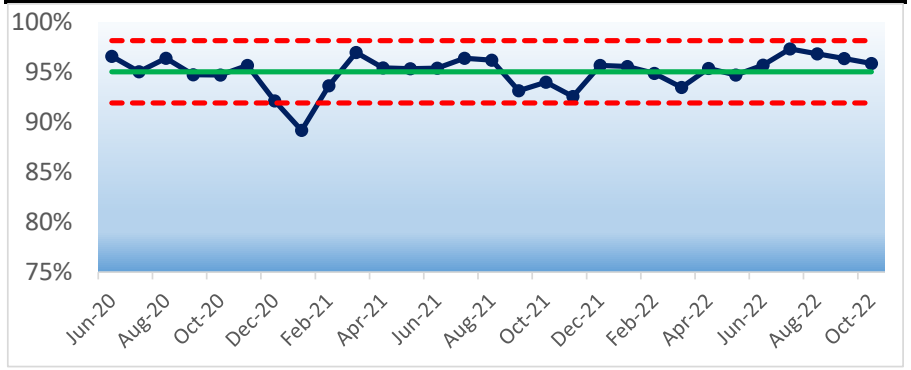


Indicator	**5.16 - Children's Services - 10-14 day new birth visit**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Oct-22
Value / RAG rating	95.9%

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

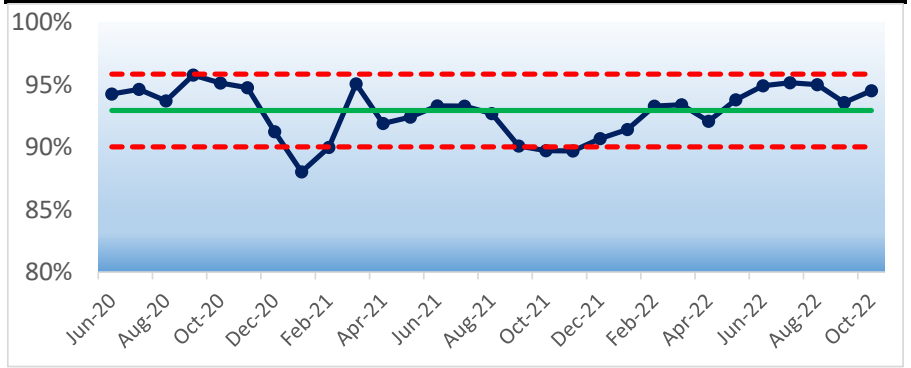
96% of infants received a new birth visit within 10-14 days of birth during October.

Indicator	**5.17 - Children's Services - 6-8 week visit**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Oct-22
Value / RAG rating	94.5%

Indicator description

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

SPC chart



Narrative

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

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

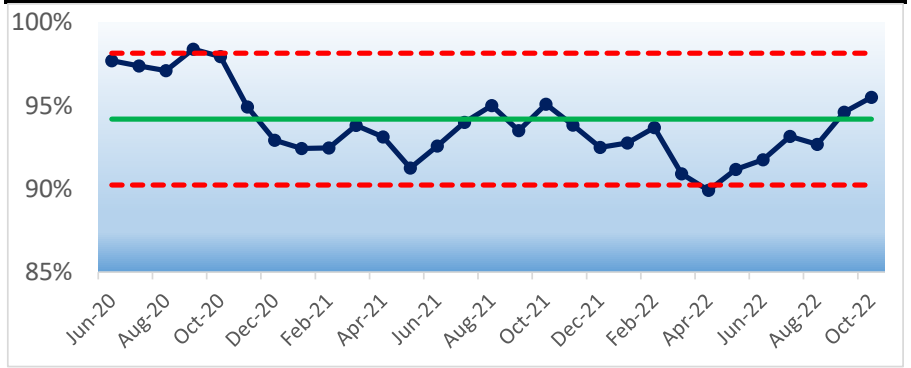
Indicator description

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

Narrative

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

SPC chart

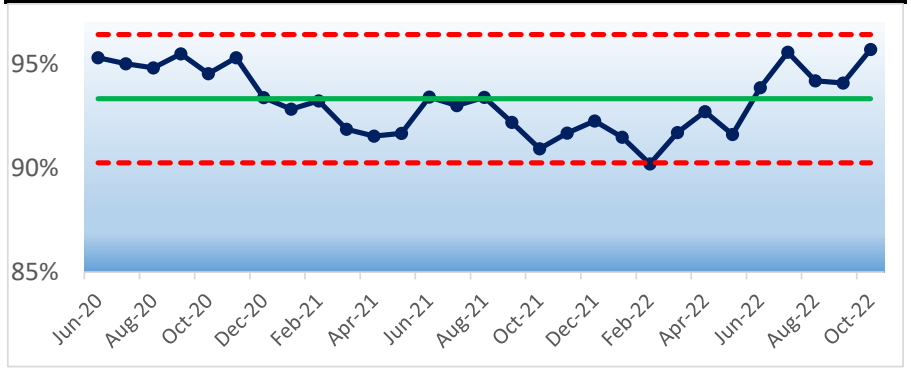


Indicator	**5.19 - Children's Services - 2.5 year review**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Oct-22
Value / RAG rating	95.7%

Indicator description

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

SPC chart



Narrative

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

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

Indicator description

This indicator is under development.

SPC chart

Narrative

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 October was:
Darlington - Level 1
Durham - Level 3
Gateshead - Level 2
Immunisation DDT - Level 2
Immunisation NY - Level 3
Middlesbrough - Level 3
North Yorkshire - Level 3
Northumberland - Level 3
Safeguarding - Level 3
Stockton - Level 3
Sunderland - Level 3

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

Indicator description

This indicator is under development.

SPC chart

Narrative

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

From March, the Trust has started to submit data related to this standard as part of the monthly Community Services Data Set submissions to NHS England. We are awaiting confirmation from NHS England as to how organisations wil be assessed against the standard. Provisional data suggests that the Trust achieved the 2 hour standard for 100% of eligible cases in October. This is the fourth consecutive month where we have reported 100% compliance.

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

Indicator description
This indicator is under development.

SPC chart

Narrative

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

Indicator description
This indicator is under development.

SPC chart

Narrative

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

Indicator description

This indicator is under development.

SPC chart

Narrative

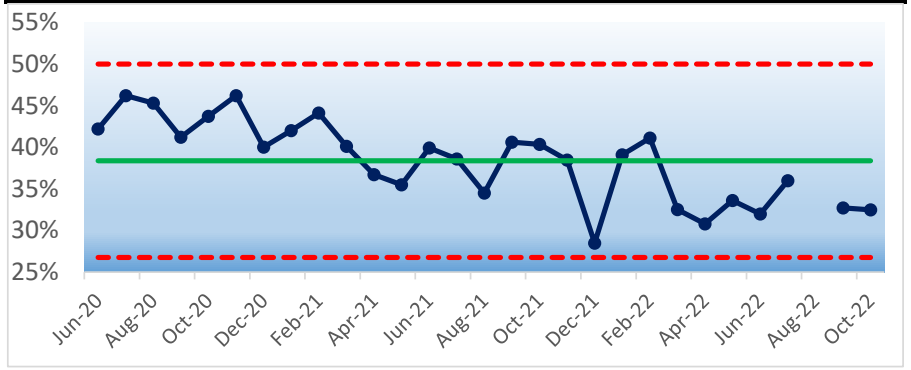
CC Directorate have started to discuss and record OPEL levels for Adult Community Services at their Safety and Governance huddles. The overall position for October remained at level 3.

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	Oct-22
Value / RAG rating	32.5%

Indicator description

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

SPC chart



Narrative

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

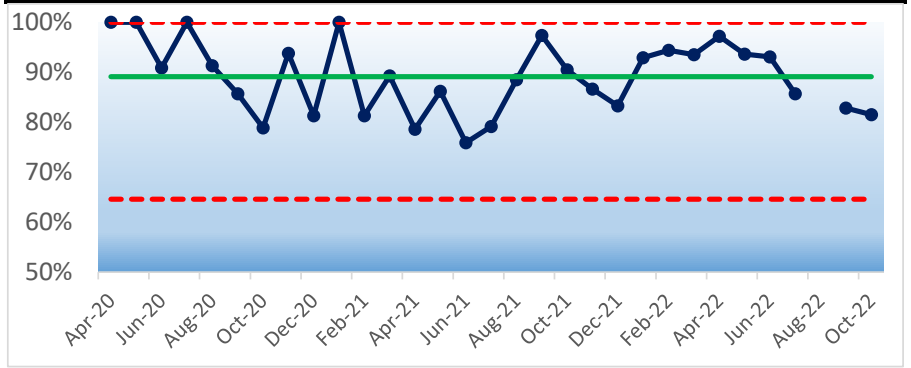
In October, 33% of urgent cases received a telephone clinical assesment within 20 minutes of call prioritisation.

Indicator	**5.28 - GPOOH - Home visit: Face to face consultations started for URGENT cases within 2 hrs**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Oct-22
Value / RAG rating	81.5%

Indicator description

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

SPC chart



Narrative

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

In October, 82% of urgent cases received a home visit within 2 hours, a reduction on the previous month.

Integrated Board Report - October 2022

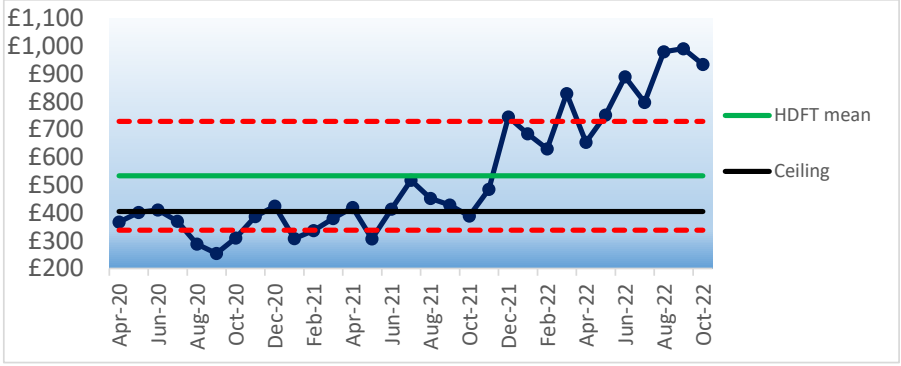
Domain 6 - Efficiency and Finance

Indicator	**6.1 - Agency spend**
Executive lead	Jordan McKie, Finance Director
Board Committee	Resources Committee
Reporting month	Oct-22
Value / RAG rating	£934

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

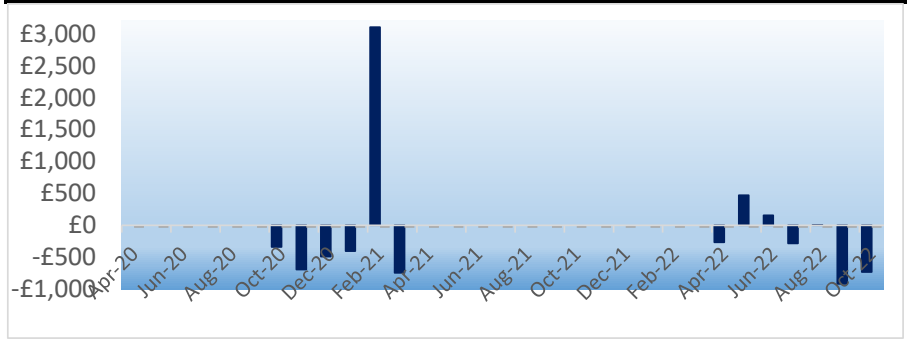
Continued pay pressure in wards and medical staff costs from use of agency staff mainly to cover vacancies and escalation wards. YTD costs are now £323k over our annual agency ceiling of £5,676k. Actions to reduce reliance on agency staff are being taken via the monthly agency review meetings and directorate performance review meetings. Actions and mitigations identified and discussed at SMT and Resource committee.

Indicator	**6.2 - Surplus / deficit and variance to plan**
Executive lead	Jordan McKie, Finance Director
Board Committee	Resources Committee
Reporting month	Oct-22
Value / RAG rating	-£732

Indicator description

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

Trend chart



Narrative

Month 7 has been a challenging position with an in month deficit of £0.7m. This takes the YTD position to £2.3m deficit. Key drivers include performance against Savings programme, Medical Staffing expenditure, ward expenditure, costs associated with the delivery of activity, inflation and escalation.

Indicator	**6.3 - Capital spend**
Executive lead	Jordan McKie, Finance Director
Board Committee	Resources Committee
Reporting month	Oct-22
Value / RAG rating	£2,974

Indicator description

Cumulative Capital Expenditure by month (£'000s)

Trend chart

Narrative

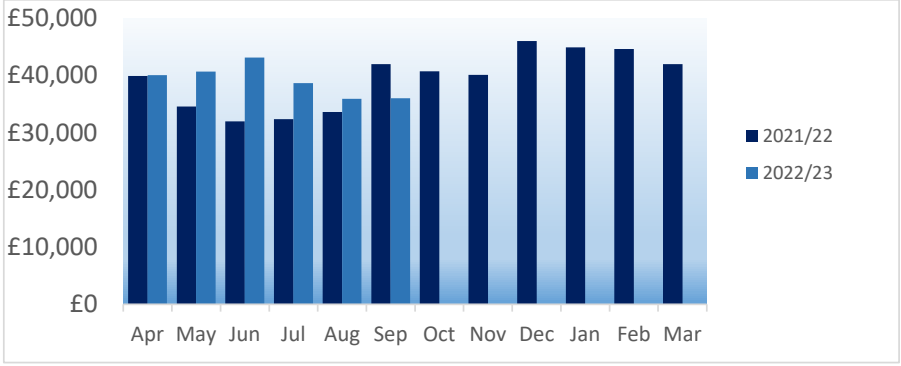
Capital spend is £2,974k to month 7. Plan has been reprofiled to reflect slippage.
Progress on schemes planned for 2023/24 already underway.

Indicator	**6.4 Cash balance**
Executive lead	Jordan McKie, Finance Director
Board Committee	Resources Committee
Reporting month	Oct-22
Value / RAG rating	£38,660

Indicator description

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

Trend chart



Narrative

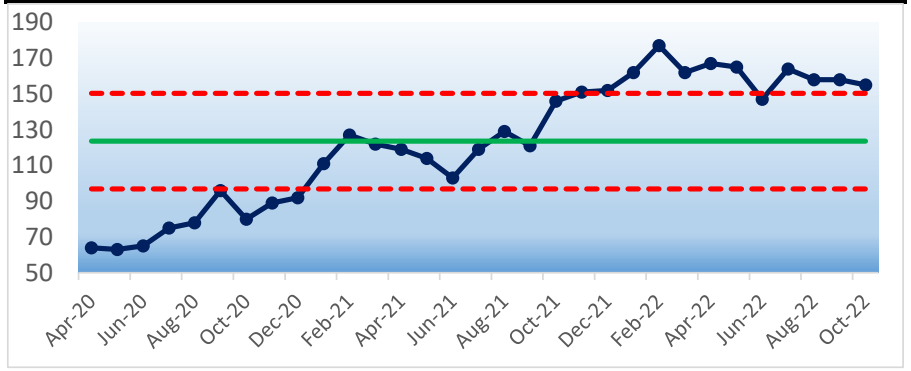
Trust cash balance remains positive.

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

Indicator description

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

SPC chart



Narrative

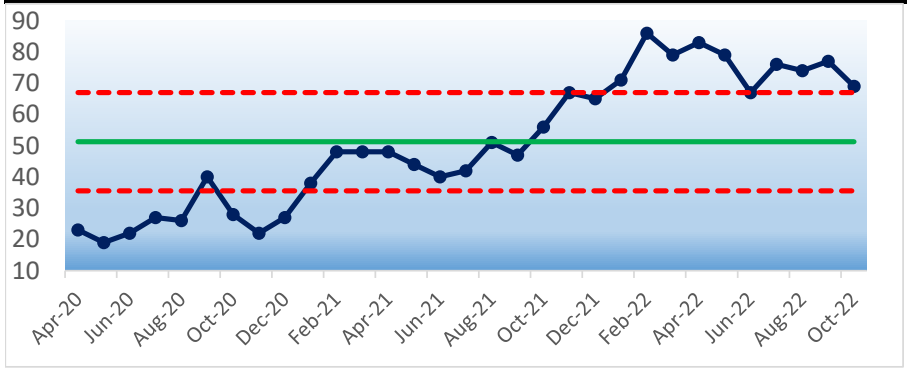
The number of long stay patients (> 7 days) was 155 in October, no significant change on last month and remaining high. This is being driven by the increase in COVID patients, COVID 'pop ups' at day 7 and patients requiring observation as COVID contacts alongside the impact of COVID on POC, residential and nursing home providers.

Indicator	**6.5.2 - Long stay patients - superstranded (>21 days LOS)**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Oct-22
Value / RAG rating	69

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

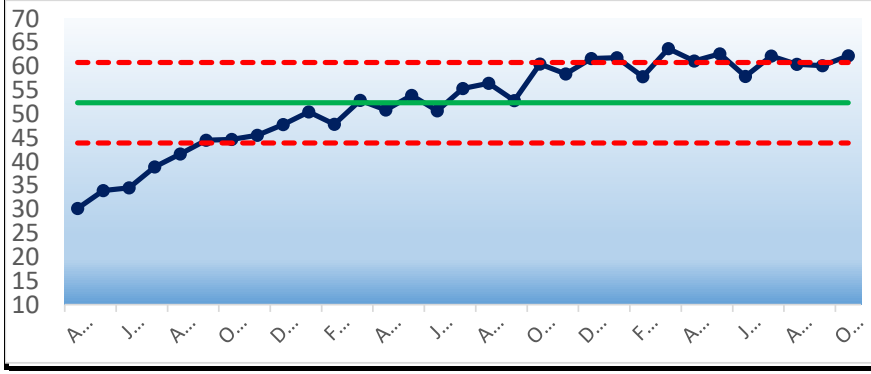
The number of long stay patients (> 21 days) was 69 in October, a reduction on last month but remaining high. This is being driven by the increase in COVID patients, COVID 'pop ups' at day 7 and patients requiring observation as COVID contacts alongside the impact of COVID on POC, residential and nursing 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	Oct-22
Value / RAG rating	62.2

Indicator description

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

SPC chart



Narrative

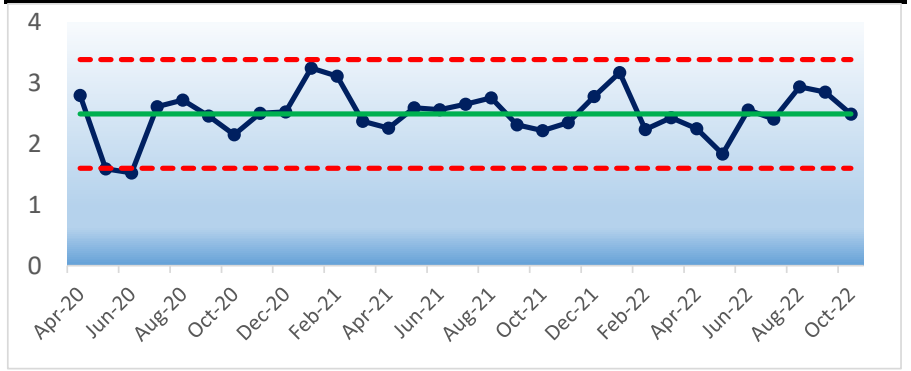
Occupied bed days per 1,000 population rose to 62.2 in October. In the 2 years prior to the pandemic, occupied bed days per 1,000 population averaged 57.8, below the current level.

Indicator	**6.7.1 Length of stay - elective**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Oct-22
Value / RAG rating	2.49

Indicator description

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

SPC chart



Narrative

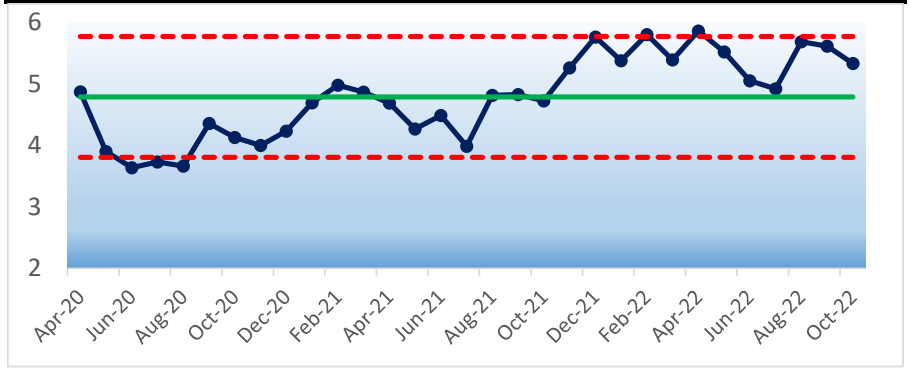
Elective length of stay decreased in October and is now below our local stretch target of 2.5 days.

Indicator	**6.7.2 Length of stay - non-elective**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Oct-22
Value / RAG rating	5.3

Indicator description

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

SPC chart



Narrative

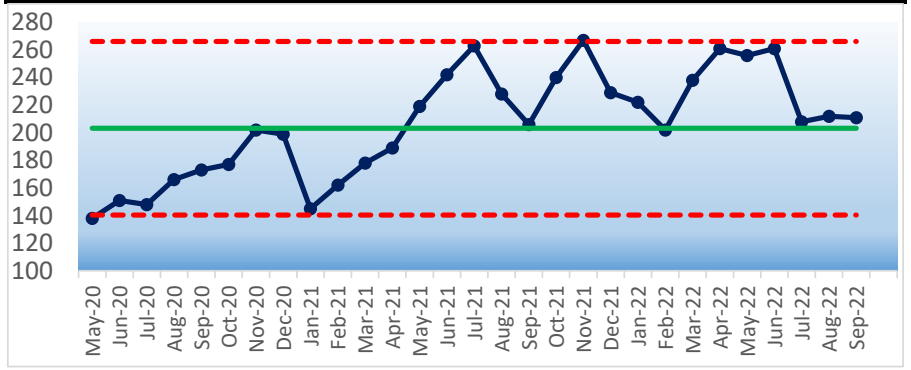
Non-Elective length of stay decreased in October but remains above our local stretch target. There is a combination of factors affecting patient flow, as described in indicators 6.5.1 - 6.7.1.

Indicator	**6.8 - Avoidable admissions**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Sep-22
Value / RAG rating	211

Indicator description

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

SPC chart



Narrative

Provisional data indicates that there were 211 avoidable admissions in September, no change on recent months and remaining within the expected range. The most common diagnoses this month remain as urinary tract infections and pneumonia. Excluding children and admissions to SDEC, the September figure was 127.

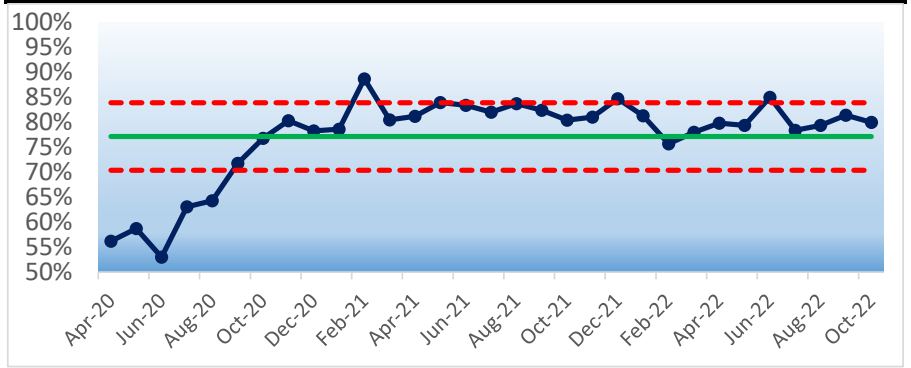
This is below pre-Covid levels - the average per month in 2018/19 was 270.

Indicator	**6.9 - Theatre utilisation (elective sessions)**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Oct-22
Value / RAG rating	80.0%

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

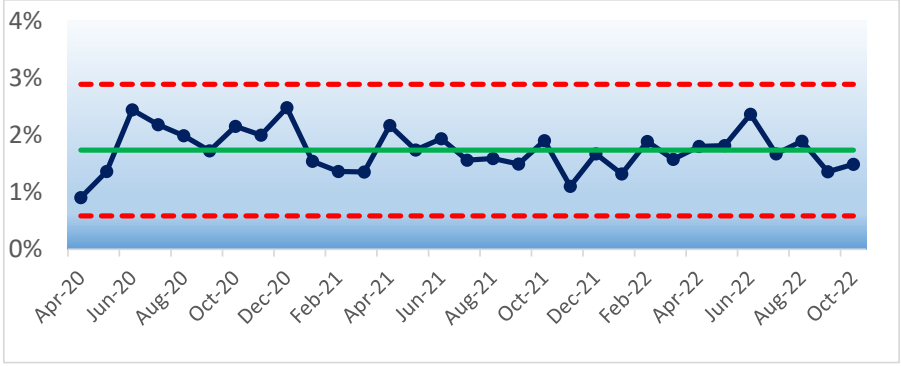
Theatre utilisation was at 80% in October, remaining below the local intermediate target of 90%.

Indicator	**6.10 - Day case conversion rate**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Oct-22
Value / RAG rating	1.5%

Indicator description

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

SPC chart



Narrative

1.5% (36 patients) of intended day cases stayed overnight or longer in October, an increase on last month but remaining within the control limits.

Integrated Board Report - October 2022

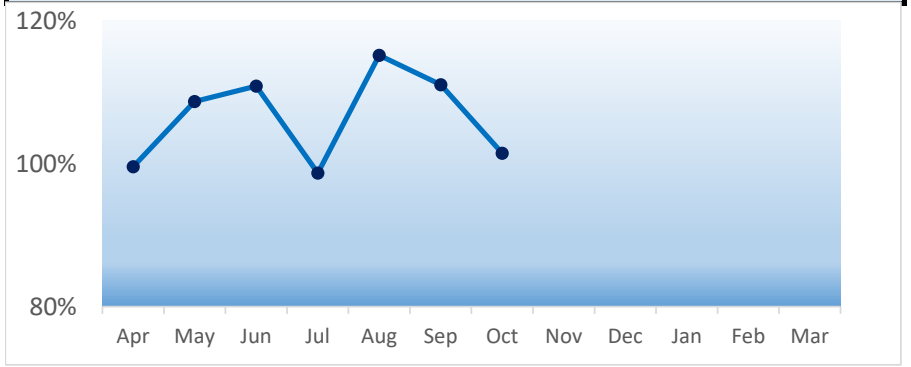
Domain 7 - Activity

Indicator	**7.1 - GP referrals against 2019/20 baseline**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Oct-22
Value / RAG rating	101.5%

Indicator description

GP referrals against 2019/20 baseline.

SPC chart



Narrative

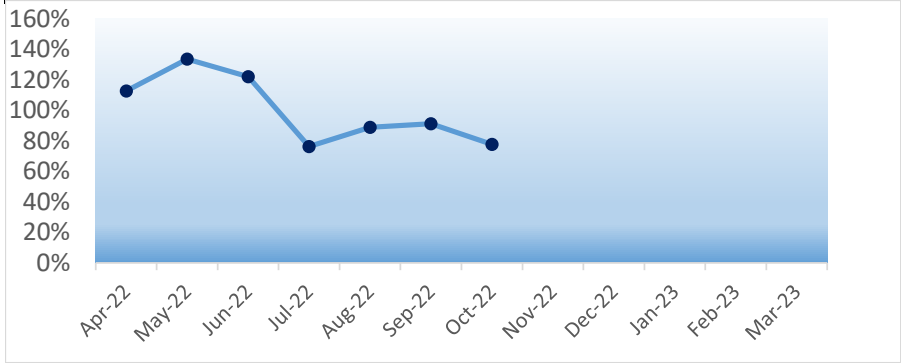
In October, GP referrals were 1% above the equivalent month in 2019/20.

Indicator	**7.2 - Outpatient activity (consultant led) against plan**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Oct-22
Value / RAG rating	77.7%

Indicator description

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

Trend chart



Narrative

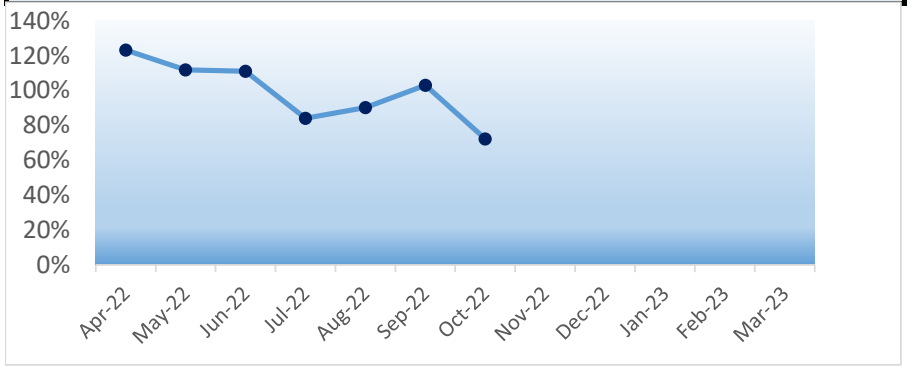
Outpatient activity was 22% below plan in October. New outpatient attendances were 32% below plan and follow up attendances were 17% below plan.

Indicator	**7.3 - Elective activity against plan**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Oct-22
Value / RAG rating	72.3%

Indicator description

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

Trend chart



Narrative

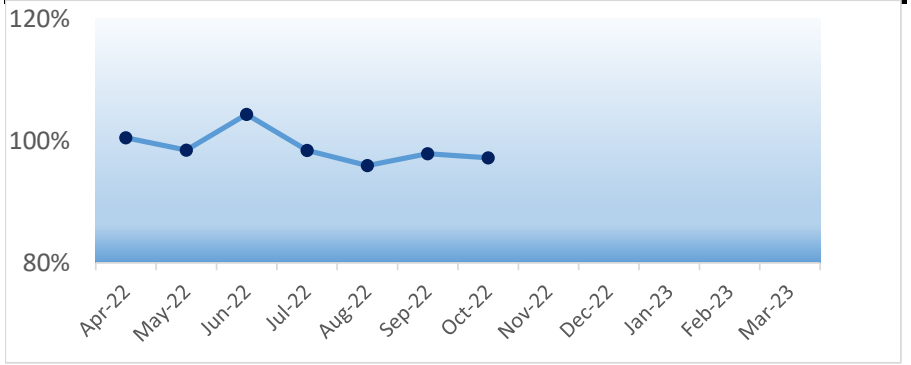
Elective admissions were 28% below plan in October. Elective day cases were 27% below plan and elective inpatients were 33% below plan.

Indicator	**7.4 - Non-elective activity against plan**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Oct-22
Value / RAG rating	97.2%

Indicator description

Non-elective activity against plan.

Trend chart



Narrative

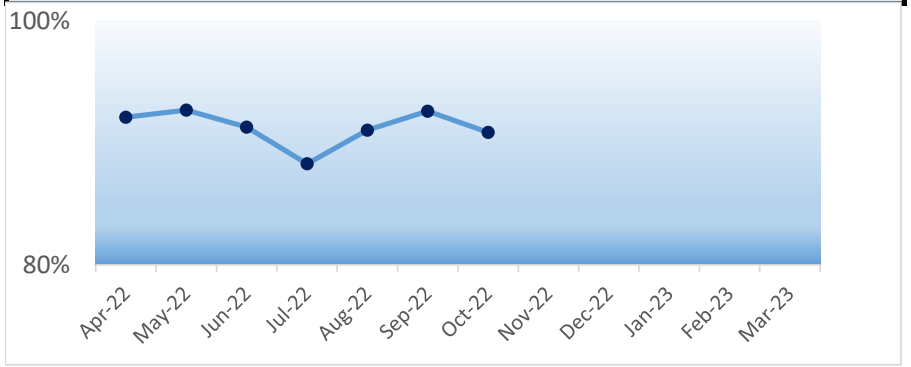
Non-elective activity was 3% below plan in October.

Indicator	**7.5 - Emergency Department attendances against plan**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Oct-22
Value / RAG rating	90.9%

Indicator description

Emergency Department attendances against plan.

Trend chart



Narrative

Emergency Department attendances were 9% below plan in October.

Integrated Board Report -October 2022

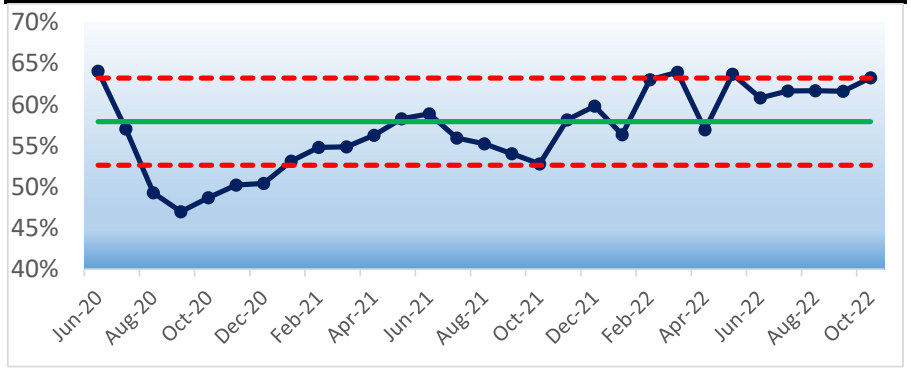
Domain 4 - Workforce

Indicator	**4.1 - Staff appraisal rate**
Executive lead	Angela Wilkinson
Board Committee	People and Culture Committee
Reporting month	Oct-22
Value / RAG rating	63.3%

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 October is 63.3%, which is an increase in comparison to September(61.6%). All Directorates, with the exception of LTUC, have seen an increase in appraisal rates this month. PSC Directorate saw the greatest increase in appraisal compliance from 46.9% in September to 53.0% in October. LTUC Directorate saw a minimal decrease in appraisal rates from 61.6% to 61.5%.

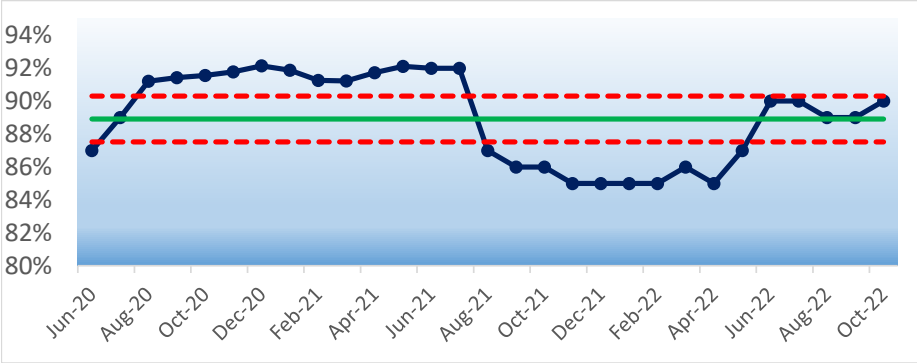
- Non-Medical appraisal % = 62.3% (previous month 60.3%)
- Medical appraisal % = 74.3% (previous month 77.6%)

Indicator	**4.2 - Mandatory training rate**
Executive lead	Angela Wilkinson
Board Committee	People and Culture Committee
Reporting month	Oct-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 October for the Mandatory Core elements of training. The overall compliance rate for substantive Trust staff has risen by 1% to 90%.

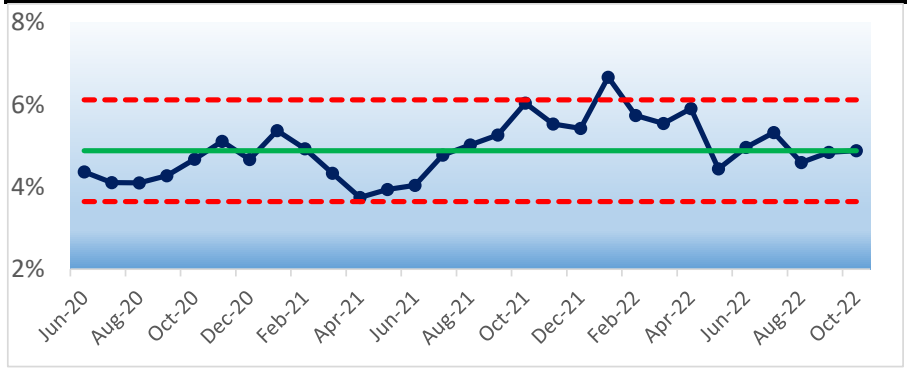
The Mandatory Core overall compliance for bank staff is 78% remaining the same as the two previous months. The overall compliance for Mandatory core and role based training for Trust substantive has also risen by 1% to 84%.

Indicator	**4.3 - Staff sickness rate**
Executive lead	Angela Wilkinson
Board Committee	People and Culture Committee
Reporting month	Oct-22
Value / RAG rating	4.9%

Indicator description

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

SPC chart



Narrative

Sickness remains high in October and has seen a slight increase this month from 4.8% to 4.9%. Covid sickness absence has seen a decreasing trend and the rate in October is 0.6%, which accounts to 11.7% of the overall sickness in the month. Excluding Covid related sickness, the Trust's sickness rate is 4.3%, which is an increase from 4.2% last month.

Long term sickness remains at 2.6%, however short term sickness has seen an increase from 2.2% to 2.3%.

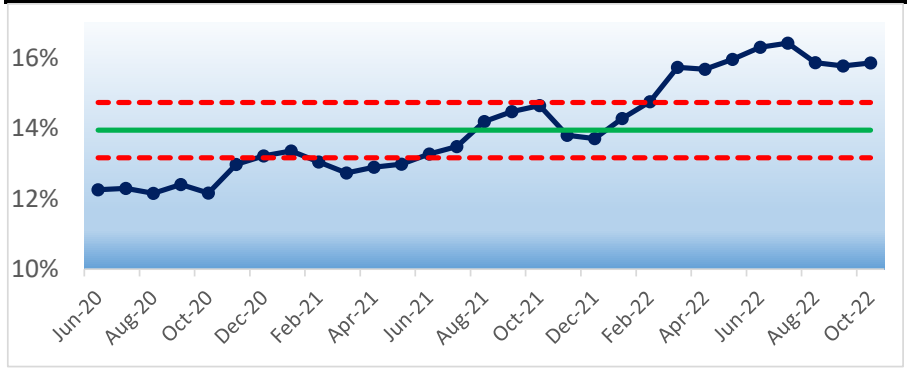
CC Directorate currently has the greatest sickness rate of 5.3%, however this is a decrease from 5.4% in last month. "Anxiety/stress/depression/other psychiatric illnesses" remains the top reason for sickness this month and contributes to 29.4% of the overall sickness. 104 employees were absent due to this reason in October.

Indicator	**4.4 Staff turnover rate**
Executive lead	Angela Wilkinson
Board Committee	People and Culture Committee
Reporting month	Oct-22
Value / RAG rating	15.9%

Indicator description

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

SPC chart



Narrative

Turnover had seen a decreasing trend since July, however October's turnover has increased slightly from 15.7% to 15.9%. Involuntary termination turnover remains at 3.5%. Voluntary termination turnover has increased from 12.3% last month to 12.4% in October.

With the exception of LTUC, all directorates have seen a decrease in turnover rates in October. LTUC's turnover has increased from 14.8% last month to 15.8% in October. Turnover remains higher than expected in PSC Directorate, with a rate of 18.1%, however this is a decrease from the previous month of 18.4%.

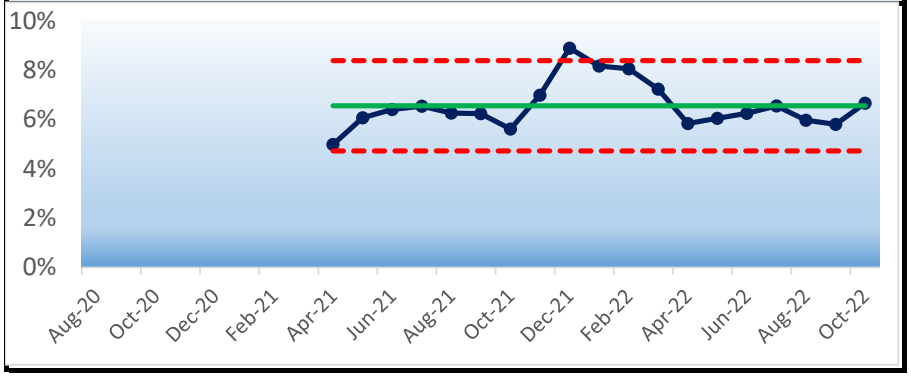
Of the October leavers (49.56wte), 9.38wte were Health Visitors, of which almost half were due to retirement age and 6.77wte were CSWs on inpatient wards. The 'Additional Clinical Services' staff group remains the staff group with the highest turnover rate, which is 20.0% in October (19.4% last month). The areas which saw the greatest increase in turnover this month within this staff group were Pharmacy and Maternity Services.

Indicator	**4.5 - Vacancies**
Executive lead	Angela Wilkinson
Board Committee	People and Culture Committee
Reporting month	Oct-22
Value / RAG rating	6.7%

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 October is 6.7%, which is an increase from 5.8% from the previous month. This equates to 288.78wte vacancies. The vacancy data includes the 0-19 Wakefield Children's Services from October following the TUPE transfer to the Trust.

PSC and LTUC Directorates have the greatest vacancy rates of 10.2% (104.69wte vacancies) and 9.5% (106.70wte vacancies) respectively. PSC has seen a decrease in vacancies this month from 11.5% to 10.2%, however LTUC has seen an increase from 8.0% to 9.5%.

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

Date	**04/10/2022**	**Location**	Microsoft Teams
Chair	**Julian Hartley**	**Minutes prepared by**	Hayley Conlon
Attendees	Julian Hartley (LTHT), Chair Jonathan Coulter (HDFT) Anna Basford (CHFT) Foluke Ajayi (ANHST) Mel Pickup (BTHFT) Lucy Cole (WYAAT)		
Apologies			

Agenda

ITEM		WHO
2	Review previous meeting minutes and action points	Chair
3	WYAAT Collaborative Programme Report • NSO update • Haematology	Lucy Cole
4	West Yorkshire HCP Report	Lucy Cole
5	Pharmacy Aseptics OBC • Support process to progress to WYAAT CIC	Phil Deady
6	Winter Planning	All
7	ICS Strategy development	Gary Cooper & Ester Ashman
8	Follow-up from WYAAT Exec Time-out • Key themes • Next steps / follow-up actions	All
9	Revised clinical leadership proposal	Lucy Cole/All
10	Committee in Common Agenda	All
11	AOB	All

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

West Yorkshire Association of Acute Trusts

NHS

PREVIOUS MEETING ACTION POINTS			
Category	Action	Status/Update	Lead

By Agenda Item	Main Points and Decisions from Discussions	Agreed Actions
Review previous meeting minutes and action points	The minutes from the previous meeting were accepted as a true record.	
WYAAT Collaborative Programme Report • NSO update • Haematology	Julian Hartley (JH) recognised the visit on elective recovery and praised the colleagues involved in the work. Lucy Cole (LC) gave the following updates: • Good progress on digital deployment. • LIMS – ANSHT & BTHFT go live on 1st November. • Inventory management system S4S – all trusts will be live by the end of March. • S4S will become a network from a programme as of March 2023. • Planned Care – Theatre workforce session yesterday with good attendance, timeout couple of weeks ago looking specifically at outpatients. Putting in an approach for outpatients to look at potential opportunities for best practice work and mutual aid. • Bid for funding around mutual aid. • NSO – got delivery group established & trying to map out how we start to balance between sectors. • Neurology – programme been initiated, and workshop planned for next week. • CDC – all of business cases have been submitted.	**ACTION: LC and FA to develop presentation for the Regional recovery event in York**

	Event on 27th October focus of cancer and elective recovery, this event is organised by Jim Mackay. Expectation is that each system will do a presentation. Haematology review and recommendation was to pursue through place-based partnerships, Medical Directors & Chief Operating Officers have raised this is a high concern and wanted it escalated here. Engagement with Head of Operations is supported by the Chief Executives. Len Richards said there is issues in regard to north and south sector in relation to the NSO programme.	
West Yorkshire HCP Report	LC informed that YAS is recruiting 3 new partnership leadership roles and they will be taking a lead on strategic operational leadership. The group raised concern in being able to attend all the meetings.	
Pharmacy Aseptics OBC • Support process to progress to WYAAT CIC	Phil Deady joined the meeting. PD shared a presentation and informed the members that last year there was approval to go into phase one of the Pharmacy Aseptics. PD informed the members that Pharmacy has been identified 1 of 5 pathfinders in England and therefore received the funding. A full refresh of the business case has been done, with the still same outcomes and hub and approach but knowing the capital is over £15M a robust evaluation has been done of all the options considered. Programme Board came to the conclusion of preferred model, WYAAT groups have all been kept up to date. The recommendation from the Programme Board is option 3 which is the new facility at Leeds, this has the lowest 25-year overall risk adjusted cost1 - £296m vs £327m of the next best option, has the lowest workforce requirement (having available workforce for these models is recognised as a significant risk nationally) – this accounts for a c. £1.65m per year revenue cost difference between option 3 and the next best option, has the highest incremental production capacity and requires the development of a single facility rather than two separate sites. PD expressed they are seeking several recommendations in order to proceed to the WYAAT Committee in Common in a couple of weeks' time. It is recommended that WYAAT Programme Executive: • Confirms its support for the recommended option (Option 3) as the basis for finalising the outline business case for the WYAAT pharmacy Aseptics service.	

	• Devolves sign-off of the final document to the WYAAT Pharmacy Aseptics Board, with SRO Jonathan Coulter confirming the final case on behalf of WYAAT Programme Executive. • Subject to confirmation of the final OBC, support to submit the OBC to WYAAT CIC on 25 October 2022, and to NHS England and WYAAT Trust Boards thereafter. Len Richards asked if it will come to capital infrastructure board. It was confirmed that it will. Mel Pickup said BTHFT need a resilient spoke. MP asked about ownership and the labelling of the unit. Charlotte Cleveland said that due to risk and security that she imagines no logo or name will be put on the unit. PD confirmed that this is West Yorkshire. The OBC will go to Committee in Common then to NSH England and trust boards in parallel. MP asked if there is going to be workforce movements, LC said its new workforce, CC said that what workforce would be needed has been planned, there is a designated workforce sub group looking into this. A workshop is being hosted later this week with national and regional colleagues joining. JH highlighted that all pharmacy colleagues involved in this should be praised. The members support the recommendations and are happy for this to proceed to the Committee in Common.	
Winter planning	• LTHT – got a winter plan, session last week at Board where social care and Tim Riley attended where a tough but important conversation was had in terms of having big gaps on handling the issues. Biggest challenge is reason to reside and out of hospital care. • BTHFT – Rob Webster quoted the regional director public of health around the expectation due to COVID. In Bradford – Expectation to have more latitude than they do have. • MYHT – perspective around local authority looking to take money out of under capacity in terms of delivery of social care requirement. • HDFT – work on community service and safeguarding children – have experience in how to do this but doesn't take away the risk. • ANSHT – Need to speak with Public Heath colleagues about the messages that are said about COVID during the winter.	

	• CHFT – similar to other trusts, exploring what they can do on domiciliary care but there is a financial challenge in system. Len Richards raised they have people in critical care in MYHT due to COVID. LC said that the COO's have had a meeting about winter planning, and looking at trying to have an escalation framework whereby if they get to a certain stage do they reinstate WYAAT gold. Trudie Davies is trying to link into wider UC programme.	
ICS Strategy development	Gary Cooper & Ester Ashman joined the meeting. Changes: • Tackling poverty • Strengthening young people & families. • Refining climate change • Approach to end of life care • Access to services. MP thanked for the presentation and said its right to point out we heard this in many forums, but the reality is each time you are presented people may be sat with a different hat of representation. JH supports work around strategy and Gary Cooper will keep us involved from WYAAT perspective and added it would be great to have WYAAT support and participation in the delivery.	
Follow-up from WYAAT Exec Time-out • Key themes • Next steps / follow-up actions	Colleagues from across WYAAT Executive teams came together for a 'time out' session on 6 September 2022. The purpose of the session was to reflect on the experience, successes and learning of collaboration since WYAAT was established in 2016 and consider our focus for the next five years, to inform a WYAAT Strategy. The session was structured around the following: • Lessons learned from WYAAT collaboration • Developing the Strategy (with a focus on service planning and delivery) • WYAAT efficiency opportunities • Collaborative workforce opportunities • Future ways of working.	**ACTION: LC to bring a draft of the WYAAT Strategy to Programme Executive in January**

	Efficiency Strategy • Focus on the link to quality (improvement) • Workforce – talent bank/new models of care (link to WYAAT strategy) • Shared digital resource/expertise • Maximising current workforce / resources • Procure 'internally'. Workforce • Focus on supply as opposed to demand • Maintaining talent at the end of careers – offering a portfolio career proactively and early, with collaboration enabling a broader range of opportunities • Test, learn and spread approach e.g., pilot different models / skill mix and share the learning • Leadership and talent management Future ways of working • Greater focus on multi-professional working at executive level outside of formal programme structures • Opportunities to come together as a group of executive teams once or twice a year • Opportunities to come together with other sectors – leadership role in driving this discussion • Structure to oversee and manage networked services collaboratively. Actions There are a series of priority actions / next steps to inform our Strategy and workplan: • Agree an approach to how we grow our clinical networks and other peer groups below executive level, creating relationships with a focus on learning and improvement, with an established network to respond to service fragility where needed. Consider how a revised clinical leadership model can support this approach. • Establish working groups of cross-functional executives on specific issues as required (outside of formal programmes)	

	• Design approach to sharing intelligence on services to inform the workplan with a focus on innovation and improvement, as well as fragility • Develop and approve approach to operating WYAAT operational delivery networks • Agree workforce priorities • Finalise efficiency strategy with agreed priorities for collaboration. • Set-up a further all executive session in April 2023 to set priorities for 23/24.	
Revised clinical leadership proposal	A revised proposal has been drawn together following a meeting between the WYAAT Medical Lead, WYAAT Director and Chair of the WYAAT MDs group: • Operational networks – clinical leadership should be at the appropriate delivery unit / sector level, through the lead provider, with close working across sectors where required. Programmes and projects – additional PAs are made available (up to two per trust) to identify leads to support specific programmes or initiatives as these arise. The expectation is that these PAs would fund input from Deputy MDs, Associate MDs (or equivalent) to provide clinical leadership capacity, rather than subject matter expertise. These would be identified as required according to current priorities.	
Committee in Common Agenda	The members noted the Committee in Common agenda.	
AOB	Foluke Ajayi highlighted the ongoing challenges with the building at ANHST. The challenge they are experiencing is in addition to RAC issues, and now more issues arisen some near misses. It has been escalated to ICB and ask for support. There is another work in regard to emergency response, there is a chance this could happen in the next few years in terms of the building not being fit for use for the work. LR said he will get Foluke Ajayi to the capital infrastructure board.	**ACTION: LC to work with Fran Hewitt at ANHSFT to update the risk register in relation to the RAAC issue at AGH to ensure consistent description** **ACTION: LR and FA to discuss if update on RAAC needs to be brought to ICB Capital and Infrastructure Board**

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

OTHER ISSUES TO NOTE
NA

NEW RISKS/ISSUES RAISED
NA

Next Meeting	**WYAAT Programme Executive**		
Date	01/11/22	**Location**	MS Teams

Humber and North Yorkshire
Health and Care Partnership

Collaborative of Acute Providers (CAP) Board Meeting
26th September 2022 10.30 – 12.30
Via Teams

Those Present:	Chris Long (CL), CEO HUTH (Chair) Wendy Scott (WS), COO, Y&STFT Ivan McConnell (IMc), Director of Strategic Development, NLaG Jonathan Coulter (JC), Acting CEO, Harrogate Matt Graham (MG), Director of Strategy, Harrogate Andy Bertram (SB), Chief Financial Officer, York Shaun Jones Locality Director, NHSE, Shaun Stacey (SS), COO (NLaG), Peter Reading (PR), CEO, NLaG
In Attendance:	Carla Mitchell, (CM) Executive Assistant (Note Taker) Shauna McMahon (SMc) Chief Digital

1 **Apologies:** Simon Morritt, CEO Y&STFT
Simon Cox (SC), NHS Place Director – East Riding of Yorkshire
East Riding of Yorkshire Health and Care Partnership
Michelle Cady (MC), Director of Strategy and Planning, HUTH

2 **Minutes of the meeting held on the 25.07.22**
Wording amending to paragraph 2 page 2 to be rectified. Once amended, the minutes were approved as an accurate account of the meeting.

3 **Action Log from 25.07.22**
Action log will be updated and available at the next meeting.

4 **Digital Update**
SMc gave an overview of the digital mission, to *deliver digital and information services and solutions that enable citizens to: start well, live well, age well and end their lives well.* SMc shared the rationale for the need for digital and how it is a 'Super Enabler' to enable a joined up heath and care service with the ultimate aim of giving our patients confidence that all their information is easily and quickly accessible by the right care professionals.

SMc shared the details of how the ICB Digital Strategy is being developed within the HNY ICB and what the Digital Strategy priorities are. She shared the solutions and Initiatives for *Digital Inclusion, End of Life Care Planning and Full System Planning.* In terms of digital prioritisation, SMc shared a matrix of what this process may look like ie digital support request, how it is assessed and the following up actions.

SMc concluded that with System wide collaboration and shared digital priorities, HNY can greatly improve health and care delivery.

A discussion ensued around prioritisation and how as a system we need to work more collaboratively to figure out what the priorities are. SMC added that there is currently a lot of requests from PLACE, local Trusts, Acute

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Collaborative' s etc which proves that these requests must follow an assessment process so that they can be put into a list and prioritised.

CL showed concern of where all of this is being 'held' together?
SMc agreed that there is still work to be done in bringing the collaboration together and managing requests as the ICS is not quite there yet in terms of how those decisions are being made. This is in the portfolio of Dr Nigel Wells, SMc to give Nigel the heads up on this discussion and to advise him that he is to be invited to the CAP Board in order for the group to share their concerns. **SMc/WS/CM**

The Board agreed that there is a requirement to escalate to the ICB that they need to revisit its digital strategy approach**.**

WS updated on the acute OPTICA work, sponsored via CAP. Wendy Scott is SRO on behalf of the 4 Trusts. Functionality assessments are to take place to assess current functionality of Trust systems vs that offered via OPTICA. In this way it will help to better understand the offer and the benefits of the proposed tools. SE is keen to pursue therefore the functionality assessment is important in order to determine what OPTICA has/can offer.

A discussion ensued around the importance of understanding the digital priorities in terms of Emergency Care, Elective work streams (including diagnostics) so a coherent and credible plan can be developed as something that CAP can sign up to. These will then become the digital priorities for the collaborative.

It was discussed and agreed that it should not be digital that agree the priorities list but that each organisation needs to be clear what its priorities are and then look at what we do as a collaborative and extend that then to what we do as a system

WS advised that she is planning to develop an assurance framework which will support what and how we report on performance and improvement in relation to the key programmes of work that CAP will have oversight of. Lynette Smith has been released from York 2 days a week.

PR suggested that Andy Williams, ICS CHO should also be invited to the CAP Board so that the Board can engage with himself and Dr Nigel Wells in order that the Board can explain its concerns. This was unanimously agreed. **WS/CM**

5 Director of CAP Update

WS shared an update on the CAP OD Programme (Workshop 2 to be held on the 7th October) and the work that is being developed for discussion ie *A CAP purpose statement, key priorities, CAP Governance arrangements, the CAP approach to communications and Future organisational development priorities.*

WS gave the details on the purpose of the CAP, the emerging priorities and what the draft architecture looks like in terms of how the H&NYCAP Board links into the H&NY Integrated Care Board and Acute Trust Boards (this is work in progress). WS added that It is intended that the emerging priorities are signed **ALL**

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off on the 7th October. WS asked for any final comments or feedback, to be shared ahead of the 7th.

WS advised that the draft architecture has not been formally signed off, nor the governance arrangements yet, however there is an emerging architecture to CAP that we are beginning to work on. WS added that we have our own CAP Board so the plan would be to define the membership of that once our formal governance arrangements are signed off and potentially stand up a programme executive that would have oversight of all CAP work Programmes. WS gave the details of the proposed professional partnership groups and noted that we are beginning to see an emerging model that we can build on and formalise as a result of the governance arrangements that are being worked on.

WS confirmed that the CAP has agreed to lead and deliver a number of programmes on behalf of the HNY system, these are Elective, Diagnostic, Urgent and Emergency Care and hosting the Cancer Alliance. Supporting Programme Director posts are being appointed to support these programmes. WS gave the details.

Discussions are underway in relation to the hosting of clinical networks aligned to system programmes and/or key strategic work areas. WS gave the details and noted that she is really keen to get those clinical networks (in terms of the programmes that are working better) aligned to the programmes of work that we need to deliver on.

WS shared the details of the Oversight of H&NY system programmes. She advised that if the CAP Executive Group is stood up, there will be 3 programme directors attached to the programmes. WS added that if we appoint a CAP core team, within that CAP core team could be this role but also admin and BI support as well. She added that the plan is to have a Deputy post that leads on planning and assurance.

A conversation ensued around the funding of posts and the importance of ensuring that resource is aligned.

WS advised that the next steps for consideration by CAP Board are:-

1) Confirm CAP funding/resources – yet to be confirmed how the CAP is going to be resourced going forward.
2) Confirm workforce hosting arrangements (& nominate HR support) – it was discussed that this should be hosted by an Acute organisation and should not be part of the ICB.
3) Appoint to CAP core team – ICB to go out to consultation to those CCG staff of where they have been placed/slotted in to.

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SMc raised that in terms of the governance around diagnostic imaging there isn't any clarify of how this is being looked at in terms of the overall strategy, and what internal support there is for it. **WS and SMc to discuss offline.** **WS/SMc**

JC suggested that the next steps for consideration should be looked at in a slightly different order adding that we should look at point 2, 3, and then 1 to

confirm the funding. He added that if we wait to confirm funding we will be in stagnation for some time. The Board agreed.

AB raised that WS has a core team structure so taking JC's point, the CAP Board needs to sign off that structure now to enable work to commence. He noted that in terms of the funding, there is still a debate going on with the ICB to make sure we can secure the funding that we are hoping to receive. AB gave the details and noted that Acute Finance Directors are sighted on what these sums are and that he is working on a way of funding the core team however if the CAP board is signing off WS's core team structure then by definition the Board is agreeing to underwrite the costs associated.

The Board confirmed approval/support of the core team structure and formally signed this off. It was also agreed that York will be the host Trust for the CAP.

A discussion ensued around the networks and how they need to involve all of the players in the system in order to get into the delivery of the programmes. WS confirmed that herself and Anil have met with the regional specialist commissioning team and others and that they are happy to work along-side us. Conversations are underway on how programmes of work are devised that sit with those networks that are more closely aligns to local authorities

WS concluded that discussions have not yet taken place regarding appointing SRO's from within our groups to the networks. WS to pick up **WS**

6 CAP Strategy – Scope/approach/timing

IMc shared an overview on suggested thoughts for the CAP Acute and Planned Care Strategy – Approach/Risks

IMc confirmed that a Strategy Directors Group is being established and that this group will work with the COO group every three months and establish an overarching programme to develop a CAP strategy by the end of March 2023. IMc advised that this is going to be complex due the environment and that the ICB is still evolving its own strategy which will not be complete until October 2023 however there is still an indicative strategy from October this year

IMC advised that:

- There will be an initial stocktake in order to understand where people's priorities are, what the organisational strategies are, what some of those network strategies are, and where there are overlaps in order to create a map of where the system is. A team will be set up to do this work.
- There will be a range of engagement events/work groups that will be established post the October session.
- There will be a dependency mapping exercise undertaken in order to understand the issues
- A prioritisation matrix will be created looking at what will drive our priorities which will then be agreed as a Board and then fed back into the system
- IMc gave the details around financial support and added that there is a strategic capital issue before we start so we need to work through what

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the implications are for the service delivery moving forward, what are the priorities and how we are to resource this. A strategy will be produced end of March 2023.

In terms of risks, IMc shared the details that the major risks on the potential group structure are timing issues associated with strategic capital investment, and that performance needs to be factored into this.

A discussion ensued that it is important to manage the CDC's. IMc gave the details that the programme is not well structured. IMc confirmed that he has picked this up with the SRO and the Safe Bank for CDC's. IMc concluded that it is about getting these dependencies right and getting clarity that know where we are going and where investment is going to be.

PR noted that it is important to connect with 'place' at an early stage so that we connect in with local initiatives to ensure no duplication. PR suggested that Place Directors join us in shaping this strategy to align with their strategies and priorities. IMc has already had initial discussions with Place and is in the process of establishing a reference group.

The board signed up to the proposal and time frame. IMc agreed to establish the working group and bring back to a post August session, the timeline, plan and activities **IMc**

8

7 Elective/Diagnostic Programme Update

SS shared that it is recognised that there is a need to work together on the elective programmes and confirmed that:-

- Although the number of 104 week waits has reduced considerably, there is still work to do to get that concluded however this is on trajectory to close by September
- Outpatients has seen an improvement due to the use of technology to support outpatients, advice and guidance
- Work is continuing on the long elective waiting list patients and that this is the next milestone for the 78 week waits and above. SS added that there are a lot of patients on this list including a number of 52 week.
- There is real challenge around the growth of diagnostic demand therefore some of the challenges are around diagnostic capacity.
- Activity to the end of March – working on delivery around the 78 week waiters, the ongoing improvement in diagnostics and the reduction in waiting lists overall across the piece is our objective. SS shared how this is going to be achieved.
- Work has started in the Humber looking at the ability to do a high volume, low complexity hub with the intention of opening a hub by December and a second one in Mid Feb. The locations are still being discussed.
- Continuation of the mutual aid programme, this will be done at ICS level SS gave details of the work done to date.
- By the end of October there will be a plan re transitioning work into other locations

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- Waiting well - SS advised that there is a high volume of patients on the 'waiting well' list and that joint MD's have looked at a solution however as part of the hub, it will be about how we can support the management of the waiting well. SS shared the details.
- Funding asks – SS advised we need to financially support the hubs and a bid has been submitted. SS added we should get some money to the end of March but we will need to recurrently fund that to work on how to build the hub beyond the end of March. Funding is also required to enable us to move forward re waiting list management, we are going to need clinical networks and clinical leads to step into those leadership roles. SS added that he needs funding to support the staffing requirements and gave the details. WS and AB are aware of this ask and the need to quantify what this looks like with the 4 networks and agree that this will be the model going forward.
- Diagnostics – continue the long term aim around workforce and workforce management
- Productivity – we have got to push up the productivity piece around reporting as well as access to the short term CSC solution.

A discussion ensued regarding data sharing and that it needs to be transformed into data that is telling us where we need to be going. The Board agreed.

8

SS advised that Professor Briggs (GIRFT) is coming back on the 9th November to do an ICS GIRFT review of the programmes. Anil has begun preparations looking at what has been delivered against the asks in the plan. WS to share the plan with Board for information **WS**

WS advised that she has spoken with Dr Nigel Wells regarding engaging with GPs re managing demand across all the programmes as there is a risk that with the CCG's disbanding, that some of the networks may not be as robust as they were. WS gave examples and added that we need to understand what is driving demand and have robust discussions with GP colleagues. There is also the issue of clinical leadership and how these programmes, whilst they sit under CAP, require the clinical leadership of all parts of the patch including GP's. Dr Nigel Wells has given assurance around the structure that he is putting in place and that there will be named individuals at Place. WS to keep the Board updated.

CL concluded that there is a requirement for Clinical Leadership to make this happen and noted this will come at a cost. SS is going to work to identify with colleagues what the cost is going to be and come back to the Board. All agreed. **SS**

8 Governance Update

WS advised that there is nothing further to add to the update given earlier in the meeting. She noted that the Governance paper will be completed by the 21st October.

9 Time Out Session on the 7th October

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WS advised that she is in the process of finalising the agenda/arrangements and gave the Board a brief rundown of the day's plans.

10 ICB Responsibilities Agreement

WS advised that she has discussed with S Eames, working with Robert McGough to help us do a piece of work around what a responsibilities agreement may look like, what we would like to see in this agreement along with confirmation of resources. WS asked for the approval of the CAP Board. Board members agreed with this approach. CL concluded that the document is work in progress and will become more refined in time.

11 Finance and Procurement

AB advised that as an ICB we are reporting an 8.5m adverse variance from plan. AB shared the breakdown and noted the adverse positions are being reported in all of the acute trusts, with bed pressures and efficiency target shortfalls being the main reasons. The ICB as the commissioner is reporting a balanced position however there is pressure on the wider ICS as it is all sitting within the providers.

Issues to highlight:

- Pay award funding looks like it is going to be short across our patch. The modelling that has been done as providers, is 5m short as a system. This is being fed into national discussions. He advised that the national team are likely to be waiting to see what actually goes through the ledger at the end of this month before having a view to articulate. AB added that this will be kept under review.
- There is still no clarity on what is happening with Elective Recovery Funding (ERF) in the second half of the year. We do know that it is not being recovered therefore we may have to move some money around the system. Still awaiting the national view on ERF however AB advised that the Treasury are wanting to keep hold of the use of the ERF funding in the second half of the year.

AB confirmed that in terms of capital positions, the capital total plan is a £152.3m programme that we are all managing between us this year from various sources. There are no issues to notify the Board on this at this point. Forecast out turn on the revenue side is still forecasting we are going to be on balance.

AB advised that following the national meeting this morning, we can expect more scrutiny to start around finances from both the ICB and from NHSE also

AB concluded that the key message is that there is growing concern both nationally and regionally around general finance performance in the provider sectors.

CL showed concern around the national silence on the financial position adding that you would expect at this stage of the year for some real concerns to be starting to come out. SJ advised that unfortunately the detail around the announcement last week for 500m for social care, is at this stage limited however it is not new money it is recycled money so it is not clear where this is

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coming from and whether it will be channelled through ICB's or Local Authorities as an extension of the better care fund

12 Any Other Business

There were no further items of business

Date and Time of the Next Meeting

24.10.22

10.30 – 12.30 via teams