COUNCIL OF GOVERNORS' MEETING (held in PUBLIC)

Monday 5th December 2022 from 2:00-3:30pm
To be held at the Crown Plaza, Harrogate

AGENDA

Item No.	Item	Lead	Action	Paper
1.0	**Welcome and apologies for absence** *Welcome to the public, set the context of the meeting and receive any apologies for absence.*	Sarah Armstrong Chair	Note	Verbal
2.0	**Declarations of Interest** *To declare any interests relevant to the agenda and to receive any changes to the register of interests*	Sarah Armstrong Chair	Note	Verbal
3.0	**Minutes of the meeting held on 06th September 2022** *To review and approve the minutes*	Sarah Armstrong Chair	To Approve	Attached
4.0	**Matters arising and Action Log** *To receive updates on progress of actions*	Sarah Armstrong Chair	Note	Attached
5.0	**Chairman's update** *To note*	Sarah Armstrong Chair	Note	Verbal
6.0	**Annual report and annual accounts**	Azets	Note	Verbal
7.0	**Non-Executive Directors Briefings** *To receive updates*	Non-Executive Directors	Note	Verbal
8.0 **8.1** **8.2**	**Chief Executive and Executive Director strategic and operational update** **Integrated Board Report** **Questions from Governors**	Executive Directors Executive Directors & NEDs	Note	Verbal Attached Verbal
9.0	**Any other relevant business not included on the agenda** *By permission of the Chair*	Sarah Armstrong Chair	Note	Verbal
10.0	**Evaluation of meeting**	Sarah Armstrong Chair	Note	Verbal
11.0	**Date and Time of Next Meeting** Tuesday, 7th March 2023 4:00-5:30pm Venue: TBC	Sarah Armstrong Chair	Note	Verbal

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Council of Governors' Meeting (held in Public)

Minutes of the public Council of Governors' meeting held on 6th September 2022 at 4.30pm at The Cedar Court Hotel, Harrogate

Present:
Sarah Armstrong, Chair
Clare Illingworth, Stakeholder Governor & Lead Governor
Donald Coverdale, Public Governor
Tony Doveston, Public Governor
Sue Eddleston, Public Governor
Doug Masterton, Public Governor
Kathy McClune, Staff Governor
Richard Owen-Hughes, Public Governor
Prof. Karen Stansfield, Stakeholder Governor
Steve Treece, Public Governor
Ian Barlow, Public Governor
Richard Sweeney, Public Governor
William Fish, Public Governor
Jackie Lincoln, Public Governor

In attendance:
Jonathan Coulter, Acting Chief Executive
Emma Edgar, Clinical Director, Long term & Unscheduled Care Directorate (LTUC)
Matt Graham, Director of Strategy
Jordan McKie, Acting Director of Finance
Russell Nightingale, Chief Operating Officer
Emma Nunez, Acting Deputy CEO & Executive Director of Nursing, Midwifery and Allied Health Professionals (AHPs)
Andy Papworth, Non-Executive Director
Laura Robson, Non-Executive Director
Kate Southgate, Company Secretary
Richard Stiff, Non-Executive Director
Maureen Taylor, Non-Executive Director
Angela Wilkinson, Director of Workforce & Organisational Development
Jeremy Cross, Non-Executive Director-
Wallace Sampson, Non-Executive Director
Juliette Harris, Executive Assistant to Chief Executive and Chair (Minutes)
Hannah Cummins, Administration Assistant

COG/09/2022/1.0 Welcome and apologies for absence

The Chair, Sarah Armstrong, welcomed everyone to the meeting and began by welcoming all new Governors to their first Council of Governors meeting. A warm welcome was also extended to those new Governors not in attendance at the meeting.
Sarah Armstrong went on to note many questions had been received from the Governors to be addressed later on in the meeting and this would be done in a slightly different fashion to previous meetings in order to encourage a more relevant discussion.

Apologies were received and noted from the following: Andrew Jackson (Staff Governor), Maureen Taylor (Non-Executive Director), Kathy Gargan (Public Governor), Sue Lumby (Stakeholder Governor), Stuart Wilson (Staff Governor), Jackie Andrews (Medical Director), Natalie Lyth (Clinical Director for Children's and Community Directorate), Kat Johnson (Clinical Director for Planned and Surgical Care Directorate), Cllr John Mann (Stakeholder Governor).

COG/09/2022/2.0 Declarations of Interest

No declarations of interest were noted.

COG/09/2022/3.0 Minutes of the last meeting held on 7th March 2022

The minutes of the previous meeting held on 7th March 2022 were agreed and approved as an accurate record.

Resolved: The minutes of 7th March 2022 were approved as an accurate record.

COG/09/2022/4.0 Matters Arising and Action Log

The open actions on the Action Log were reviewed in turn:

COG/12/2021/10.1 Q&A Session – Glaucoma waiting times:
It was noted a plan has been formulated to reach the revised target date in December. The backlog has decreased but there continues to be a high referral rate system wide. Further strategic conversations are ongoing.
Item to remain open on the action log.

COG/12/2021/10.1 Q&A Session – Seating arrangements
Sue Eddleston confirmed a meeting had taken place with regards to available seating arrangements. Emma Nunez confirmed a variety of chairs and seating options were now available.
Item CLOSED

In relation to matters arising, Jordan Mckie updated the Council that new external auditors, Azets, had been commissioned. A number of Governors had been involved in the tendering process.
Richard Stiff, as Chair of Audit Committee, confirmed the process of appointing an external auditor had been difficult, however, Azets were eventually appointed and work has now commenced.

William Fish sought reassurance with regards to the process followed for involving Governors in the tendering process.
Jordan Mckie confirmed emails had been sent out to Governors seeking engagement.

There were no further matters arising or actions to review.

COG/09/2022/5.0 Chairman's update

The Chair began her update by noting this meeting as being the first opportunity to formerly thank the Council for her appointment to Chair of HDFT. Sarah Armstrong confirmed she was now in the process of undertaking a series of activities to understand current processes. Furthermore, Sarah Armstrong and Clare Illingworth are currently assessing the effectiveness of Governors and a Governor Effectiveness workshop had recently been held with NHS Providers, covering items such as what its like to be a Governor.

Sarah Armstrong thanked the Council of Governors for their time invested and a special thanks was also extended to ex-Governors, Doug Masterton and Dave Stott.

Resolved: The Chairman's update was noted.

COG/09/2022/6.0 Non-Executive Director Briefings

The Chairman confirmed the appraisal process for Non-Executive Directors (NEDs) had recently been completed and thanked everyone involved for completing the surveys. Feedback from the NED appraisals would follow at the next Council of Governors meeting.

Laura Robson (Non-executive Director) provided an update to the Council with regards to the Organ and Tissue Donation Committee, of which she is chair. Laura Robson confirmed she had taken over the role of chair from Chris Thompson and went on to update the Council as to the work being undertaken by the Committee. It was noted Sue Eddleston (Public Governor) also sits on this Committee as a representative of patient voices, and has done so for approximately 7 years. The Committee has two main aims: firstly, to ensure that everyone who meets the criteria for organ donation has been spoken with in relation to considering donation, and secondly, to raise the profile of organ and tissue donation and in doing so generate discussion about donation. To assist with this, a campaign is underway to promote Organ Donation week (19-25th September).

Sarah Armstrong thanked Laura Robson for this update and requested for the link promoting the Organ Donation week to be shared with the Council. (ACTION)

Donald Coverdale noted acute traumatic deaths may also be a source of organ donation, as well as those from managed deaths.
Laura Robson responded that a discussion had taken place around this and that the Trust had a good working relationship with the Coroner.
Sue Eddleston further noted that living donations may also be made in cases such as kidney donation.
Emma Nunez commented that raising the profile of organ donation and encouraging discussion was important, especially before families are faced with the trauma of losing a loved one and thinking about organ donation at this point.
Andy Papworth enquired where this Committee currently sits in regards to the quality assurance framework.
Emma Nunez confirmed the committee reported into the Patient Safety Committee, which reports into Quality Governance Management Group, which reports into Quality Committee.
William Fish enquired if HDFT have a good relationship with the coroner, does this present an opportunity to influence the message more widely on a national level.

Laura Robson confirmed Sarah Marsh was already in attendance at national meetings.
Sarah Armstrong commented the raised messaging would also help to raise the profile for the service within the regional system.

Jeremy Cross was invited to present a summary relating to Resources Committee to the Council.
Jeremy Cross began his presentation by confirming Resources Committee was a full sub-committee of the Board, meeting on a monthly basis to report on figures received from the end of the previous month's activity.
The focus of the committee is on three key areas: Firstly, the financial focus on the year to date; secondly, the operational focus, looking at items such as ED performance, referral to treatment times, cancer metrix, children's services; and thirdly, the human resource focus, looking at hotspots, if the right people are in the right place, areas of high turnover, agency and bank costs.
Further to these three main items, business cases may also be presented, along with comparative data from across the ICS.
Jeremy Cross further noted Resources Committee had good Governor representation.
Sarah Armstrong thanked the Governors who support this committee and asked if there were any further points to be raised in relation to this committee's work.

No further comments or questions were received.

The Chairman thanked the Non-Executive Directors for their updates.

Resolved: *The Non-Executive Director's updates were noted.*

COG/09/2022/7.0 Chief Executive and Executive Director Strategic and Operational update

Jonathan Coulter began his update by confirming the current focus within the system was on urgent and emergency care.
Jonathan Coulter want on to update the Council on a visit that morning to meet new colleagues joining the Trust from the 0-19 Wakefield service. A very positive meeting was had and Jonathan Coulter praised the organisation and seamless transfer of the new service into HDFT. There was an opportunity to learn and develop different roles within the organisation. Furthermore, by obtaining the Wakefield service, HDFT maintain a presence within West Workshire.
Andy Papworth noted that there had been a previous opportunity for the Board to meet with colleagues from Northumbria after that service was acquired, and queried if a similar opportunity would be forthcoming to meet with Wakefield colleagues.
Jonathan Coulter confirmed there was an intention to hold a Board meeting in Wakefield in due course.

Russell Nightingale gave a presentation around Urgent and Emergency Care.
A copy of this presentation will be forwarded to all Council members.

Wallace Sampson noted much focus was on admissions into ED and bed blockages and queried if enough thought was being given as to prevention to hospital in the first place.
Russell Nightingale responded by noting HDFT were fairly good at preventing these admissions, particularly during the week. However, frailty remains a concern and requires

quicker intervention. However, it is the case that not enough attention is given to prevention within the ICB.
Kathy McClune queried if staff had been involved in the ED improvement plans, as outlined in the presentation.
Russell Nightingale confirmed Jen Lockwood (ED Consultant) had been involved with developing the new ED models, and acknowledged some staff are feeling some anxieties around the impact from the build but the current ED model is too funnelled.
Kathy McClune enquired as to how staff will be supported throughout this development.
Emma Edgar confirmed this would present a challenging time for staff and as much support as possible would be offered, which will also include Wellbeing support.
Karen Stansfield enquired as to the confidence to adequately resource the social care provision.
Russell Nightingale confirmed packages and staff would be slowly taken on as the service progressed.
Richard Owen-Hughes queried to what extent HDFT could rely on support from system partners should things not progress as planned.
Russell Nightingale confirmed good links were in place across the HNY system and there was confidence mutual aid could be relied upon.
Jeremy Cross enquired if there was a risk if the whole system is under pressure.
Russell Nightingale confirmed this was a risk. However, Matt Graham added there was the need to begin somewhere.
Richard Sweeney queried if there was a risk of poaching staffing from other current care providers.
Russell Nightingale confirmed there was a risk this would happen, although the focus would be on training our own staff.

Sarah Armstrong thanked the group for an interesting discussion. This had already been discussed at Board and at the Informal Governor briefing, however, as a group, further discussion may be wanted or required.

Jonathan Coulter confirmed further information and updates would follow over the coming months.

There were no further questions or comments from Council members.

Resolved: *The Acting Chief Executive's strategic and operational update was noted.*

COG/09/2022/7.1 Integrated Board Report

The Integrated Board Report for August 2022 has been received and noted.

No questions or comments were received.

Resolved: *The IBR was noted.*

COG/09/2022/7.2 Questions from Governors

The Chair thanked Governors for the questions submitted in advance of the meeting. The responses to these questions are noted as below.

Question One and Question Three: Mental Health Services
Russell Nightingale confirmed a new facility was now available in York. Generally HDFT would've receive between 4-5 bed admissions each month. There is a 24hr mental health liaison team within the hospital. Bed admissions for voluntary admissions are very quick with any delays experienced due to bed availability with wait times when admitted through ED of approx. 15-20hrs. Involuntary admissions can experience longer wait times in ED of up to 36hrs. There is a dedicated room for mental health patients within ED.

Donald Coverdale confirmed his question had been satisfactorily answered. No further questions or comments were received.

Question Two: Mental Health Services
Russell Nightingale confirmed at present there was no further capacity at Tees Esk and Wear Valley NHS Foundation Trust (TEWV). Work is ongoing to develop further mental health support and capacity, as well as mental health support within ambulances.
At present there are approximately 4-5 patients having to be placed out of area due to this lack of capacity within the Harrogate area.

Question Four: Mental Health Services
Jonathan Coulter confirmed TEWV are the local service provider but we are all part of the wider ICS system and as such, a co-ordinated service is provided. It is acknowledged the cost of living crisis will have a possible impact and current resource availability is being discussed and divided across the system. All partners within the system are required to protect funding for mental health with this funding ring-fenced. As demand increases, there will be increased pressures and it is the responsibility of services to manage these additional pressures. Additional funding of £75m has been allocated nationally for mental health providers, with HDFT to receive £1.5m.

Question Five: Health Checks at pop-up NHS clinics
Russell Nightingale confirmed Matt Graham was currently assessing plans for Community Diagnostic Centres, although no actual plans are currently in place.
Matt Graham confirmed work was ongoing with Primary Care to explore options available., with one of the bigger challenges around staffing.

Question Six: Requests for information from Coroner's offices
Emma Nunez confirmed there were currently no performance measures in place to assess response times to requests from Coroner's offices. HDFT have a good relationship with the Coroner's office and positive feedback had previously been received, with no Regulation 28s been received within the previous two years. With regards to inquests and investigations, action plans are managed via the Directorate Performance review meetings as well as the Serious Incident committee, which reports into the Patient Safety Committee, Quality Governance Management Group and Quality Committee, which reports to Board.
Within the Serious Incident process, learning is identified and acted upon before going to inquest.

Question Seven: Electronic Patient Record system
Jonathan Coulter confirmed the benefits of an electronic patient record system were significant, with the amount of money allocated to HDFT for this improvement as significant enough for the provision of a very good system. HDFT were allocated this amount of money due to the Trust being deemed 'digitally immature'.

It was further noted governance of the EPR programme will be overseen by a new committee, the Innovation Committee.

Questions Eight and Nine: Mental Health
It was noted the answers to these questions have been covered in previous answers in relation to mental health.

Resolved: Responses to Governor's questions were noted.

COG/09/2022/8.0 Governor Development and Membership Engagement Committee update

Clare Illingworth provided a verbal update to the Committee with regards to the Governor Development and Membership Engagement committee.

Clare Illingworth confirmed a Governor Effectiveness Survey workshop had taken place recently, led by NHS Providers. This workshop included feedback received from NEDs and it was noted the following key issues were raised:

- Representation
- Full induction and regularly updated handbook
- Further training and development

An action plan is in place and many ideas for improvement have been received.

No further questions or comments were received.

Resolved: *The Governor Development and Membership Engagement Committee update was noted.*

COG/09/2022/14.0 Any other relevant business not included on the agenda

Sarah Armstrong noted the appointment of a Deputy Company Secretary, confirmed to begin within the next two weeks.
Kate Southgate provided a brief update to the Council with regards to this new appointment.
Donald Coverdale queried the amount of allocated time the new role would have for the management of the Governor body, as previously this had been a full time position, and the concern was the amount of support the Governors would receive going forwards.
Kate Southgate confirmed the role would primarily focus on the provision of Governor support, alongside providing additional support to the Company Secretary.
Sarah Armstrong confirmed the Deputy Company Secretary role would link all strands of governance.

Sarah Armstrong noted Maureen Taylor, who was not present at the meeting will be retiring from her Non-Executive role and thanked Maureen for her contributions to the role and to the Trust.

There were no other items of business raised at the meeting.

COG/09/2022/15.0 Evaluation of the Meeting

Sarah Armstrong requested any reflections on the meeting be emailed to her.

Steve Treece commented key risks and headlines of coming meetings were previously sent out.
Jonathan Coulter noted this comment and agreed to consider this going forward.

COG/03/2022/16.0 Date and Time of Next Meeting

The next meeting would take place on Monday, 5th December 2022 with venue and timings to be confirmed.

The meeting closed at 18:25

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Paper 4.0

HDFT Council of Governors' Meeting Action Log – December 2022

This document logs items agreed at Council of Governor meetings that require action following the meeting. Where necessary, items will be carried forward onto the Council of Governor agenda in the relevant agreed month. The Director/Manager responsible for the action will be asked to confirm completion of actions or give a progress update at the following Council of Governor meeting when they do not appear on a future agenda. When items have been completed, they will be marked as such and transferred to the completed actions schedule as evidence.

Ref	Meeting Date	Subject	Action Description	Director/Manager Responsible	Date due at CoG meeting or date when completion/ progress update is required	Comments	Status - completed is defined as confirmation that the action is completed as described
COG/12/2021/10.0	6 Dec 2021	Q & A Session	Glaucoma waiting times to remain on the agenda with further updates to take place on a regular basis at Informal Governor briefings	Chief Operating Officer	Dec 2022	Update provided	Open

HDFT Council of Governor Meeting Closed Action Log

COG/09/2020/4.1.2	29-09-2020	Ophthalmology Services	Agreed the Interim Chief Operating Officer would investigate provision of an Ophthalmology mobile testing facility and provide an update to the next meeting	Chief Operating Officer	14 December 2020 3 March 2021 8 June 2021	Update provided	Closed
COG/03/2021/5.7	03-03-2021	External Audit Process	Governors to confirm to Angie Colvin if they are interested in participating in the external auditor process	Interim Company Secretary / Corporate Affairs and Membership Manager	8 June 2021	Update provided	Closed
COG/06/2021/8.0	8 June 2021	Update on Deloitte Report	Further update would be provided after People and Culture Committee had received a full update (next meeting – 12 July 2021)	Chief Executive	6 September 2021	Update provided	Closed
COG/06/2021/7.0	8 June 2021	Major quality priority for 2021/22	Update on quality priority based work to be provided at the next Council of Governors meeting	Chief Executive	6 September 2021	Update provided	Closed
COG/09/2021/10.0	6 Sept 2021	Questions & Answers	Chair's report from People & Culture Committee to be added to Bulletin once through Board	Corporate Affairs & Membership Manager	December 2021	September reports circulated, ongoing after each Board.	Closed
COG/06/2021/8.0	8 June 2021	Acute stroke services	Trust level outcome data was yet to be published	Medical Director	December 2021	The latest return had been received and no significant changes were noted. Agreed to close the action.	Closed
COG/09/2021/10.0	6 September 2021	Questions & Answers	A presentation to Governors relating to Serious Incident investigations and Medical Examiner role to be arranged	Director of Nursing/Corporate Affairs & Membership Manager	December 2021	Medical examiner scheduled for March 2022 meeting. Agreed to close the action.	Closed

Council of Governors (held in Public)
5th December 2022

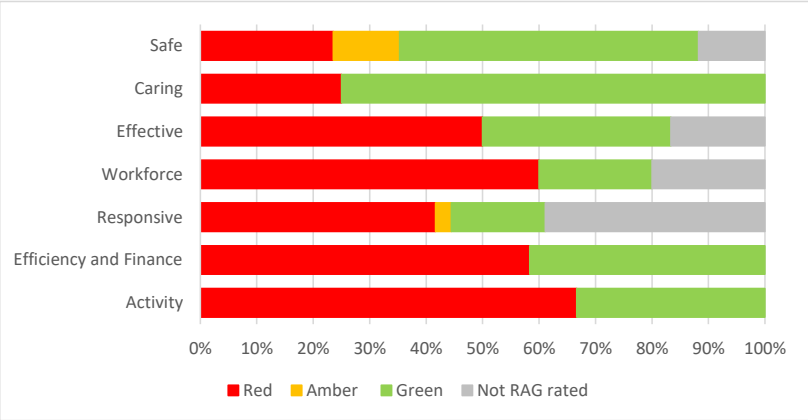
Title:	***Integrated Board Report***
Responsible Director:	Executive Directors
Author:	Head of Performance & Analysis

Purpose of the report and summary of key issues:	The Council of Governors is asked to note the items contained within this report.	
BAF Risk:	AIM 1: To be an outstanding place to work	
	BAF1.1 to be an outstanding place to work	Y
	BAF1.2 To be an inclusive employer where diversity is celebrated and valued	Y
	AIM 2: To work with partners to deliver integrated care	
	BAF2.1 To improve population health and wellbeing, provide integrated care and to support primary care	Y
	BAF2.2 To be an active partner in population health and the transformation of health inequalities	Y
	AIM 3: To deliver high quality care	
	BAF3.1 and 3.4 To provide outstanding care and outstanding patient experience	Y
	BAF3.2 To provide a high quality service	Y
	BAF3.3 To provide high quality care to children and young people in adults community services	Y
	BAF3.5 To provide high quality public health 0-19 services	Y
	AIM 4: To ensure clinical and financial sustainability	
	BAF4.1 To continually improve services we provide to our population in a way that are more efficient	Y
	BAF4.2 and 4.3 To provide high quality care and to be a financially sustainable organisation	Y
	BAF4.4 To be financially stable to provide outstanding quality of care	Y
Corporate Risks	None	
Report History:	A draft version of this report was presented to Senior Management Team and Trust Board in November 2022.	
Recommendation:	The Council of Governors is asked to note the items contained within this report.	

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

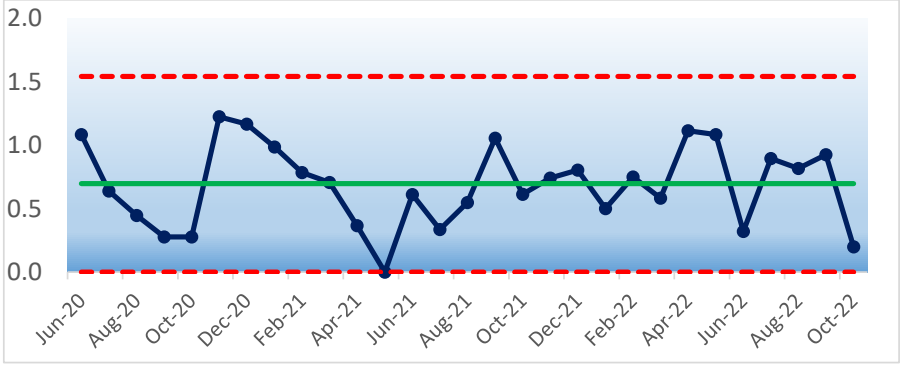
Domain 1 - Safe

Indicator	**1.1 - Pressure ulcers - hospital acquired - cat 3 or above - per 1,000 bed days**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Oct-22
Value / RAG rating	0.20

Indicator description

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

SPC chart



Narrative

There has been a significant reduction in pressure ulcers developing or deteriorating in hospital care in October. Of those pressure ulcers that were category 3 and above, the majority were deep tissue injuries (9). This type of tissue damage may evolve or resolve over a number of weeks and therefore the true nature of damage is undetermined and this figure may reduce. Of note, there were no unstageable pressure ulcers that developed in hospital care, a reduction from 5 in September.

As in September, there were no device related mucosal pressure ulcers in October, providing further assurance that the implementation of fixation devices across the acute trust and associated teaching sessions have successfully met an identified risk.

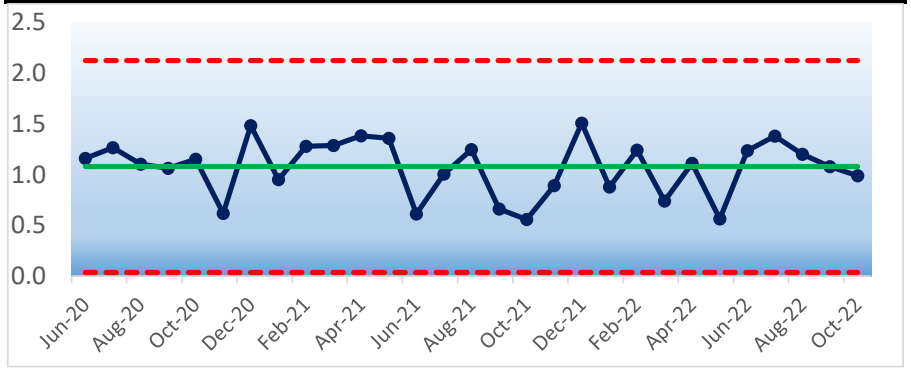
Preventing Pressure Ulcer training continues to be delivered twice a month, hospital attendance continues to be significantly reduced due to capacity and demand across inpatient areas however the TVN team continue to undertake bedside training in identified areas. Feedback from clinical areas has been positive.

Indicator	**1.2 - Pressure ulcers - community acquired - cat 3 or above - per 1,000 patient contacts**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Oct-22
Value / RAG rating	0.99

Indicator description

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

SPC chart



Narrative

Pressure ulcers developing or deteriorating in our community care decreased in October, with the majority of pressure ulcers reported as unstageable (8) and category 3 pressure ulcers (5). One TVN per day continues to be ring-fenced to support community services as required.

Pressure ulcers requiring investigation through root cause analysis have shown no omissions in care provided to patients in the community and action plans formulated have been completed with positive learning taking place.

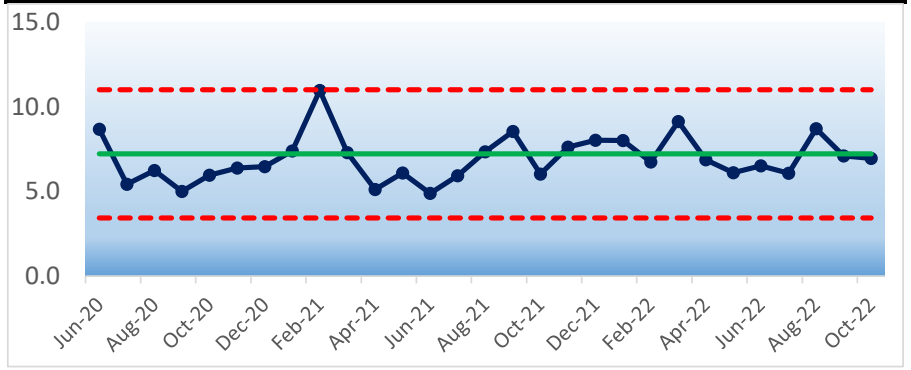
Uptake for both preventing pressure ulcer training and a two-day leg ulcer workshop organised by the TVN team has been excellent with positive feedback received.

Indicator	**1.3 - Inpatient falls per 1,000 bed days**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Oct-22
Value / RAG rating	7.0

Indicator description

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

SPC chart



Narrative

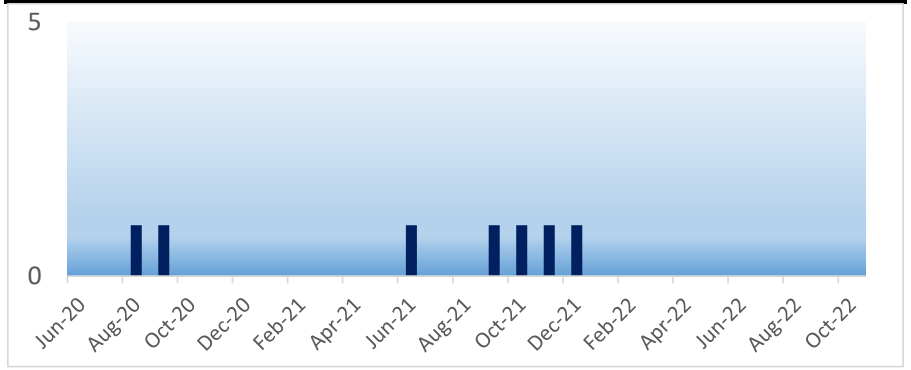
There has been a reduction in the number of falls since August 22 when the Falls Specialist Nurse started in post. A number of training sessions and education is currently ongoing. Monthly falls audits have commenced and the data is interpreted to identify areas for futher improvement or training required. QIP implemented to identify patients at risk of falls, with a view of reducing the numbers. Length of stay remains longer than necessary due to gaps in social care provision and therefore patients are in ward areas for longer and contributing to deconditioning.

Indicator	**1.4 - Infection control - Hospital acquired C.difficile cases, lapse in care identified**
Executive lead	Jacqueline Andrews, Medical Director
Board Committee	Quality Committee
Reporting month	Oct-22
Value / RAG rating	0

Indicator description

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

Trend chart



Narrative

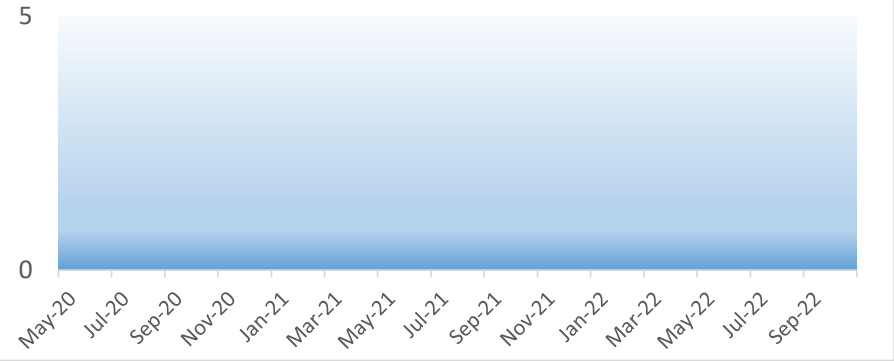
There were 2 hospital acquired case of C.difficile reported in October, bringing the year to date total to 18. RCAs have been completed and agreed with the CCG for all 18 cases - all cases were deemed to be unavoidable.

Indicator	1.5 - Infection control - Hospital acquired MRSA cases, lapse in care identified
Executive lead	Jacqueline Andrews, Medical Director
Board Committee	Quality Committee
Reporting month	Oct-22
Value / RAG rating	0

Indicator description

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

Trend chart



Narrative

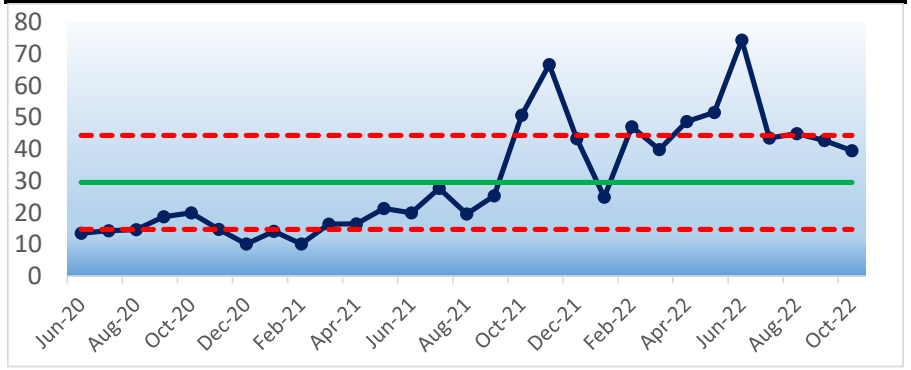
There were no hospital acquired MRSA cases where lapses in care were identified for October.

Indicator	**1.6 - Incidents - ratio of low harm incidents**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Oct-22
Value / RAG rating	39.5

Indicator description

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

SPC chart



Narrative

In October, the top categories for the number of incidents reported:
- Pressure Ulcers & Other Skin Damage (28%)
- Appointments, Admission, Transfer & Discharge (10%)
- Records & Consent (9%)
- Medication, IV Fluids & Medical Gases (8%)
- Diagnosis, Treatments, Procedures & Tests (7%)

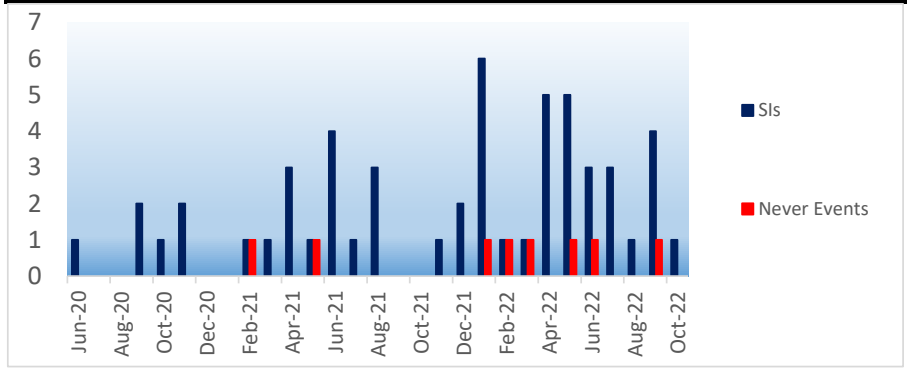
The number of incidents being reported has fallen for the third consecutive month, and for the second consecutive month the number of incidents reported has fallen below the upper control limit.

Indicator	**1.7 - Incidents - comprehensive serious incidents (SI) and Never Events**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Oct-22
Value / RAG rating	1 (SI), 0 (Never Events)

Indicator description

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

Trend chart



Narrative

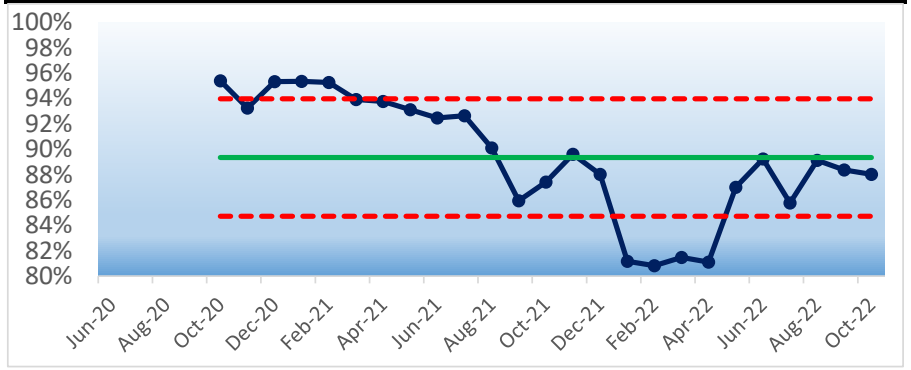
There was one serious incident declared in October. A lead investigator has been appointed and the investigation is underway.

Indicator	**1.8.1 - Safer staffing - fill rate**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Oct-22
Value / RAG rating	88.0%

Indicator description

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

SPC chart



Narrative

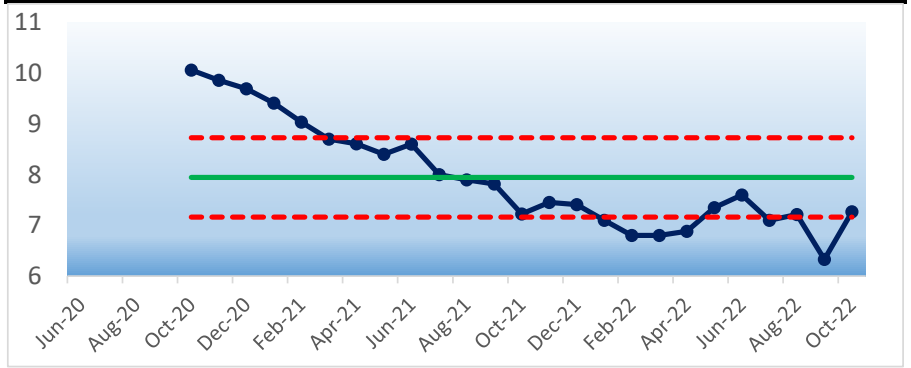
Staffing remains challenged with increased CSW and RN vacancies this month. The Acute Frailty Unit is currently staffed by the escalation team but recruitment is due to complete by the end of November with 3 successful external applicants so far. Covid sickness absence is improving and positively impacting on fill rate.

Indicator	**1.8.2 - Safer staffing - care hours per patient per day (CHPPPD)**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Oct-22
Value / RAG rating	7.3

Indicator description

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

SPC chart



Narrative

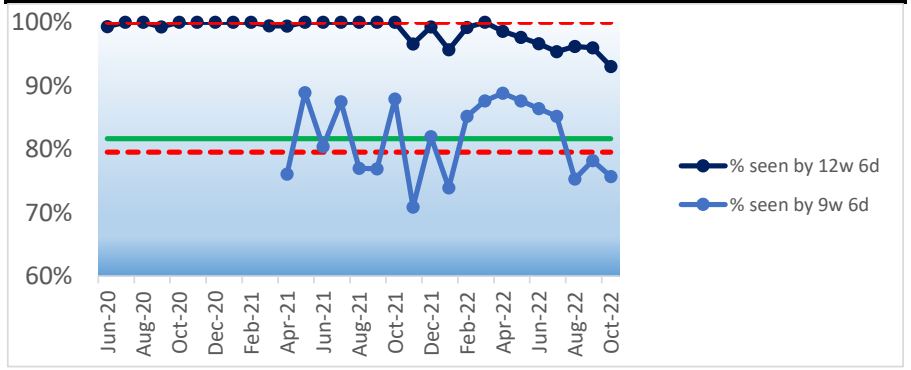
Reduced Covid sickness absence has shown a positive impact on CHPPPD. The Acute Frailty unit is still being staffed by the escalation team, which is top sliced from existing wards. Paediatric vacancies remain but SCBU vacancies, in particular, Qualified in Speciality nurses, are improving following some targeted recruitment. Staff not currently in post but in the pipeline due to start in December and January.

Indicator	**1.9 - Maternity - % women seen by a midwife (or healthcare professional) by 12w 6d**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Oct-22
Value / RAG rating	93.1%

Indicator description

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

SPC chart



Narrative

The introduction of the first contact clinic enables women to be seen prior to the booking appointment at 12 weeks gestation.

Continuous evaluation of the first contact clinic continues and trends will be investigated if rates fall.

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

Indicator description

This indicator is under development.

SPC chart

Narrative

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

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

Work continues on building blocks to enable implementation when staffing allows.

Indicator	**1.11 - Maternity - % women smoking at time of delivery**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Oct-22
Value / RAG rating	7.4%

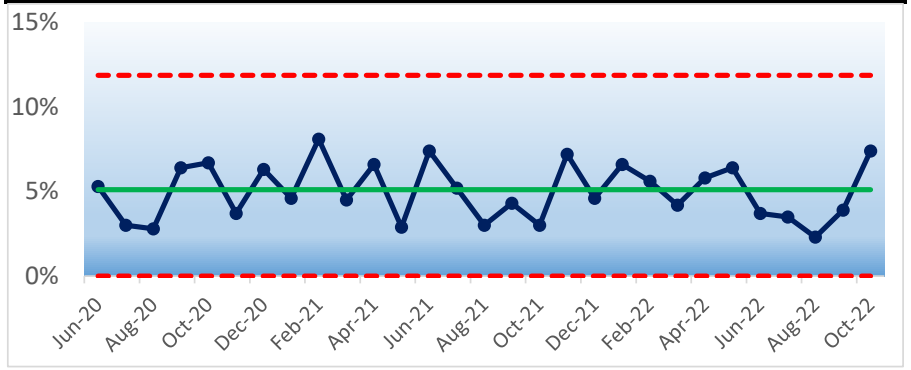
Indicator description

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

Narrative

The current smoking at time of delivery has shown an increase this month, although it remains below the national target. Work is commencing to develop tobacco dependency treatment services in Harrogate with the support of the ICB.

SPC chart

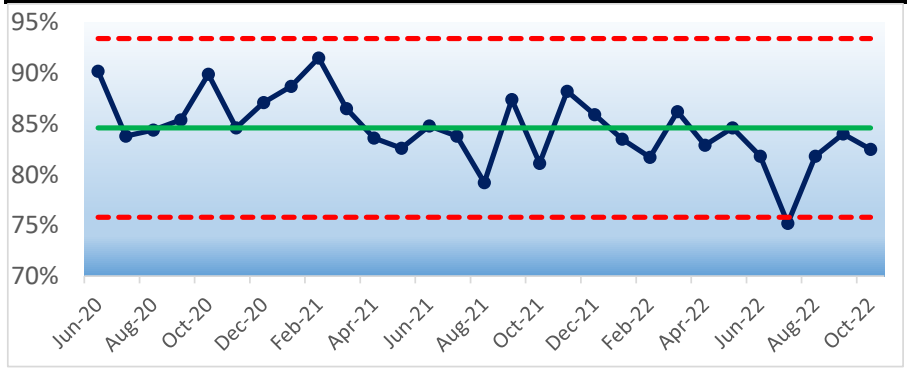


Indicator	**1.12 - Maternity - % women initiating breastfeeding**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Oct-22
Value / RAG rating	82.5%

Indicator description

The % of women initiating breastfeeding

SPC chart



Narrative

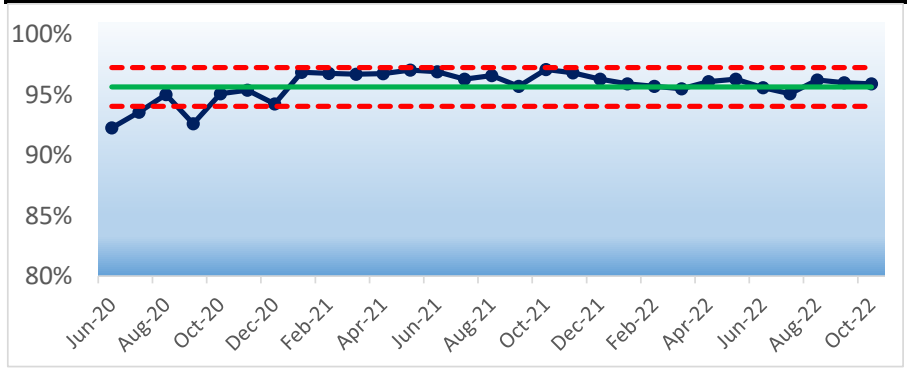
Initiation of breastfeeding at birth has returned to the target baseline amount. Discussions have taken place with staff to ensure data quality and work is ongoing to ensure staff are maintaining their skills appropriately. Auditing of staff practice is planned to take place in the coming months.

Indicator	**1.13 - VTE risk assessment - inpatients**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Oct-22
Value / RAG rating	95.9%

Indicator description

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

SPC chart



Narrative

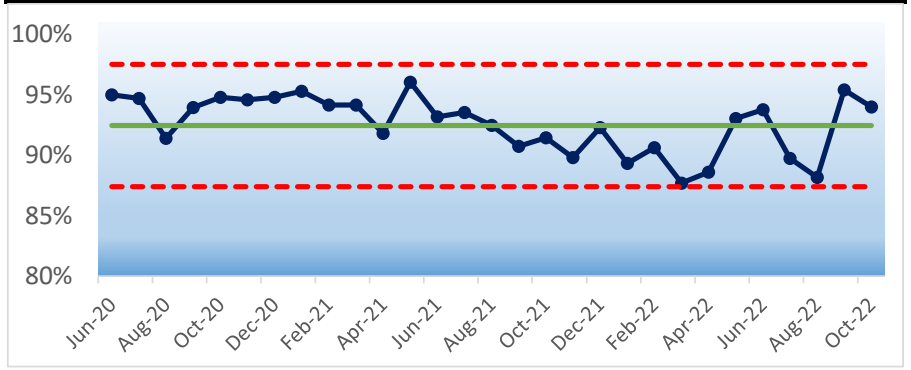
VTE continues to slowly improve, monitoring of this remains in place >95% standard.

Indicator	**1.14 - Sepsis screening - inpatient wards**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Oct-22
Value / RAG rating	94.0%

Indicator description

The percentage of eligible inpatients who were screened for sepsis.

SPC chart



Narrative

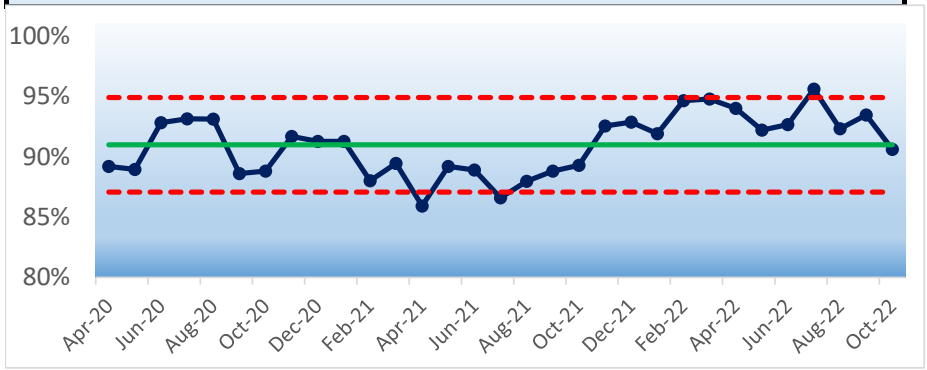
Monitoring of compliance with screening remains in place via Nursing Leadership.

Indicator	**1.15 - Sepsis screening - Emergency department**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Oct-22
Value / RAG rating	90.6%

Indicator description

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

SPC chart



Narrative

Continued systems in place and monitoring from matrons.

Integrated Board Report - October 2022

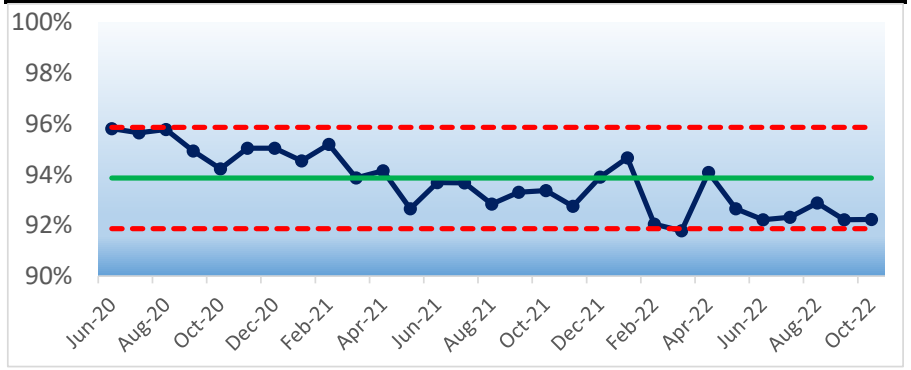
Domain 2 - Caring

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

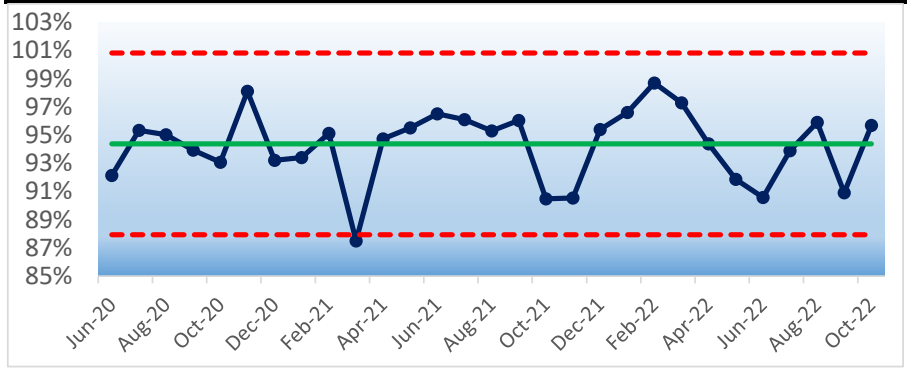
Performance against this standard continues to fluctuate but overall remains above 90% which is positive.

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

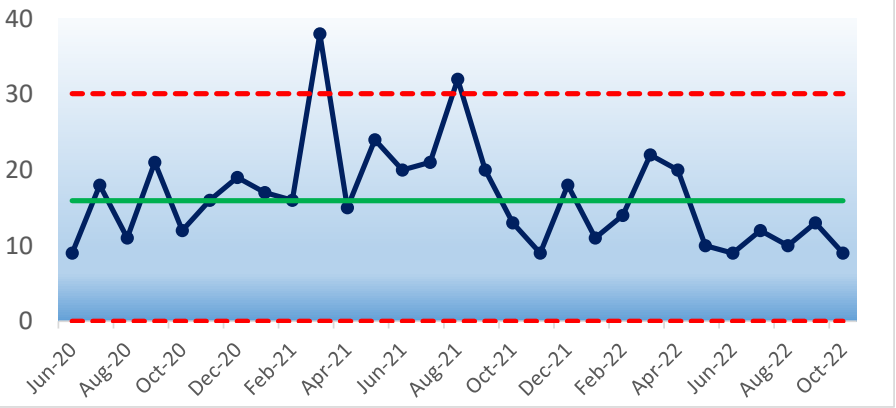
Performance against this standard continues to fluctuate but overall remains above 90% which is positive.

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).

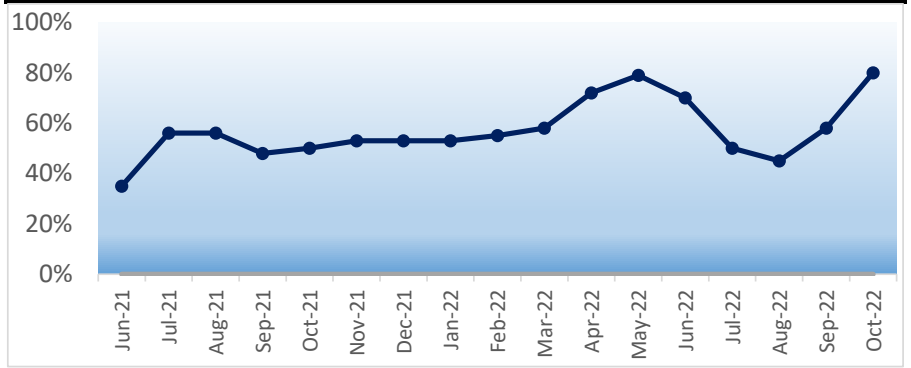
This is the 6th consecutive month that the number of complaints received by the Trust has fallen below the mean.

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

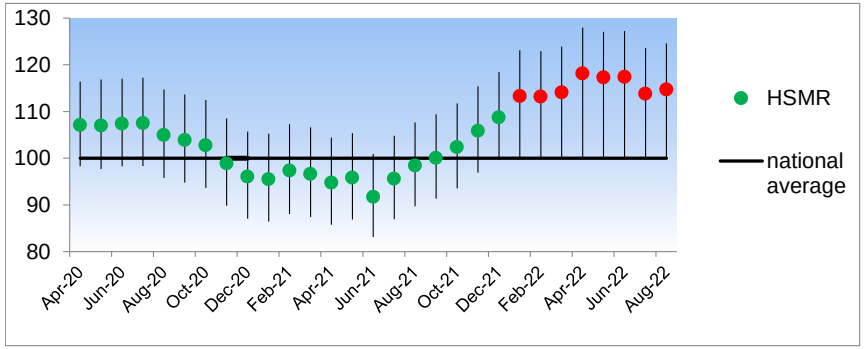
Domain 3 - Effective

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

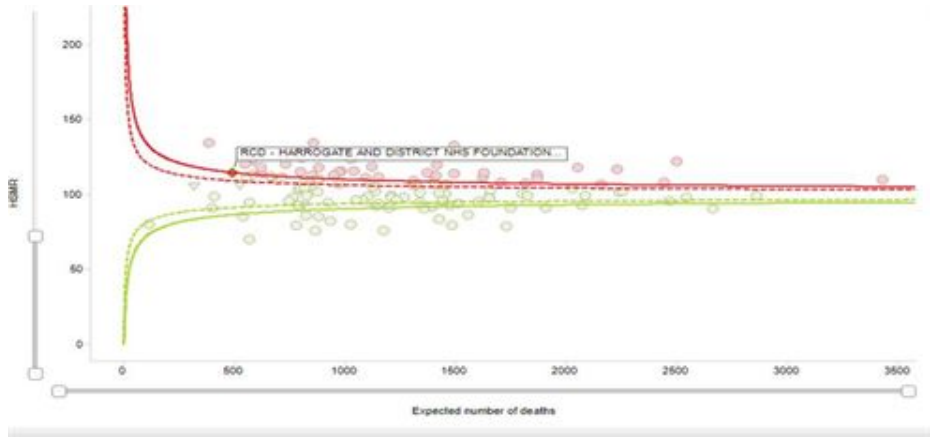
The HSMR looks at the mortality rates for 56 common diagnosis groups that account for around 80% of in-hospital deaths and standardises against various criteria including age, sex and comorbidities. The measure also makes an adjustment for palliative care.

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.

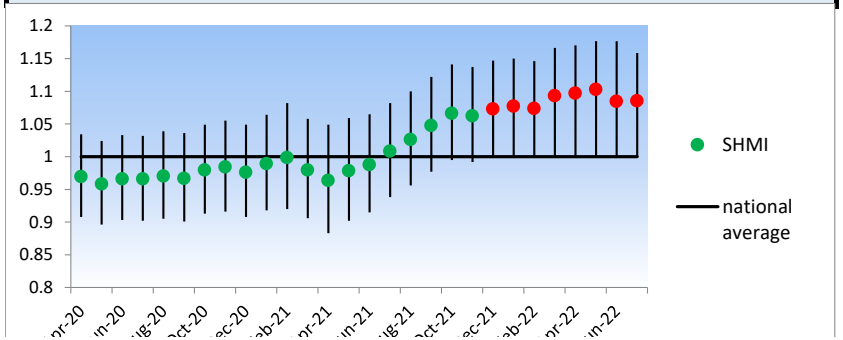


Indicator	**3.2 - Summary Hospital Mortality Index (SHMI)**
Executive lead	Jacqueline Andrews, Medical Director
Board Committee	Quality Committee
Reporting month	Jul-22
Value / RAG rating	1.085

Indicator description

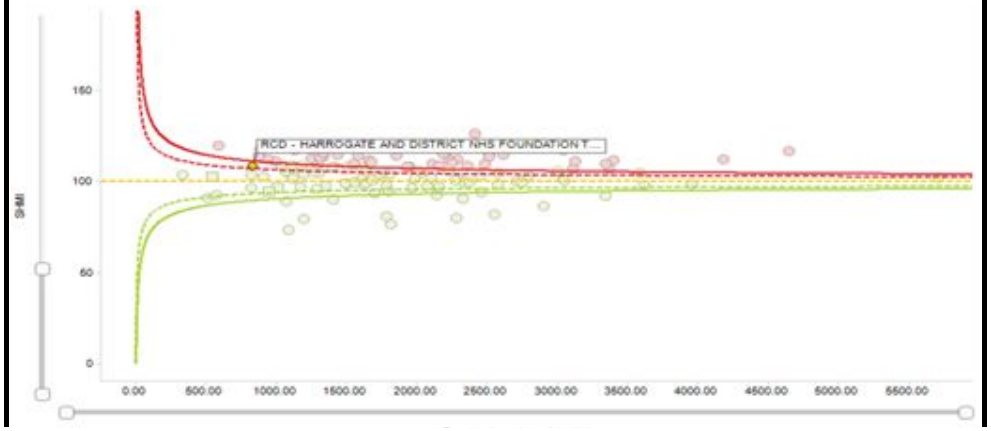
The SHMI looks at the mortality rates for all diagnoses and standardises against various criteria including age, sex and comorbidities. The measure does not make an adjustment for palliative care.

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.

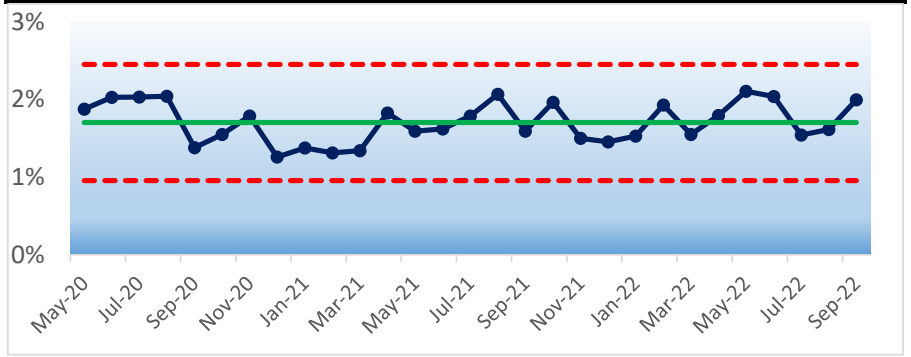


Indicator	**3.3.1 - Readmissions to the same specialty within 30 days - following elective admission**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Sep-22
Value / RAG rating	2.0%

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

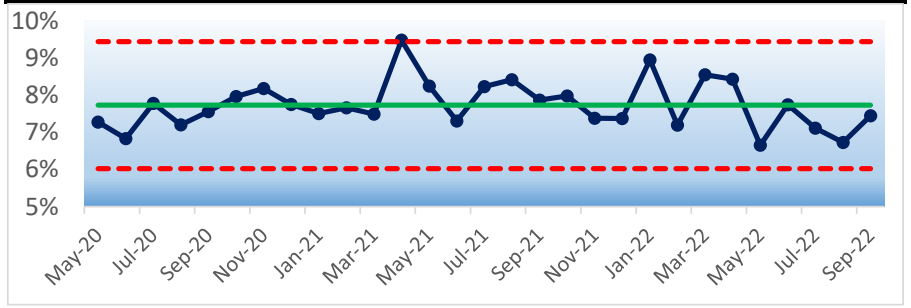
Readmissions following an elective admission increased to 2.0% in September but remain within control limits and less than national average.

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

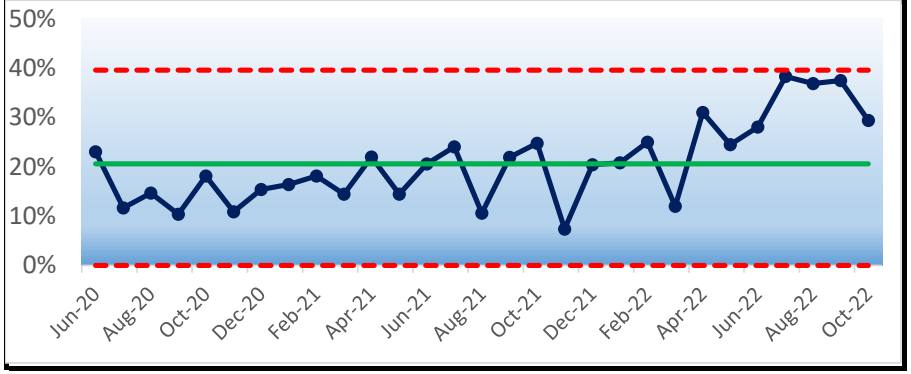
Narrative

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

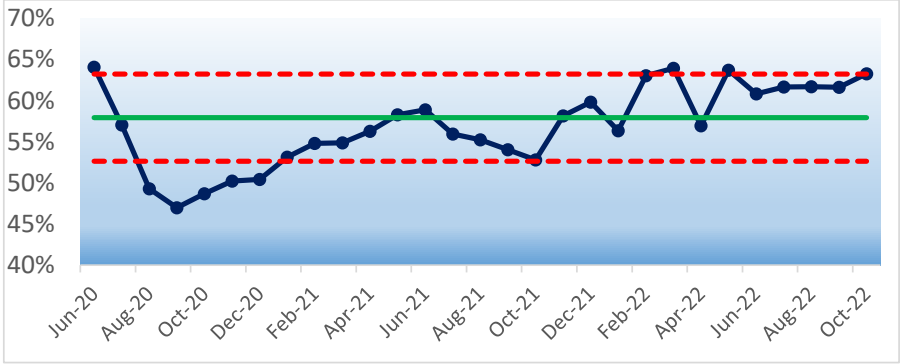
Domain 4 - Workforce

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%.

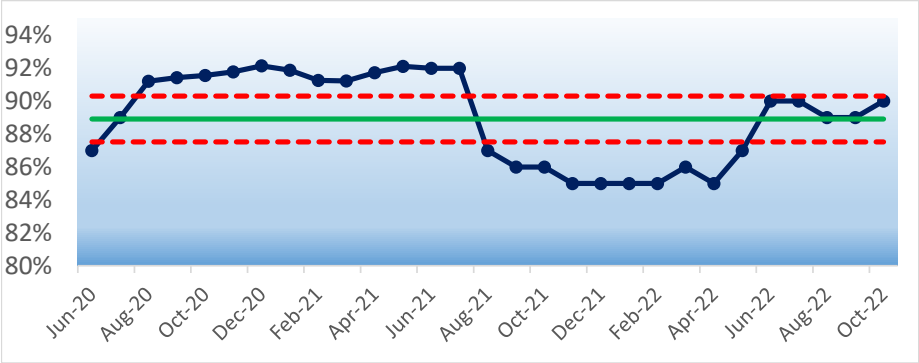
- Non-Medical appraisal % = 62.3% (previous month 60.3%)
- Medical appraisal % = 74.3% (previous month 77.6%)

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%.

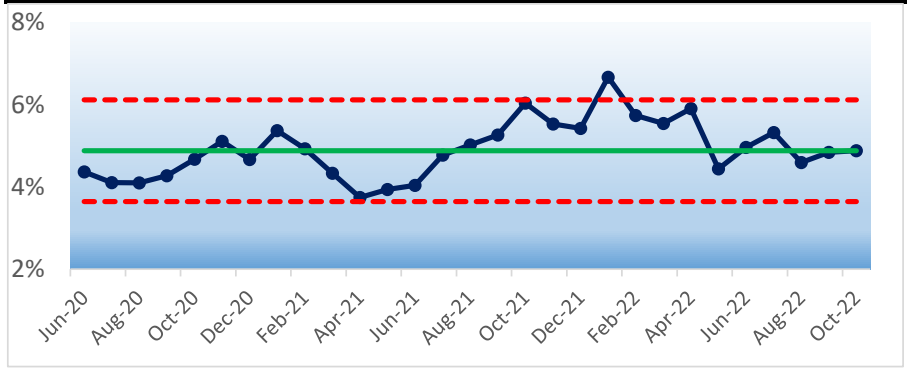
The Mandatory Core overall compliance for bank staff is 78% remaining the same as the two previous months. The overall compliance for Mandatory core and role based training for Trust substantive has also risen by 1% to 84%.

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%.

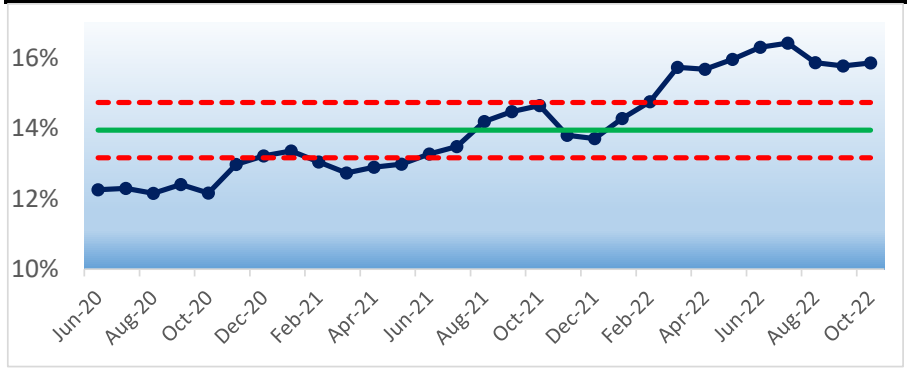
CC Directorate currently has the greatest sickness rate of 5.3%, however this is a decrease from 5.4% in last month. "Anxiety/stress/depression/other psychiatric illnesses" remains the top reason for sickness this month and contributes to 29.4% of the overall sickness. 104 employees were absent due to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

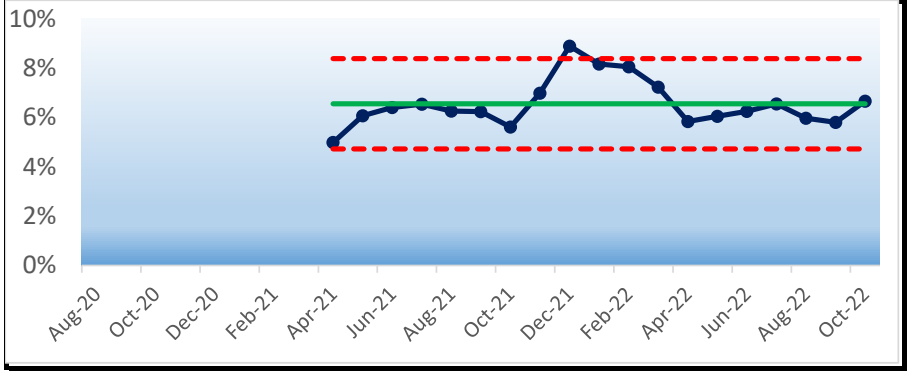
Of the October leavers (49.56wte), 9.38wte were Health Visitors, of which almost half were due to retirement age and 6.77wte were CSWs on inpatient wards. The 'Additional Clinical Services' staff group remains the staff group with the highest turnover rate, which is 20.0% in October (19.4% last month).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

Integrated Board Report - October 2022

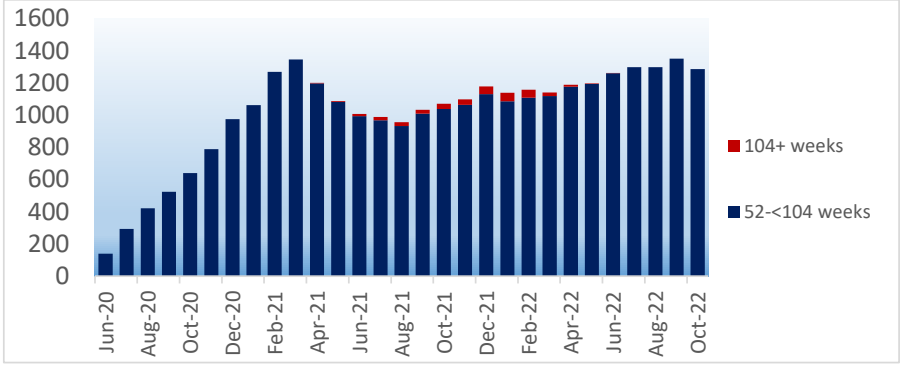
Domain 5 - Responsive

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

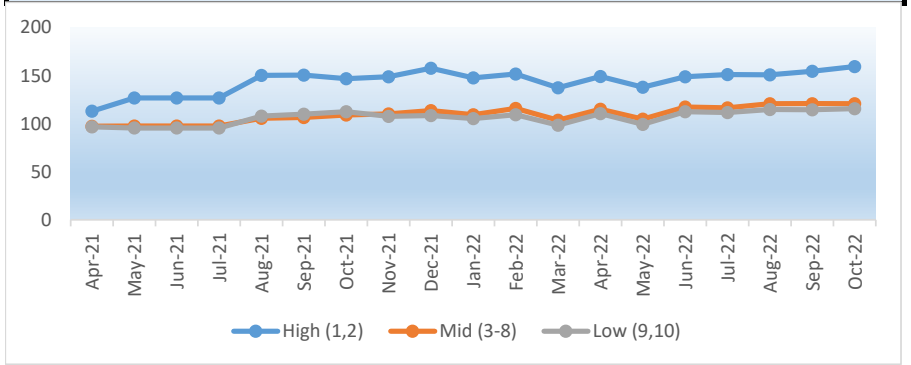
The Trust reported no patients waiting over 104 weeks at the end of October. The number of over 52 week waiters stands at 1,285, a reduction on last month. Risks remain in two main specialties of T&O and Community Dental (which together account for 59% of the over 52 week waiters). There are plans in 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.

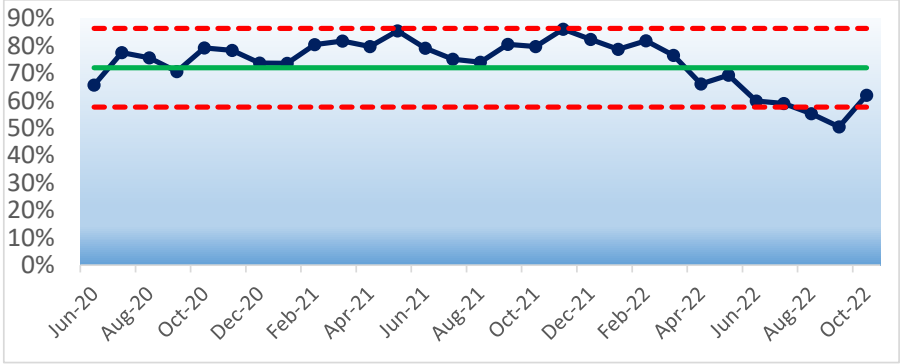
Work also continues in improving the recording of ethnicity and use of the learning disabilities flag across our clinical systems (this will improve further with the reinstatement of patient kiosks).

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

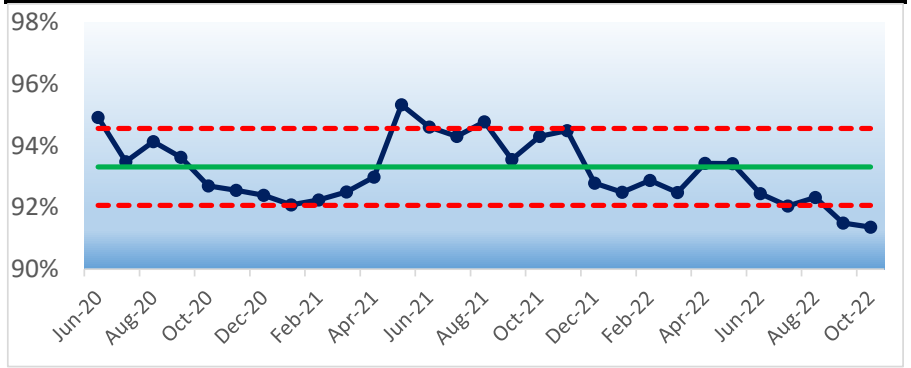
Narrative

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.

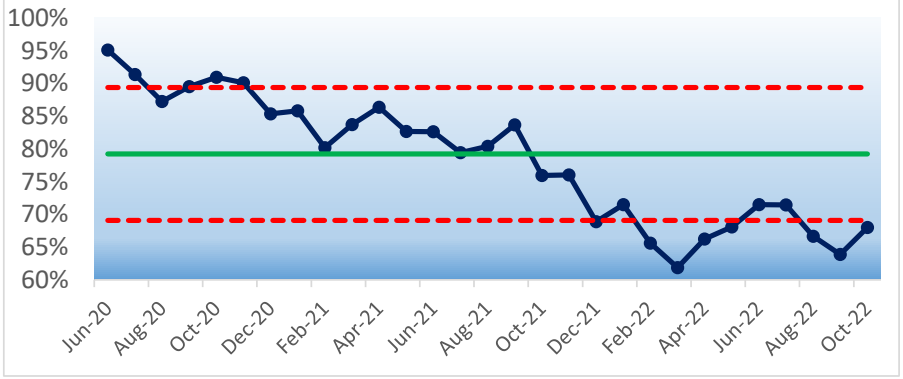
- Made contact with the lead at Central London Community NHS Trust (CLCH) who have improved their ethnicity recording rates on their patient records – they are organising a webinar to talk through their actions
- Reminded staff of the process regarding the collection of this data including reception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

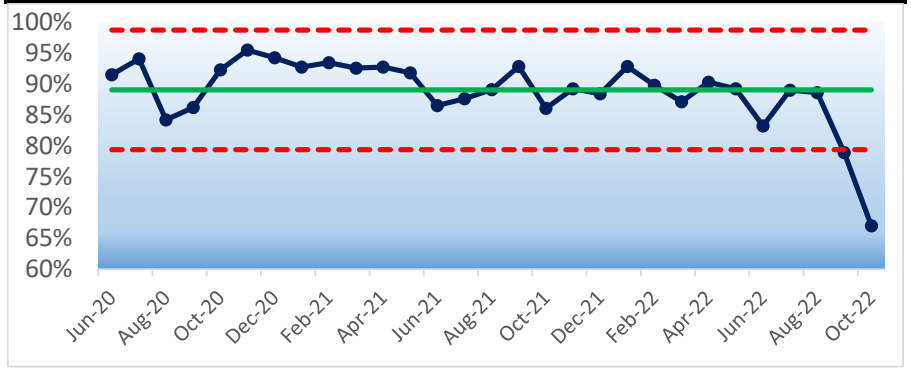
- delivering 7 day SDEC service and a direct to SDEC pathway with YAS;
- streaming of minors at the front door;
- utilising Criteria to Reside flow software to identify patients no longer requiring hospital care;
- developing a 2 hour crisis response service, expanding ARCH in-reach to ED and maximising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

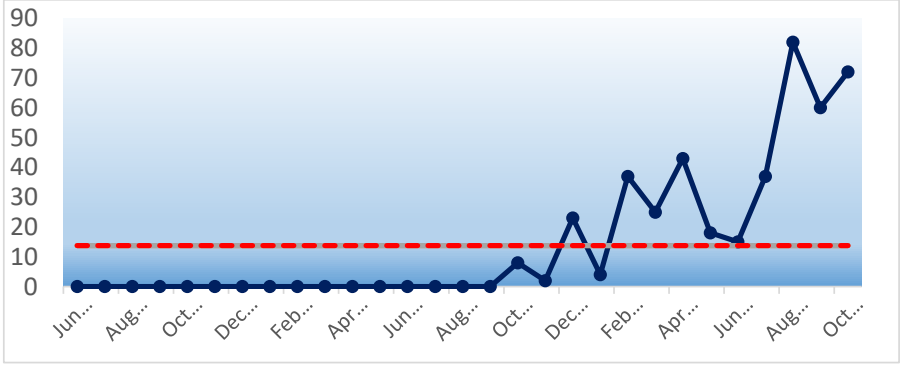
67% of ambulance handovers took place within 15 minutes in October, a deterioration on previuos months. There were 147 over 30-minute handover breaches with 64 over 60-minutes in October. Prevention of ambulance handover delays continues to be a focus with the Trust operational processes being shared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

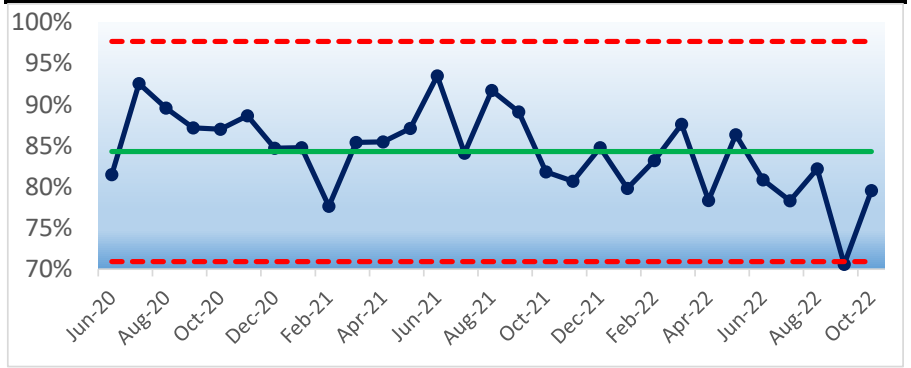
72 over 12 hour trolley waits were reported in October. RCAs have commenced and will be reviewed at internal quality and performance meetings. A preliminary review of the Datix reports submitted suggest no reports of patient harm.

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.

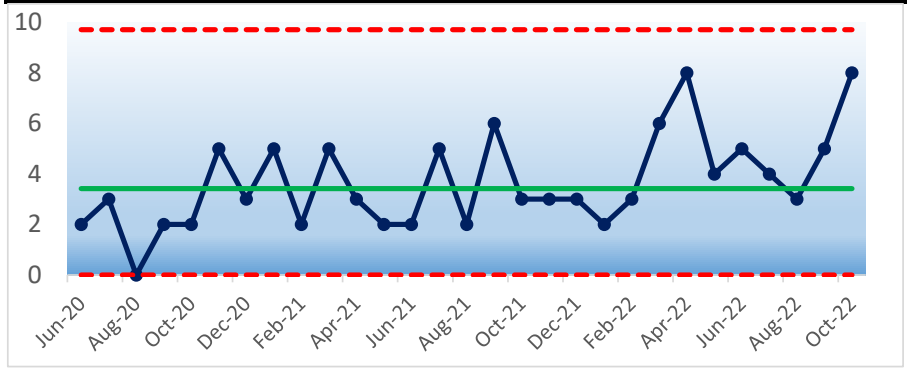
Deteriorating performance against the 14 day standard is having an impact on other targets, especially 62 days. Higher volumes of referrals in Lower GI, Skin and Breast are also impacting on delivery.

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.

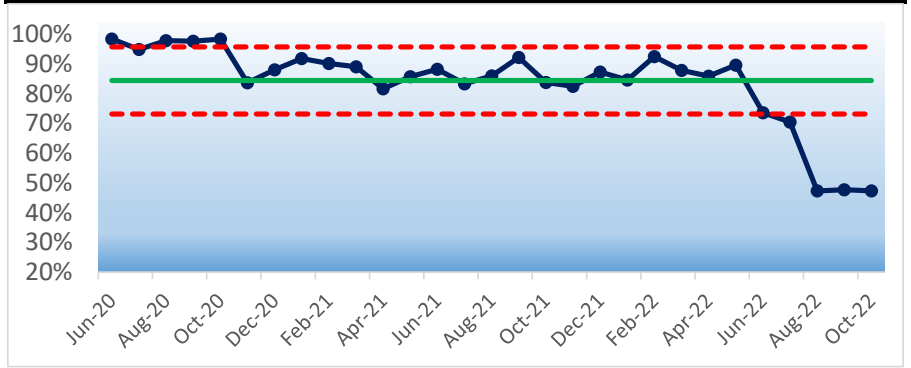
All patients have now received treatment and their pathways. Following the implementation of a new cancer system in October (Somerset Cancer Registry) and the time constraints on the tracking team, it has been agreeed to stand down the October, November and December breach panel meetings. This means 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.

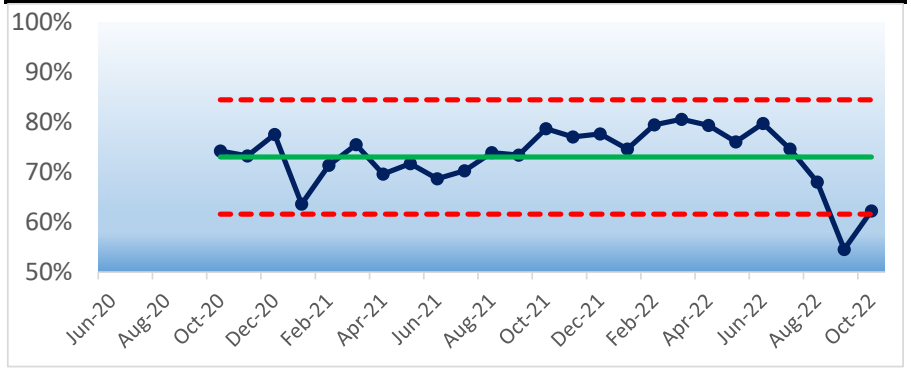
Poor performance for the breast 2WW standard continued in October with 8% patients seen within 14 days (4 out of 50).

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

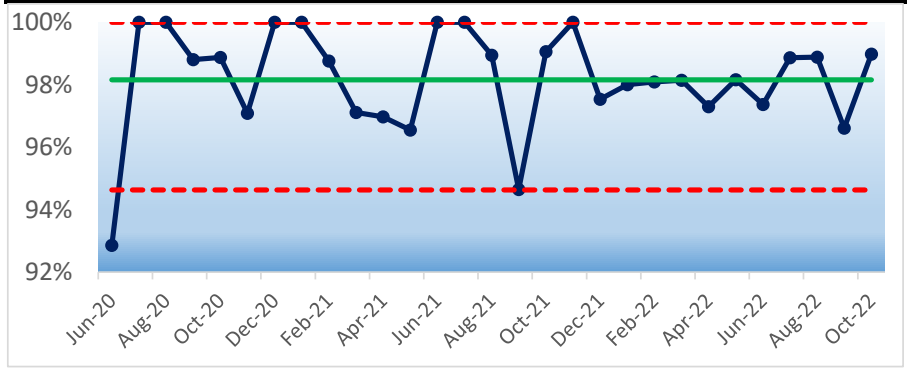
Provisional data indicates that in October combined performance for the three 28 days standards (2WW suspected cancer, 2WW non-cancer breast symptoms, Screening) continued to be below the proposed operational standard of 75% at 62.3%, although this is slight improvement on last month (2WW cancer – 64.6%; 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.

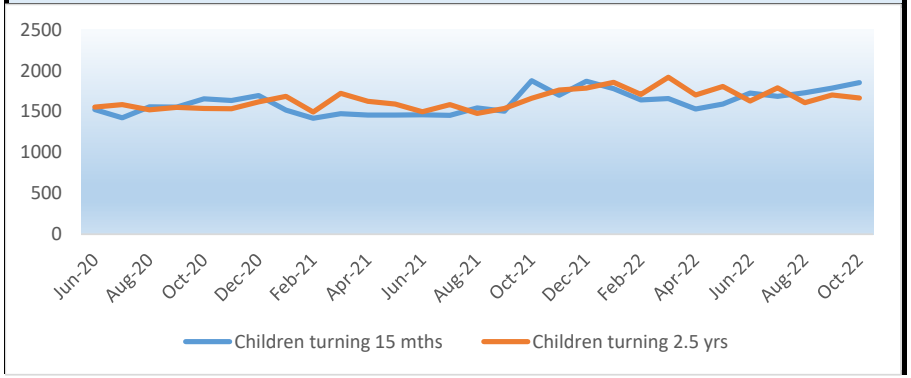
Overall performance was above the expected standard of 96%.

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

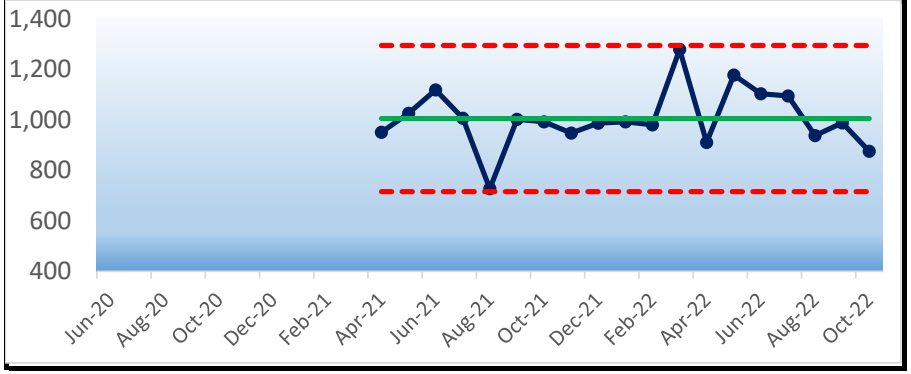
Both caseloads remain fairly static.

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.

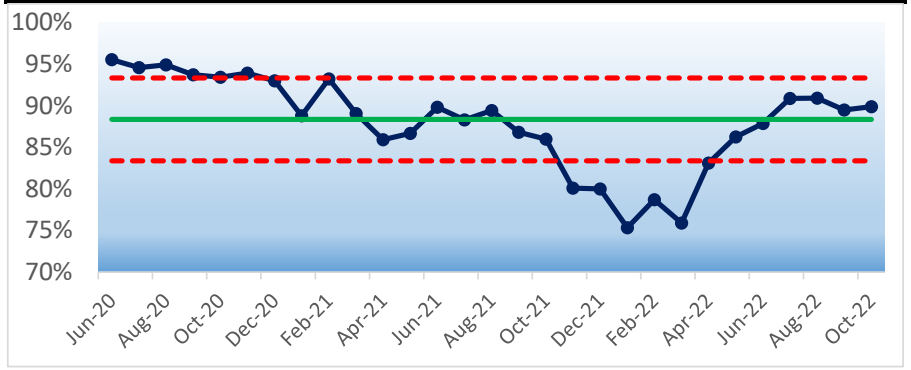
We continue to see very high levels of Safeguarding across our 0-19 Contact Areas which is in excess of the levels seen over the last three years. Additional resource has been added to the Safeguarding team to support these levels of activity.

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.

SPC chart



Narrative

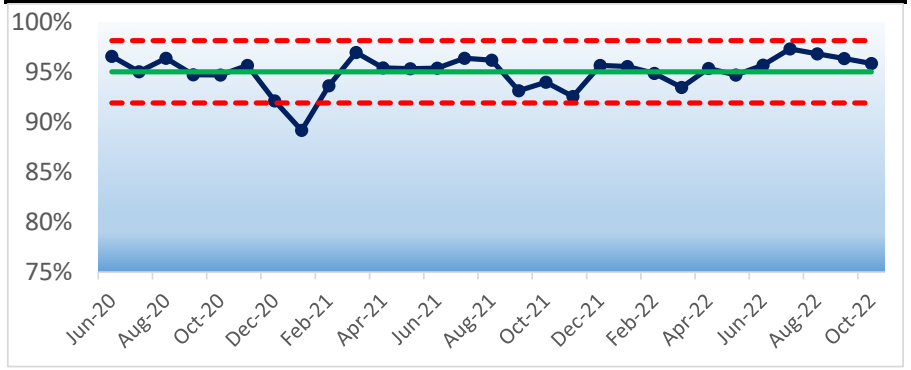
Just less than 90% of eligible pregnant women received an initial antenatal visit in October. Middlesbrough performance (which was the main reason for the deterioration seen earlier in the year) is now in line with that of other localities and above 90%.

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%

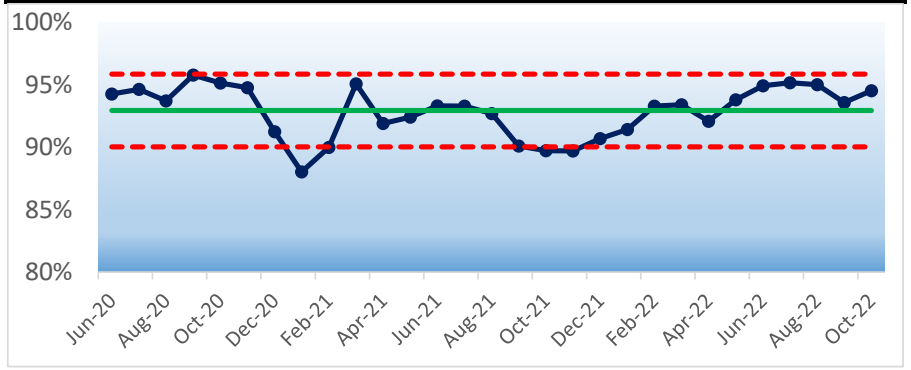
Indicator description

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

Narrative

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

SPC chart



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%

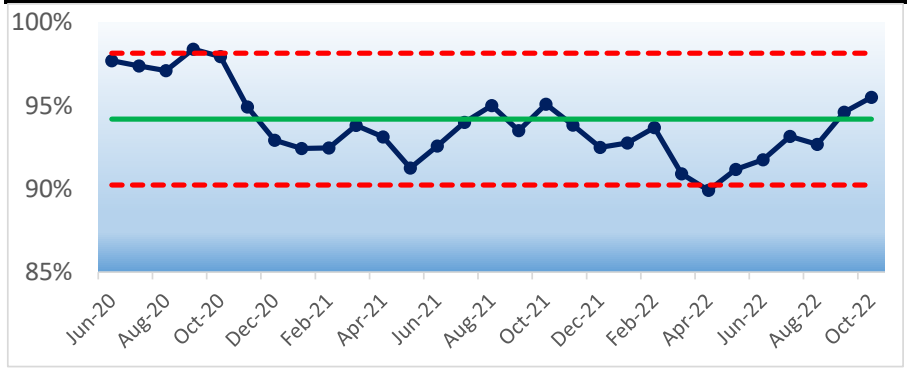
Indicator description

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%

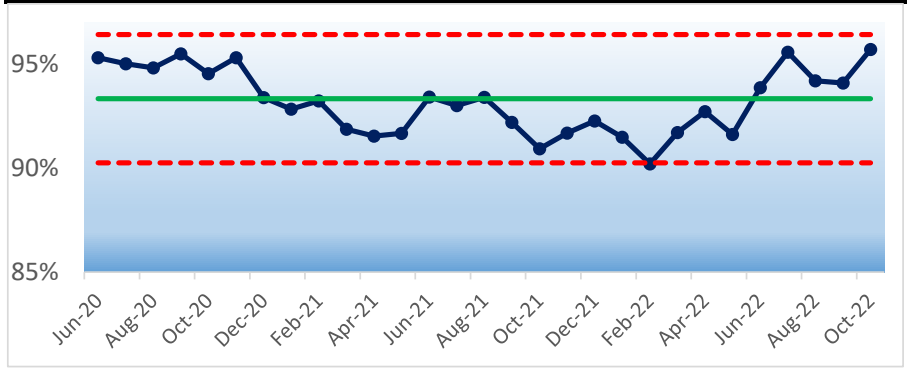
Indicator description

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

Narrative

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

SPC chart



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.

Narrative

SPC chart

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

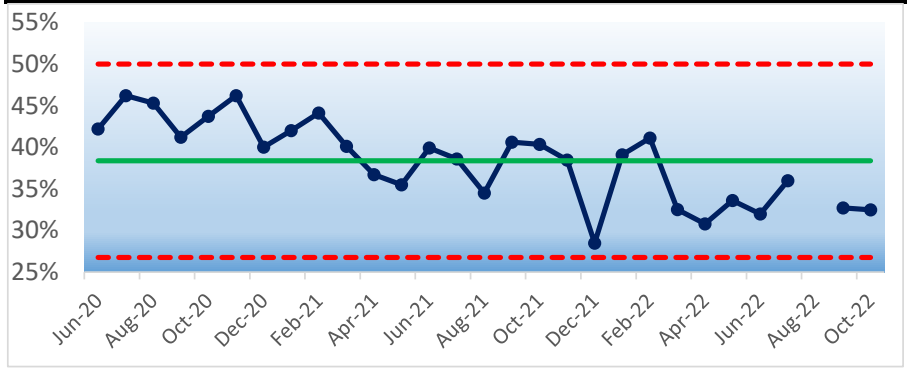
CC Directorate have started to discuss and record OPEL levels for Adult Community Services at their Safety and Governance huddles. The overall position for October remained at level 3.

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.

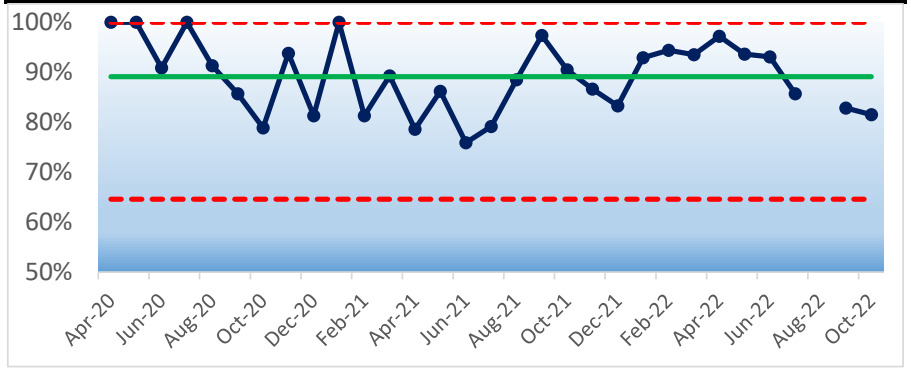
In October, 33% of urgent cases received a telephone clinical assesment within 20 minutes of call prioritisation.

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

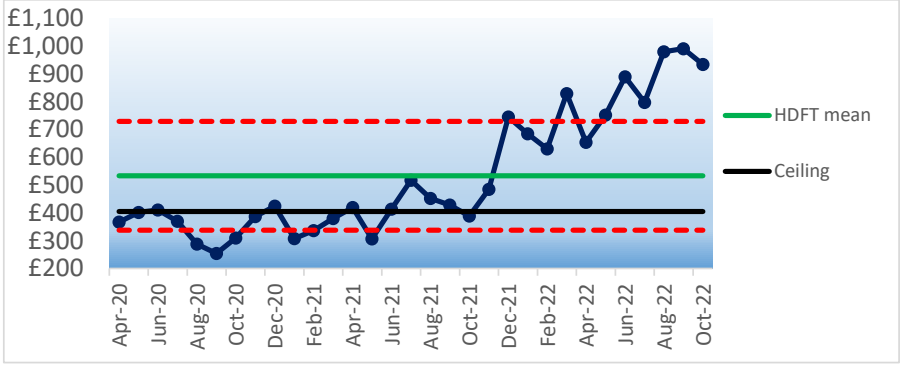
Domain 6 - Efficiency and Finance

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

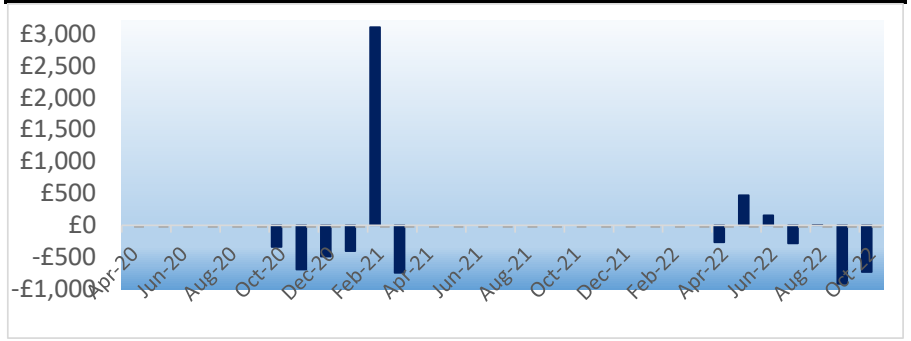
Continued pay pressure in wards and medical staff costs from use of agency staff mainly to cover vacancies and escalation wards. YTD costs are now £323k over our annual agency ceiling of £5,676k. Actions to reduce reliance on agency staff are being taken via the monthly agency review meetings and directorate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

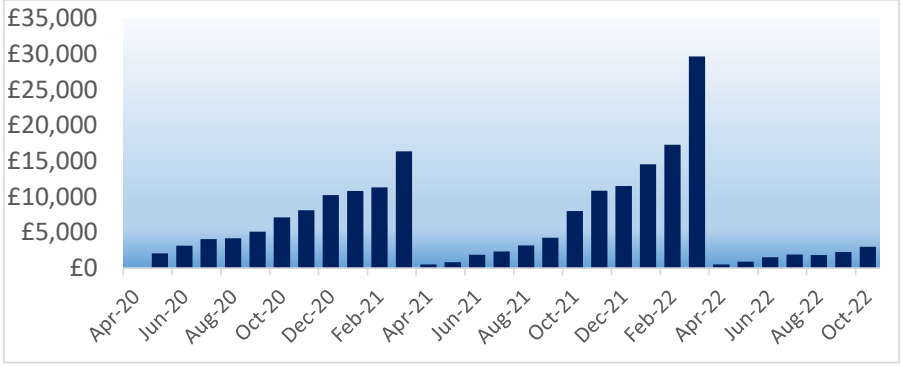
Month 7 has been a challenging position with an in month deficit of £0.7m. This takes the YTD position to £2.3m deficit. Key drivers include performance against Savings programme, Medical Staffing expenditure, ward expenditure, costs associated with the delivery of activity, inflation and escalation.

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

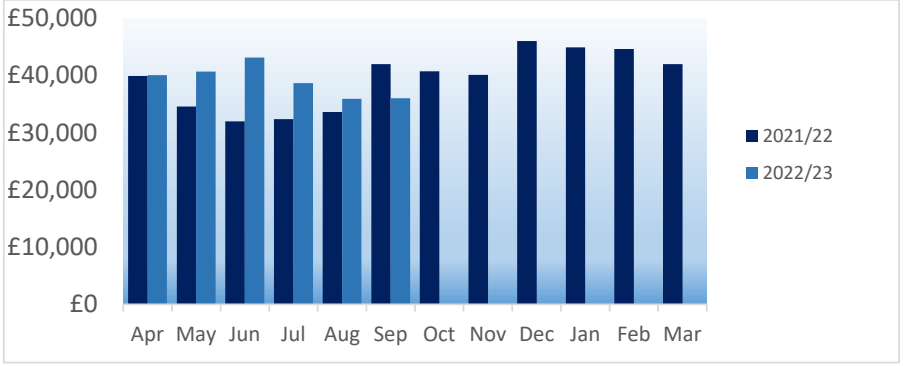
Indicator description

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

Narrative

Trust cash balance remains positive.

Trend chart

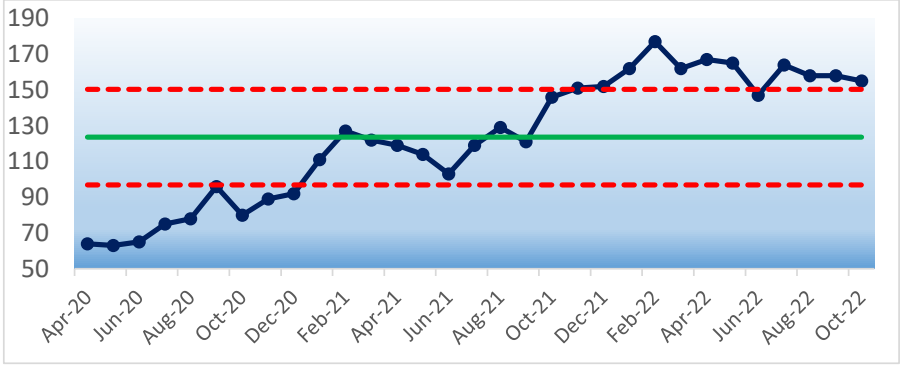


Indicator	**6.5.1 - Long stay patients - stranded (>7 days LOS)**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Oct-22
Value / RAG rating	155

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

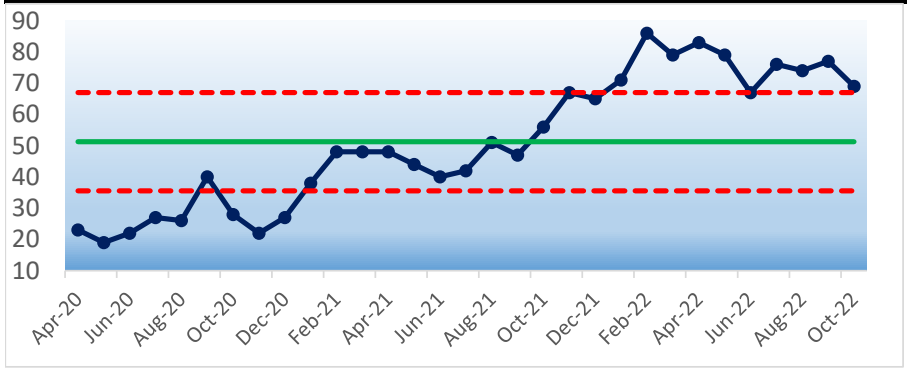
The number of long stay patients (> 7 days) was 155 in October, no significant change on last month and remaining high. This is being driven by the increase in COVID patients, COVID 'pop ups' at day 7 and patients requiring observation as COVID contacts alongside the impact of COVID on POC, residential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

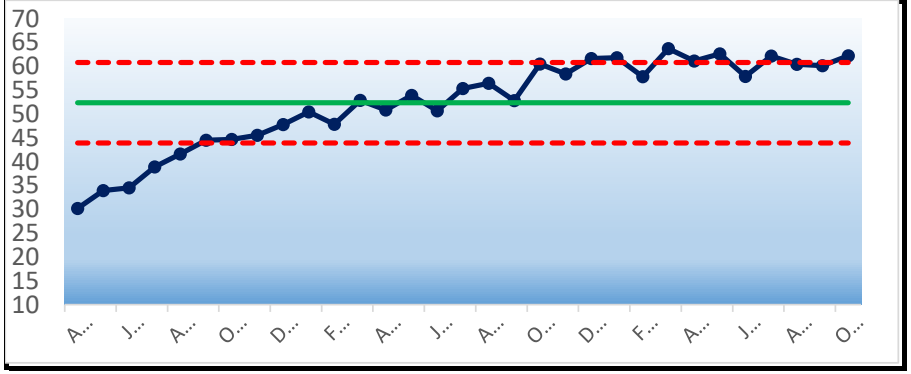
The number of long stay patients (> 21 days) was 69 in October, a reduction on last month but remaining high. This is being driven by the increase in COVID patients, COVID 'pop ups' at day 7 and patients requiring observation as COVID contacts alongside the impact of COVID on POC, residential and nursing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

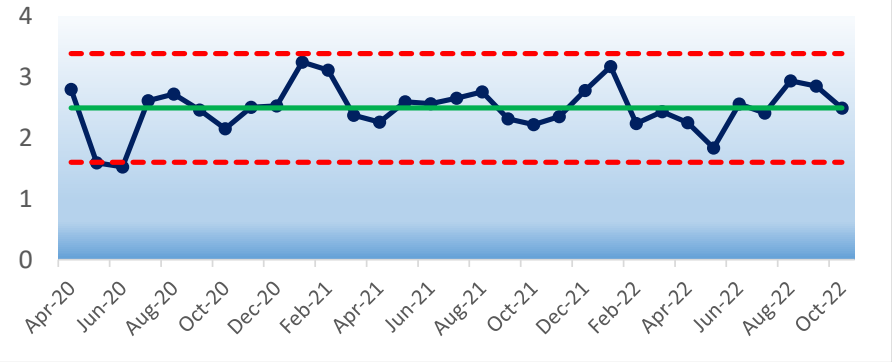
Indicator description

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

Narrative

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

SPC chart



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

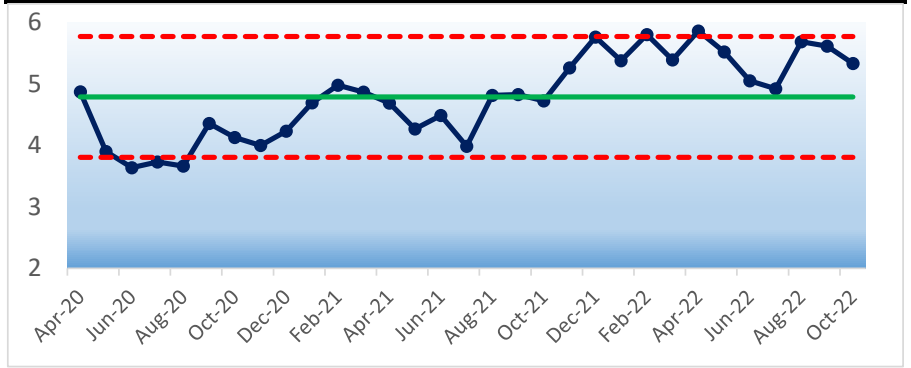
Indicator description

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

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.

SPC chart

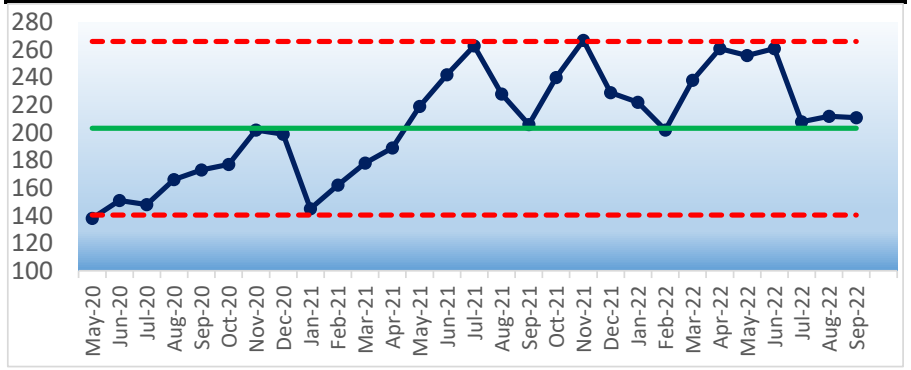


Indicator	**6.8 - Avoidable admissions**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Sep-22
Value / RAG rating	211

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.

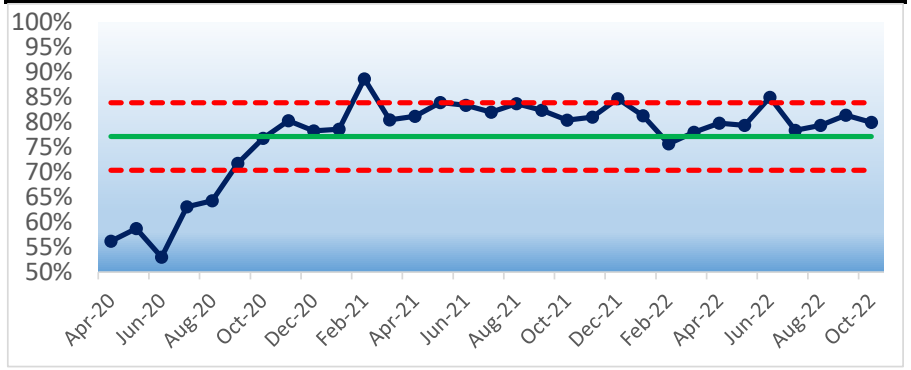
This is below pre-Covid levels - the average per month in 2018/19 was 270.

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%

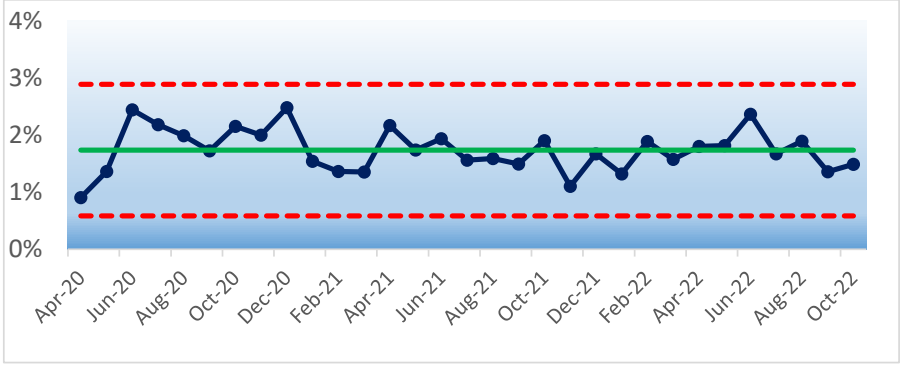
Indicator description

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

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.

SPC chart



Integrated Board Report - October 2022

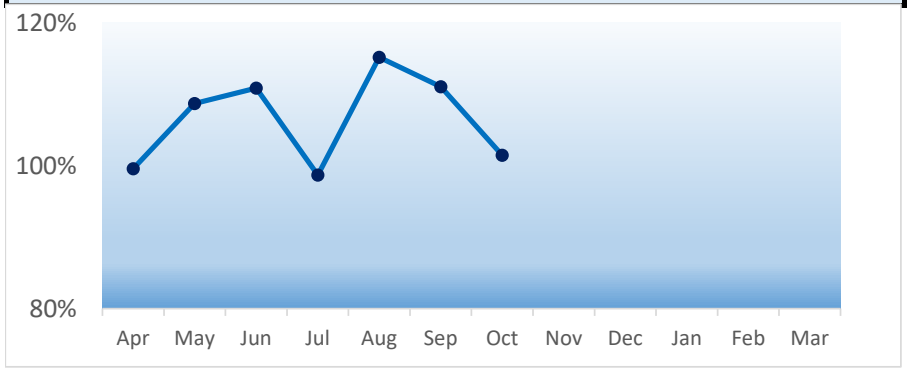
Domain 7 - Activity

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

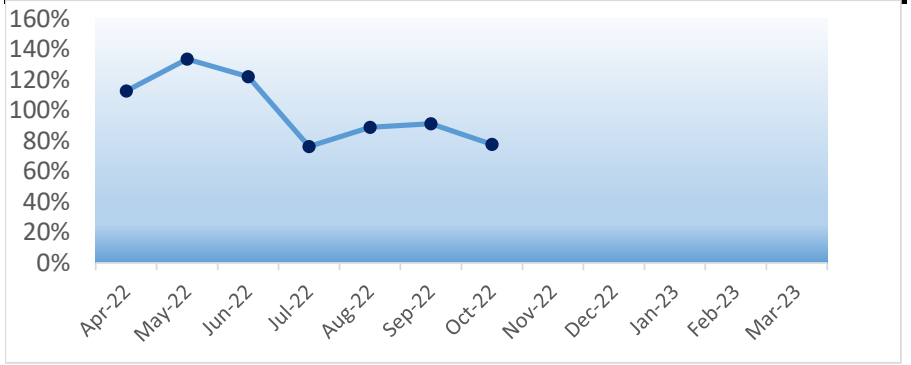
In October, GP referrals were 1% above the equivalent month in 2019/20.

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

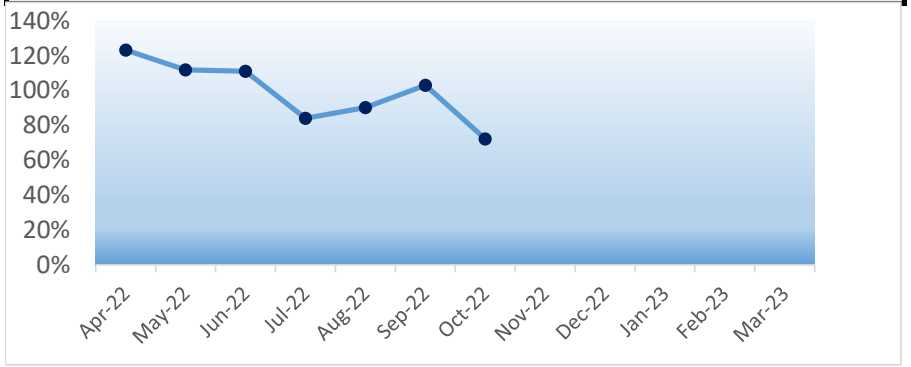
Outpatient activity was 22% below plan in October. New outpatient attendances were 32% below plan and follow up attendances were 17% below plan.

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

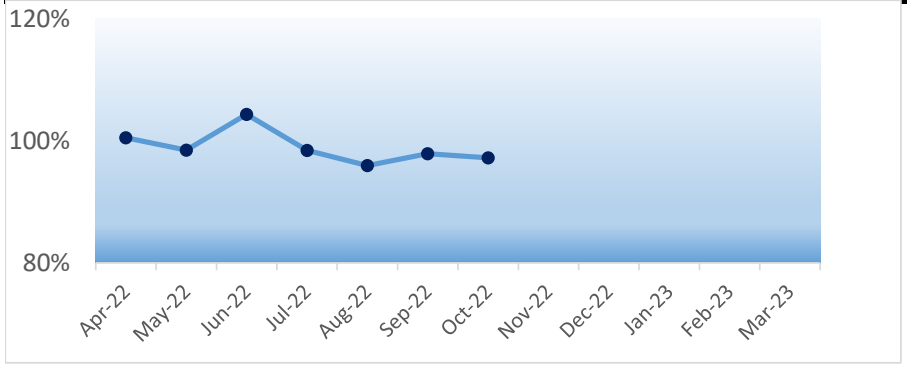
Elective admissions were 28% below plan in October. Elective day cases were 27% below plan and elective inpatients were 33% below plan.

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.

Narrative

Emergency Department attendances were 9% below plan in October.

Trend chart