CORPORATE RISK REGISTER

CQC SAFE DOMAIN

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

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

Lead Committee	Quality Committee	**Risk Type**	Clinical	Workforce	**Risk Appetite**	Averse	
Executive Committee	Quality Management Group (QGMG)	**Summary in Month:** This area of the Corporate Risk Register is linked to Safe Domain. Currently there are 3 Corporate Risks within this Domain. Health & Safety (CRR75) remains a high level risk including multiple factors, with a combined High Level risk of 16. Nursing Shortages (CRR5) remains a High Level risk, however mitigation is in place. Insufficient staffing for the special care baby unit (CRR73) remains a High Level risk of 12, however this will be closely monitored in the next few months to consider decrease. Clarity will be sought regarding the regional position relating to this risk, and the risk updated to include this information based on the information on the regional risk register, if any.					
Initial Date of Assessment	1st July 2022						
Last Reviewed	19th January 2023						

Strategic Ambition	Corporate Risk ID	Principle Risk	Key Targets	Current Position (January 2022)	Plans to Improve Control and Risks to Delivery	Risk Rating Target (CvL)	Risk Rating Current (CvL)
Best Quality, Safest Care	CRR5: Nursing Shortages	Risk to service delivery and patient care due to failure to fill registered nurse vacancies due to the national labour market shortage.	Vacancy Rate Turnover Sickness Covid absences Maternity Leave – including currently commencement at 28 weeks gestation	Successful NHSE/I bid for increased international recruitment - 60 in total at the higher tariff to commence January'23 Clarity of career progression from CSW to RN and points between Agreed 'Home Trust' status with York St John University, have 100% clinical placement capacity at HDFT to support 'growing our own' Additional placement capacity agreed to accommodate additional student numbers. Which would increase the student intake from 186 currently, to 222 in September '22 and a predicted 237 by 2023 International Recruitment and associated funding to increase capacity, continue to review opportunities to increase IR intakes. Expecting 26 new arrivals between June '22 and January '23. There has been a development of 'bootcamp' style courses in preparation for OSCES Refreshed recruitment and retention operational group recommenced in June with two focused task and finish groups established – one for recruitment and one for retention. Working with Directorates re bed bases / establishments and staffing models including principles for changing WFM's to provide additional support to the ward/ departments	Focus on recruitment and retention and effective roster practice As specialty areas fill their vacancies and risk reduces, this will be reflected in local risk registers Likely to continue with risk for some time until newly qualified staff begin to emerge from undergraduate programmes. • Refreshed recruitment and retention operational group recommenced in June with two focused task and finish groups established – one for recruitment and one for retention • Preceptorship programmes to retain newly qualified and new starters refreshed	**4x2 - 8**	**(4X4) - 16**

				Preceptorship programmes to retain newly qualified and new starters refreshed Successful Bid for 2 x 0.5 wte Legacy Mentors to support retention from NNHSE Working with Directorates re: bed bases / establishments and staffing models including principles for changing WFM's to provide additional support to the ward/ departments Focused work on HealthRoster KPIs and performance of effective rostering practice Focused work on additional roles to support nursing, business case being produced. Vacancy rate has increased due to an increase in budget. It was again noted that this risk does link in with the wellbeing risk. 80% risk for RN. 20% risk for CSW. There is a vacancy increase from 75 to 150 for registered nurses. The Safer nursing care tool outputs are not included in this currently. A review of the immunisation service and the restructure of the wards means there is an establishment increase. Immunisation have reviewed their whole time equivalent, it is noted that they have temporary staff rather than substantive previously. Workforce governance approved at Review group for all of above The fill rate has improved. International recruitment has commenced HCSW recruitment is greatest challenge due to recruiting to these roles but not retaining. Nursing associate is not felt to be an option at present	• Successful Bid for 2 x 0.5 wte Legacy Mentors to support retention from NNHSE • Working with Directorates re: bed bases / establishments and staffing models including principles for changing WFM's to provide additional support to the ward/ departments • Focused work on HealthRoster KPIs and performance of effective rostering practice Focused work on additional roles to support nursing, business case being produced. Workforce governance approved at Review group for all of above		
An Environment that promotes wellbeing	CRR75: Health and Safety (CHS1, CHS2 CHS3, CHS4 & CHS8)	Organisational Risk to compliance with legislative requirements due to a failure to make a suitable and sufficient assessment of the risks to the health and safety of employees, patients and others.		Trust / HIF currently use SALUS H&S folders. These are used sporadically across both the Trust and HIF. Suitability of the assessments that exist means few are meeting legislative requirements or relevant guidance. Majority of the assessments are out of date and do not reflect current practices or relevant guidance. Auditing of the folders by SALUS, has not taken place since October 2019 (contract now expired). Previous reports were primarily a tick box exercise rather than a detailed review of content. Audit Yorkshire Report (July 2021) found that RA's were in some cases 10 years out of date, and that oversight and governance of SALUS was not operating effectively. All hazards not being identified and subsequently assessed, and therefore the Trust / HIF is failing to ensure suitable measure are being taken to protect the health and safety of its employees, patients and others who come in to contact with our activities. Meeting held with Finance manager to confirm next steps – potential to use existing budget that had been created for admin support in H&S Team Procurement to provide analysis to support business case Digital project support to be identified. Discussions held with other NHS Trusts currently using EVOTIX to assist with rollout. H&S Team receiving more frequent contact regarding SALUS, additional TRUST wide communications to be done H&S team will respond on a case by case basis to immediate concerns. Draft Implementation pack and project timeline produced. Confirmed licence users number of 250 is comparable to other NHS Trusts currently using EVOTIX. 19/01/23; The health and safety team are currently undertaking case to case reviews in the absence of salus. Appropriate roll and support of use will be requirement when the new system to replace salus is sourced. H&S team will respond on a case by case basis, work has been done with COSHH assessment for HIF and review of maternity risk assessments.	H&S team is reviewing current risk assessment provision. Temporary control measures are being created where possible. Meetings held with provider (EVOTIQ) to purchase a new digital risk management system to replace SALUS. This is a system used by multiple NHS Trusts and will provide a user friendly system, accessible to all Trust / HIF employees that will facilitate the achievement of the above conditions. Business case being developed for the purchase of EVOTIQ (approx. cost is 23k annually). • With creation of new HIF H&S Committee, work is being progressed on a review of the top ten risks in each area (Portering, Domestics, Sterile Services, Waste, Medical Equipment, Estates Maintenance, Food Safety, Security / Parking). Existing risk assessments to be reviewed and amended, or new assessments created. • Still awaiting decision on use of existing money that was assigned for H&S admin role.	**(2x4) - 8**	**(4x4) - 16**

		Organisational risk to compliance with legislative requirements, with the risk of major injuries, fatality, or permanent disability to employees, patients and others, and the unauthorised access of persons to restricted areas of the hospital through the loading bay entrance.		Risk assessment completed for the goods yard. Temporary measures have been implemented: Security guard (Mon-Fri 8am – 6pm) Temporary heras fenced walkway to access Pharmacy lift and stairwell. Instruction to all Trust staff made via email and Team talk. Use of his-vis clothing for those that need to routinely access the yard as part of their duties. Instruction to contractors that the yard area is not to be used as a car park, delivery drop off / collection only. Loading bay entrance remains unsecure 24/7 as doors do not close. Particular security issue on an evening / during the night when staff presence is limited and access remains open to patients and others. Matter still outstanding for Environment Board 24/1/23 as to whether the work can be included in the 23/24 Capital programme. Costs of replacement goods ramp doors is being priced as part of Backlog maintenance work. Risk assessment to be reviewed every 3 months being done as part of the new HIF H&S Committee, review of top ten area risks.	Capital investment will be required to implement all control measures identified within the risk assessment. Including: Security barrier. Permanently marked / protected walkways for pedestrians. Resurfacing of the yard area. Replacement of the loading bay doors. Swipe card access to estates area from within HDH Risk assessment to be reviewed every 3 months (to be carried out early March 2023) ***Risk is mitigated as far as possible. Now require some costing***	**(2x4) - 8**	**(3x4) - 12**
		Organisational risk to compliance with legislative requirements, with the risk of major injuries, fatality, or permanent disability to employees, patients and others, and the unauthorised access of persons to restricted areas of the hospital through the loading bay entrance.		Fire risk assessments are not currently available for all areas of HDH, content and quality is sporadic. Ward changes made over the last 2 months are yet to be reflected in an updated fire risk assessment or evacuation procedure. Communication of information to all relevant persons is not currently happening. Use of Fire Wardens is again sporadic. The assessment of contractors and construction work is not being reflected consistently in Trust fire assessments or evacuation procedures. Corridors, escape routes and exits continue to be blocked. Fire doors regularly found wedged open on Wards. Identification of fire compartmentation and fire doors at HDH is not in place. Testing of fire procedures is inadequate. No clear picture of the Fire safety standards in properties leased by the Trust. External provider has produced 32 fire assessments (approx. 120 to be carried out), these are being reviewed by LTHT and then will be used with the area/ward/department leads to create new evacuation plans. CONTINUING New patient evacuation equipment for use in Strayside now on site, training ti be arranged via Mark Cox (LTHT) Recent enquiries from community based teams has highlighted that some of the tenant contracts we have also require us to carry out the fire risk assessment rather than the landlord (notably Hornbeam Park and Beehive). Not clear what our potential exposure is across our community footprint? Issues continue to be raised, including Gibraltar House, Northallerton. New Fire Policy at March SMT. Corridor audits now being carried out by portering	Review of all current fire provisions by HIF and the H&S team External provision being sourced to provide, competent advice, Fire Manager and Authorising Engineer. Review of HDH fire compartmentation being carried out, to result in action plan for required remedial work. New fire safety policy and management protocols have been drafted. Fire risk assessments being completed for all HDH areas by external consultant. Corridor management protocol is being established to ensure beds etc. are removed in a timely manner. New Stores delivery process is in operation, stores being delivered and decanted on to the wards at the same time. SLA now in place with Leeds Teaching Hospitals NHS Trust (LTHT) to provide fire safety advice / management (including review of all fire risk assessments, dedicated weekly time from the Fire Manager, full access to Leeds Fire team, 24hr access to AD / Fire engineer) External provider has produced 20 fire assessments (approx. 100 to be carried out), these are being reviewed by LTHT Review meeting of progress by external provider 25/1/23	**(2x5) - 10**	**(3x5) - 15**

		Organisational risk to compliance with legislative requirements, with the risk of major injuries, fatalities, or permanent disability to employees, patients and others, due to the failure to manage the impact of contractors, and construction work at Trust premises.		Control of contractors on site is not consistent, examples of failings include corridors being blocked by contractors working in roof voids. Uncontrolled access to restricted areas (plant rooms, HDH roof), subsequently being left unsecured and accessible by any other person. (near miss of patient accessing roof above Wensleydale - summer 2022) Trust has failed to appoint a competent Principal Designer for any of the current construction projects at HDH, and has therefore accepted the legal duties of the Principal Designer by default. Salix / Plant rooms scheme has in effect been operating without a Principal Designer, and subsequent programme delays related to design issues have resulted. Trust hasn't established agreed fire protocols with the various contractors currently on site. ***To note 19/01/23:*** ***This risk was highlighted at the senior management meeting on the 18/01/23. Further discussion to take place at environment board. Conversations continue with HIF relating to contractors.*** ***To note 23/02/23:*** ***More controls and management now in place. Working party is in place. System in place for contractors compliance e.g. DBS checks*** Trust / HIF decision regarding the role of Principal Designer – Disucssed at February Environment Board to identify all current appointed Principal Designers – ensure current legal compliance Working party now reviewing all induction procedures, meeting weekly to create new induction format for all contractors – to include review of contract management, access, DBS, competencies, control of keys etc… 5 years licence taken to provide new digital system RESET, contractors will use this to upload documentation such as DBS, insurance, competency records. Demonstration meeting held with RESET in February to confirm how it will be used. Additional recruitment to the Estates team to include contractor administration and monitoring. Question posed to 2 main CDM contractors on site confirmed that they were carrying out DBS checks, one at our request the other due to their own procedures	Review of all current contractor procedures required by HIF / H&S team / Planning Temporary overview of Salix / Plant rooms work by Heads of Estates, Health and Safety, including attendance at site meetings, progress meetings. New fire protocols for raising the alarm agreed for Salix / Plant room work, new fire routes agreed and implemented for Imaging Services and Chapel. Work being done jointly HIF, H&S and Capital Design Team to agree the process, through Environment Board, for the management of all future construction projects. External consultant has been identified, costs being provided, to carry out part of the Principal Designer role, and produce the Health & Safety file at the conclusion of the Salix / Plant rooms project. Heads of H&S and Estates continue to attend regular site meetings to mitigate immediate concerns re PD role. Trust / HIF decision regarding the role of Principal Designer to be raised / discussed at Environment Board 24/1/23 HIF are to purchase new digital system RESET, contractors will use this to upload documentation such as DBS, insurance, competency records. Additional recruitment to the Estates team to include contractor administration and monitoring.	**(2x4) – 8**	**(3x4) – 12**
		Organisational requirements, with the risk of major injuries, fatalities, or permanent disability to employees, patients and others, due to the failure to manage the risk associated with RAAC roofing.		WSP contracted to conduct survey of RAAC roof at HDH site, including unique identification, deflection survey (ongoing). Temporary supports were installed to RAAC roof on corridor outside Nidderdale as part of Breathe work. (costs to replace this roof to be provided by Breathe (January 2023) – Difficulty and operational impact of replacing this roof means this is not currently feasible. Breathe have also rerouted part of the SALIX work to prevent further weight being put on this area. RAAC roof to kitchen plant room – costs to replace this roof as part of Salix scheme (quote January 2023 – remove March 2023) Currently x3 areas with panels requiring immediate action (x5 panels in Estates/Stores area, x6 panels in Therapy Services, Emergency corridor at the bottom of Swaledale) Decision taken 23/12/22 – access prohibited to all areas apart from x2 areas in DSU, ongoing risk accepted against operational loss Work on x2 panels in Opthalmic area of DSU was started on 7/8 January, however complications with the services meant original design could not be implemented – structural engineer (WSP) to identify new solution, engineer attending site on 13/1/23.	Damian Quinn has joined the regional NHS RAAC group to access support (including access to central funding) Contracted WSP to carry out the identification and surveying of the RAAC roofing at HDH Funding request of £700k has been requested from the central (NHSE) fund to cover the costs of immediate actions. WSP to design temporary engineering solutions for panels / areas at risk of collapse. Cost requested from Whittaker & Leach to install temporary supports. (Estates / Stores area)	**(2x4) - 8**	**(3x4) – 12**

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<td>Deflection survey by WSP to commence on 15 January and will continue each Sunday until complete, Whitaker & Leach to assist surveyor removing / replacing ceiling.
Funding of £490k secured from NHSE for 22/23, which will cover costs already incurred, surveying and remedial work being carried out.
• Additional at risk panel identified in corridor between ITU and Farndale – WORK COMPLETE
• Panel Therapy Services corridor by Hydrotherapy pool – WORK COMPLETE
• Panel above Silverdale reception – WORK COMPLETE
• Panel in IT infrastructure room, temp supports installed, additional loose material to be removed in area above server room
• Additional panel found in DSU dirty corridor – Supports put in place for this panel (COMPLETE). Original panel has required redesign, and additional work now required to move services – WORK OUTSTANDING
• Work in the remaining areas has been delayed by the complications of services and the need to remove and replace firestopping / brickwork to install the structural supports. Remaining work scheduled as follows:
o 18/19 Feb – Complete Silverdale side room propping. Ductwork, firestopping and ceiling to be completed during the week (sealed office so no operational impact).
o SDEC Secretaries office - Strip ceiling and light well to prep for following weekend.
o 26/27 Feb - Finish SDEC Secretaries Office - prop panels. Fire stopping, decorations and ceiling to follow in the week.
o 4/5 Mar – DSU ophthalmic waiting area

Due to the additional difficulties with access and services that need moving the remaining areas discussions are taking place with the area leads to arrange dates, with a view to have the work completed ASAP

o Therapy Services corridor (Head of Physio office).
▪ Ceiling and ducting strip out Friday
▪ Panels propped Saturday and Sunday.
▪ Monday ducting back in.
▪ Tuesday fire stopping and ceiling.
o Day surgery Dirty Corridor
▪ Pipework and ducting removed Friday navigator after surgery finish
▪ Panel propped Saturday
▪ Pipework and ducting replaced Sunday.
• Deflection survey by WSP continuing, final reports expected before end of current financial year.
• WSP also producing designs and plans to inform a new eradication plan.
• Funding of £490k secured from NHSE for 22/23, which will cover costs already incurred, surveying and remedial work being carried out. Additional bid made for 23/24</td>
<td>Task group to be established, via Environment Board. Head of Estates and Head of H&S to lead.

To note 19/01/23:
Survey complete relating to the RAAC roofing tiles. Panels identified and mitigation in place to prevent falling.

All remedial work to be completed on a weekend to limit impact on operational activities Remedial work by Whitaker & Leach commenced 7/8 January and will continue each weekend until complete.

Damian Quinn has joined the regional NHS RAAC group to access support (including access to central funding) – funding bid for 23/24 has been completed
Task group to be established, via Environment Board. Head of Estates and Head of H&S to lead – initial discussions with EPRR manager held</td>
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<td>Best Quality, Safest Care</td>
<td>CRR73 – Insufficient staffing for special care baby unit</td>
<td>Insufficient capacity to meet the key national safety standard of a Qualified in Specialty (QIS) staff member on every shift and 70% of the establishment (8.3wte) qualified on Special Care Baby Unit (SCBU).</td>
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<table>
<tr><th colspan="3">Establishment</th><th>January Plan</th><th>February Plan</th><th>March Actual</th><th>April Plan</th><th>May Plan</th><th></th></tr>
<tr><th></th><th>Budget</th><th>Amended budget plan</th><th>QIS</th><th>QIS</th><th>QIS</th><th>QIS</th><th>QIS</th><th>Minimum QIS Standard 70%</th></tr>
<tr><td>B5</td><td>8.81</td><td>6.20</td><td>3.22</td><td>4.14</td><td>4.14</td><td>4.14</td><td>4.14</td><td>2.75</td></tr>
<tr><td>B6</td><td>3.01</td><td>5.62</td><td>3.52</td><td>3.52</td><td>4.30</td><td>4.30</td><td>5.52</td><td>5.52</td></tr>
<tr><td>Total</td><td>11.82</td><td>11.82</td><td>6.74</td><td>7.66</td><td>8.44</td><td>8.44</td><td>9.66</td><td>8.27</td></tr>
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<td>Increase in % of substantive establishment with QIS or on development pathway to obtain QIS

Increase of available bank/agency QIS nurses to support SCBU

B6 recruitment

To note: Dec 22.
It was also raised regarding the leadership in SCBU as currently the line management falls under the OPS team – Sarah Walters.</td>
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<td>(3x4) - 12</td>
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				Establishment	***To note 19/01/23:*** ***Ward manager is not QIS trained.***	

	Budget	Amended budget plan	March Actual QIS	April Plan QIS	May Plan QIS	June Plan QIS
B5	8.81	6.20	3.83	3.83	4.44	4.44
B6	3.01	5.62	3.52	3.52	4.52	4.52
Total	11.82	11.82	7.35	7.35	8.96	8.96

There is planned ward QIS cover on each shift but very limited ability to react to short-notice sickness/absence, even with the shift incentive. Colleagues with QIS across wider HDFT team are being proactively contacted to identify if they would be willing to support and their training/familiarisation needs to enable increase in bank availability, including offer to cover travel expenses and travel time where contracted bases are not in Harrogate e.g. for Safeguarding nurse with QIS from Middlesbrough.

3 newly appointed B5 postholders are being supported to achieve their QIS, two are newly qualified so will commence their training when in post – they will need to complete foundation level first so development will take approx. 2years. The third has completed their foundation level. We are exploring whether a derogation of duties could apply to this third colleague whilst they complete their training to gain their QIS.

Recent retiree with QIS has returned on zero hours contract for 12months to support – is currently working 0.61wte.

SOP for QIS gap ratified at OMG 14/10/22 following input by Maternity services and clinical input from Paediatrics & CC Directorate clinical leadership and available to on call managers/directors

Fostered solid relationships with current staff therefore staff have willingly regularly worked NHSP shifts as well as being flexible with their substantive shifts to maintain the QIS cover.

Workforce & Education strategy for SCBU has been drafted in line with ODN strategy to support embedding of regional objectives to support colleague retention.

Reviewed the opportunity to operate a shadow rota – unfortunately only 2 substantive staff members have confirmed they would be willing with a significant incentive. Not feasible to put into place.- Reviewed the opportunity to operate a shadow rota – unfortunately only 2 substantive staff members have confirmed they would be willing with a significant incentive. Not feasible to put into place.

Business case being finalised to make permanent the agreed B5 to B6 changes already implemented and for creation of a B7 clinical educator/safeguarding lead post to support the retention strategy.

A discussion was had regarding this risk being operational. A review of the risk on the corporate risk register will take place in the upcoming months, and if improved the risk will be de-escalated to the directorate. If no improvement, risk will remain on corporate risk register. The likelihood could drop to a 2 when we have more staff, and then in May drop to a 1.

Action:
Need to ensure that this is a regional issue and identify what is on the regional risk register. This is then to be incorporated within this risk.

CQC EFFECTIVE DOMAIN

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

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

Lead Committee	Quality Committee	**Risk Type**	Clinical	Workforce	Operational	**Risk Appetite**	Cautious
Executive Committee	Quality Management Group (QGMG)	**Summary in Month:** This area of the Corporate Risk Register is linked to the Effective Domain. Currently there are no Corporate Risks that link to this domain.					
Initial Date of Assessment	1st July 2022						
Last Reviewed	19th January 2023						

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

CQC CARING DOMAIN

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

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

Lead Committee	Quality Committee (Clinical Risk) People and Culture (Workforce Risk)	**Risk Type**	**Clinical**	**Workforce**		**Risk Appetite**	Minimal

Executive Committee		Quality Management Group (QGMG) (Clinical) Workforce Committee (Workforce)	**Summary in Month:** This area of the Corporate Risk Register is linked to the Caring Domain. Currently there is 1 Corporate Risk within this Domain. The impact of COVID and Operational Pressures on workforce wellbeing (previously wellbeing of staff) (CRR6) remains a High Level risk at 16. Risk title is to be amended to reflect workforce in its entirety.				
Initial Date of Assessment		1st July 2022					
Last Reviewed		19th January 2023					
Strategic Ambition	**Corporate Risk ID**	**Principle Risk**	**Key Targets**	**Current Position (December 2022)**	**Plans to Improve Control and Risks to Delivery**	**Risk Rating Target (CvL)**	**Risk Rating Current (CvL)**
At Our Best – Making HDFT the Best Place to Work	CRR6: The impact of Covid and Operational Pressures on Workforce Wellbeing	Risk to patient care and safety due to current staffing levels and poor morale due to increased workload, post pandemic burn-out and poor working environment. Risk of: - both short and long term mental health impacts on staff	Inpulse engagement scores National Staff survey scores: Engagement, morale, Sickness absence levels Turnover Vacancy rate	**Staff Engagement – Survey Scores (**Benchmark Group Acute & Community Trusts**)** - 7.20 – 31 Jan 2023 (Theme Kindness) – Benchmark Score 6.3 - 6.84 - 30 Nov 2022 – National Staff Survey – Benchmark Score 6.76 - 6.91 - 31 July 2022 (Theme Teamwork) – Benchmark Score – 6.37 - 7.03 - 30 April 2022 (Theme Integrity) - Benchmark Score – 6.28 - 6.96 - 31 Jan 2022 (Theme Kindness) - Benchmark Score – 6.36 **Turnover – Target 12%** • Turnover Rate has had a slight increase from 15.31% to 15.54% as at 28 February 2023. **Sickness – Target 3.9%** • Sickness has decreased to 4.98% as at 28 February from 5.16% in January 2023%. **Appraisals – Target 90%** • Appraisal Rates have seen an increase in February to 77.04% from 71.16% in January 2023. **Vacancy Rate** Vacancy rate is 8.0% as at 28 February 2023, this is a decrease from the rate of 8.46% in January 2023. • **Turnover** Turnover is 15.54% against a tolerance threshold of 12%. Benchmarking data is available for 30 Oct 2022 – National Average was 14.71%, NEY was 13.00%, HNY was 14.24% and HDFT was 13.46% (data source – NHS Digital) • **Sickness Absence** HDFT are 9h lowest for sickness absence levels out of 31 Trusts in NEY league table. Sickness rates have further decreased this month from 5.16% in January to 4.98% in February. • **Appraisals** Appraisal rates have seen a significant increase of approx. 6%, which is in response to all Directorates being instructed to achieve 90% appraisal compliance by 31.03.23. We do however remain significantly below this target	A number of Financial supports are in place to assist colleagues with escalating cost of living. These include some of the following welfare fund, additional 10p per mile (fuel costs), free car parking. A wide range of Financial Wellbeing resources available on Living at Our Best pages of the Internet. Flu and Covid Vaccines available for all colleagues since September 2022 until January 2023. Current vaccination levels have increased from last month to 62.7% for Covid and 58% Flu. Recruitment and Retention groups underway. Wellbeing fund of 0.5 million provided to upgrade working environment. New clinical leadership model in place from December 2022. OD programme to be delivered to support new structure and enable compassionate and inclusive leadership teams who have a strong focus on the delivery of clinical excellence. Inpulse survey feedback to be handled locally by line managers to support increased engagement and morale Health & Safety Team and Occupational Health Team to work in collaboration over conducting an organisational work related stress audit to enable the development of a wider programme of work to be rolled out to directorate and team level around this issue. ***Action 19/01/23:*** ***If the risk is relating to workforce in its entirety then the wording does not reflect that. The risk title is to be changed to reflect us not having adequately trained and engaged workforce.*** ***The plans within the risk do not correlate to the conditions, which need to be met. Clarity around***	**(3x4) - 12**	**(4x4) - 16**

				• **Vacancy Rate** As at 31 January 2023, the vacancy rate was 8.46%, which is an increase on 8.36% last month. The rise in vacancies is due to an increase in budgeted establishment in January 2023 of 28.54wte.	***metrics to measure against is required. Appraisal figures and engagement scores are to be included. Review and look back at the last 5 impluse surveys along with the staff survey to review outcomes relating to questions around staff and their work.*** ***To Note 23/02/23:*** ***Current position with staff engagement is good. Sickness has decreased. The key will be self-reported staff engagement (impulse) score***		

CQC RESPONSIVE DOMAIN

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

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

Lead Committee	Resource Committee	**Risk Type**	**Clinical**	**Operational**		**Risk Appetite** Cautious
Executive Committee	Operational Management Group (OMG)	**Summary in Month:** This area of the Corporate Risk Register is linked to the Responsive Domain. Currently there are 3 Corporate Risks within this Domain. Autism Assessment (CRR34) remains a High Level risk, this has increased to 16 from 12 and working is ongoing to determine future needs of the service. Numbers on the waiting list has increased from 802, last month to 760. Longest wait has also increased from 53 to 55. RTT (CRR41) remains a High Level risk at 12 due to performance against the national standards. However, a wide range of mitigation in place and zero 104 week waits are noted. Finally ED 4 hour standards also remains a High Level risk at 15 due to the continued failure to meet the target. A wide range of mitigation is in place including a pilot of new streaming pathways. Target score may require amendment following review of national planning guidance which has been released.				
Initial Date of Assessment	1st July 2022					
Last Reviewed	19th January 2023					

Strategic Ambition	Corporate Risk ID	Principle Risk	Key Targets	Current Position (December 2022)	Plans to Improve Control and Risks to Delivery	Risk Rating Target (CvL)	Risk Rating Current (CvL)
Great Start in Life	CRR34: Autism Assessment	Risk to quality of care by not meeting NICE guidance in relation to the commencement of autism assessment within 3 months of referral. Risk that children may not get access to the right level of support without a formal diagnosis and that this could lead to deterioration in condition.	Need to reduce the backlog of referrals back to the NICE standard of 3 months (reduce the waiting list to approximately 120)	It was agreed with commissioners that HDFT would have an autism pathway review day (3/11/22) to agree a proposal which improves pathway and access but also includes waiting list stabilisation/reduction options. This followed a meeting in July where senior commissioners requested joint working to support a new referral pathway and to address waiting lists. It was envisaged this would incorporate learning from two pilots that commissioners had agreed in Scarborough & Selby. Unfortunately this evaluation data was delayed and did not give the benefits for the cost originally envisaged. In addition, NYCC raised concern around any referral pathway proposal which would give SENCOs in schools a higher workload (as per Selby pilot). A further meeting with commissioners to discuss HDFT proposal took place on 8/12/22 with Kirsty Kitching (Mental Health commissioner), Suzanne Bennett (Children's commissioner) and Jacob Gilson (CYP Neurodevelopmental Project Manager with the commissioners). Commissioners were clear at this meeting that they would like to explore the difference in our triage of referrals (HDFT do not accept 7% of referrals in comparison to 35% at The Retreat) and our diagnosis rates. They will be setting up a meeting to undertake a focused piece of work in collaboration with their provider for Scarborough & Ryedale (The Retreat) that looks at drivers for the variation. . **Date for this piece of work is agreed for w/c 13th March.** Commissioners acknowledged that the different referral pathways may account for the differing %'s (The Retreat have GP only referrals, HDFT have referrals from other health professionals). Commissioners acknowledged that given the scale of increase in referrals this work would not address the continued deteriorating waiting list position. However that also stated they do not have funding to support increase in staffing or our updated service model. **An additional £250k non-recurrent funding has now been offered to HDFT for a waiting list initiative** A comparison (in the meeting) of referral forms confirmed alignment with referral criteria.	Executive input & strategic decision around next steps for Autism Assessment service. **To note19/01/23:** ***There are outstanding actions which HDFT have tasked Sarah Walters to lead on as a focused piece of work. It is hopeful that this work will be completed by the end of January, and once complete we will go back to the commissioners with the conjecture. – This has now been completed.*** **Tender did go to a bid or no bid process. The trust chose not to bid.** **Important to note, HDFT are happy and could provide this service, but more money is required, we can not recruit on temporary funding.** **Commissioners advised the money required is double.** **Short time risk is mitigated, long term risk taken forward to the ICB.** **Contract runs until the end of 2023.**	**(3X2) - 6**	**(4X4) - 16**

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Commissioners also presented data where they raised concerns at our cost in comparison to their other provider 'The Retreat' – they indicated we were approx. twice the cost. We were able to feedback in the meeting the childhood population figures for all districts (included below for reference) to show that our districts are roughly twice the size of the other provider and our cost per assessment approximately the same.

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

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

<table>
<tr><th>NYCC District</th><th>Childhood population (0-19)</th><th>Total service population</th><th>Provider %</th><th>Provider</th></tr>
<tr><td>Hambleton</td><td>18600</td><td></td><td></td><td>HDFT</td></tr>
<tr><td>Harrogate & Rural</td><td>36000</td><td></td><td></td><td>HDFT</td></tr>
<tr><td>Richmondshire</td><td>11700</td><td>66300</td><td>68%</td><td>HDFT</td></tr>
<tr><td>Ryedale</td><td>10350</td><td></td><td></td><td>The Retreat</td></tr>
<tr><td>Scarborough</td><td>20632</td><td>30982</td><td>32%</td><td>The Retreat</td></tr>
<tr><td>Total</td><td>97282</td><td></td><td></td><td></td></tr>
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• Numbers on the waiting list: 853
• Longest wait: 56 weeks (excluding exceptions)
• Financial year to date delivery 491 completed assessments against a plan of 500
Rolling 6-month average monthly referral rate is at 85 and is higher than baseline commissioned capacity of 40 assessments per month. There is continued referral demand growth (Feb referrals at 98). Due to continuing higher referral numbers & assessment model (which is in line with NICE recommendations) we are predicting we would end the year with a waiting list of 898 children & young people with a 23 month wait to commence assessment for any CYP joining the waiting list.
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It was agreed at SMT that the issue would be escalated up the ICB by our Executive team to agree an approach between the Trust and ICB.

To note 23/03/23:
Awaiting outcome of the meeting with commissioners to understand the difference in the Trusts triage of referrals and diagnosis rates. Meeting scheduled for 13th March.
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<td>Person Centred, Integrated Care, Strong Partnerships</td>
<td>CRR41: RTT</td>
<td>Risk to patient safety, performance, financial performance, and reputation due to increasing waiting times across a number of specialties, including as a result of the impact of Covid 19 (added 13/03/2020)</td>
<td>92% 18 week incomplete performance standard

52+ Waits

78+ Waits (zero by March 23)

104+ Waits (zero by July 22)</td>
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<table>
<tr><th></th><th>Apr-22</th><th>May-22</th><th>Jun-22</th><th>Jul-22</th><th>Aug-22</th><th>Sept-22</th><th>Oct-22</th><th>Nov-22</th><th>Dec-22</th><th>Jan-23 (provisional)</th><th>Feb-23 (provisional)</th></tr>
<tr><td>Total incomplete RTT pathways</td><td>24,714</td><td>25,384</td><td>25,134</td><td>25,629</td><td>25,564</td><td>25,490</td><td>25,437</td><td>25,388</td><td>24,951</td><td>25,202</td><td>25,972</td></tr>
<tr><td>> 52 weeks</td><td>1,187</td><td>1,196</td><td>1,261</td><td>1,297</td><td>1,297</td><td>1,350</td><td>1,285</td><td>1,201</td><td>1,228</td><td>1,186</td><td>1,163</td></tr>
<tr><td>> 78 weeks</td><td>205</td><td>184</td><td>169</td><td>155</td><td>144</td><td>133</td><td>112</td><td>100</td><td>118</td><td>101</td><td>88</td></tr>
<tr><td>> 104 weeks</td><td>11</td><td>3</td><td>1</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td></tr>
<tr><td>RTT new clock starts</td><td>6,403</td><td>7,219</td><td>6,382</td><td>6,817</td><td>6,917</td><td>6,669</td><td>6,727</td><td>6,869</td><td>5,226</td><td>6,397</td><td>2,022</td></tr>
<tr><td>RTT clock stops</td><td>4,290</td><td>5,136</td><td>5,119</td><td>5,244</td><td>5,515</td><td>5,291</td><td>5,655</td><td>5,998</td><td>4,563</td><td>5,262</td><td>1,129</td></tr>
</table>

Elective recovery work continues to be a major focus, and the Trust continues to, where possible, increase elective admissions to reduce the gap to pre-COVID levels. The trust have implemented and resourced dedicated project support in theatres that commenced in October 2021 to aid elective recovery.
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Additional theatre lists at a weekend
Clinicians continue to undertake additional work on a weekend, with lists now being booked for Community Dentistry Paediatric sessions, General Surgery , Ophthalmology and Urology.

Staffing in theatres continues to be challenging with vacancies gaps and covid related sickness but there is now a greater up take for covering additional theatre lists in the evening and at weekends and there are currently 22 new starters in the workforce pipeline.

Additional capacity will become available for treating patients through the Wharefdale theatres (TIF1 Scheme)- however the
</td>
<td>(3x2) -6</td>
<td>(3x4) - 12</td>
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				To mitigate the WLI changes and annual leave rollover dynamic, clinical sessions are in place to ensure most clinically pressured activity is covered. Ring fencing of orthopaedic elective capacity is underway alongside a pilot of an LLP model to re-engage weekend and evening lists (commenced 11th June 2022 with lists alternate weekends since) 34 patients have had their care delivered through this mechanism. The 5th room to support capsule endoscopy remains operational and Endoscopy lists are available seven days per week Clinical prioritisation and review continue for elective patients with 99% of patients waiting having been allocated a P1-6 national classification. The majority of those yet to be classified have been waiting <=2 weeks and work is progressing to ensure these are rapidly coded. **104+ week waiters** Ongoing mutual aid across WYATT and more latterly HNY is used to support system clearance of long waiting patients. HDFT have supported both systems. 104 week waiting patients were cleared in advance of the July 2022 deadline. The community dental over 104 weeks is also now zero. All patients over 88 weeks have a date for surgery. Some of these treatment dates deliver surgery at 99-102 weeks. HDFT currently have no 104 week patient waits **78 week waiters (clearance target March 2023**) Weekly PTL meetings with a service manager, admissions manager and 18-week lead are ongoing. In these meetings each patient is individually reviewed to ensure that there is a clear plan in place. Each pathway is receiving additional management input to ensure vulnerable adults/children with need are not disadvantaged. All patients at risk of 78 week wait breach by 31st March have a planned appointment. Planned and Surgical Care have 68, and Community Dental have 20 (88 combined) to work through before end of March in order to reach the zero position. **Validation and real-time updating of RTT waiting lists** The following actions are underway/ completed to improve accuracy of waiting list, which will further reduce the numbers allowing closer scrutiny of genuine waiting patients. • Standardised Reporting Dashboard : piloted & in place • Elective recovery meeting: weekly in place, using new data/ format. Directorates implementing equivalent at service level. • 6:4:2 – booking levels and utilisation improving (confounded by covid absence to some degree) • RTT out coming: business case and funding are approved and moving forward procurement. • RTT team – move to embedding in directorates. Final model agreed, consultation with affected staff to commence in next 4 weeks. • Validation of full waiting list: AI supported validation tool is in place with training being rolled out. This alongside a review of current processes to close the 'gap' between clock starts, clock stops and growth in RTT waiting list. RTT team gaining some agency support for a validation exercise in January • 6:4:2 – booking levels and utilisation improving (continuing to be confounded by covid absence to some degree) • RTT outcoming has now been ordered with implementation across Q1/2 of 2023	timelines for this opening have slipped into 23-24 Limited access to an interim solution through a vanguard theatre at Wharfedale is being progressed to impact quarter 3 2022/3. The independent sector support is being increased with circa 500 cases being delivered in this way. None treatment RTT waiting over 52 weeks is minimal currently with only Gastroenterology, Neurology and specialist gender endocrinology-having patients waiting this long. Recovery plans in gastroenterology and neurology are currently in development. ***To note 19/01/23:*** ***We are currently not hitting key metrics. March 2024 to reduce the risk as per the planning guidance.*** **Additional theatre lists at a weekend** **Validation and real-time updating of RTT waiting lists**		
Best Quality, Safest Care	CRR61: ED 4-hour Standard	Risk of increased morbidity/ mortality for patients due to failure to meet the 4 hour standard.	A&E 4 hour standard (below 95% in August 2022)	A&E 4 hour standard remains below the 95% target. **4 hour performance**	Streaming launch 4 January 2023. Capital works ongoing to centralise acute services at front door and provide enhanced access to diagnostics.	**(3x2) - 6**	**(3x5) – 12**

			12 hour DTA breaches (82 in August 2022) Ambulance Handovers (15 over 30 minute handover breaches and 2 over 60 minute in August 2022)												

	May 22	**June 22**	**July 22**	**Aug 22**		**Sept 22**	**Oct 22**	**Nov 22**	**Dec 22**	**Jan 23**	**Feb 23 (so far)**
Type 1	62.7%	66.5%	65.8%	60.1%		57.5%	62.6%	60.5%	57.7%	67.4%	*73.6%*
Type 1 + 3 combined	**68.1%**	**71.6%**	**71.2%**	**66.6%**		**63.9%**	**68.0%**	**66.2%**	**63.4%**	**72.2%**	***77.6%***
York ambulance diverts*	66	83	72	65		68	59	70	86	49	*21*

*Excluding YO51 postcodes as Boroughbridge patients come under HDFT

January 2023 saw a drop in number of attendances and an increase in performance against the 4hr standard

- Performance against the 4hr standard was significantly below the 95% target
- Met targets for median time in department for non-admitted patients and average for all patients
- Significant waits for admitted patients reflecting significantly high capacity of hospital and difficulties with flow.
- Significant waits for mental health patients in the department due to delays for mental health act assessments and inpatient mental health beds

	12 Hour DTA	**12 Hour total wait**	**30 Min HO (including 60+ mins)**	**60+ Min HO**
June 22	15		30	1
July 22	37	219	14	2
August 22	82	346	16	2
September 22	60	286	77	25
October 22	72	247	42	41
November 22	67	224	79	28
December 22	165	431	183	97
January 23	89	143	80	39

In May 2023 we will lose space for ED2 as part of the final phase of building works. A new temporary location for the minors' stream needs to be identified. The minors' stream achieved 99.5% against the 4hr standard so there will be a significant impact on the department's performance as a whole without an alternative area.

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

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

AFU now relocated to Swaledale with the net increase of 8 patient spaces including frailty SDEC further enhancing flow out of the ED

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

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

To note 19/01/23:
Target risk may need to change dependant on the planning guidance, which has come out.

To note 23/02/03; A&E 4 hour standard remains below the 95% target

CQC WELL-LED DOMAIN

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

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

Lead Committee	Trust Board	**Risk Type**	**Clinical**	**Workforce**	**Operational**	**Risk Type**	Cautious
Executive Committee	Senior Management Committee (SMT)	**Summary in Month:** This area of the Corporate Risk Register is linked to the Well-Led Domain. Currently there is no Corporate Risk within this Domain.					
Initial Date of Assessment	1st July 2022						
Last Reviewed	19th January 2023						

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

USE OF RESOURCES

Use of resources area Key lines of enquiry (KLOEs)

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

Lead Committee	Resource Committee	**Risk Type**	Financial	Workforce	Operational	**Risk Appetite**	Minimal
Executive Committee	Operational Management Committee (OMG)	**Summary in Month:** This area of the Corporate Risk Register is linked to the Use of Resources Domain. Currently there are 3 Corporate Risks that are link to this domain. Agency Usage (CRR71) remains a High Level risk at 15, however it is noted that this risk is being used to off set CRR5 Nursing Shortages and CRR6 Staff Wellbeing. In addition the Operational Financial Position (CRR72) is no longer required to be on the corporate risk register, risk to be removed. Underlying Financial risk (CRR76) is a High Level risk scoring 15.					
Initial Date of Assessment	1st July 2022						
Last Reviewed	19th January 2023						

Strategic Ambition	Corporate Risk ID	Principle Risk	Key Targets	Current Position (December 2022)	Plans to Improve Control and Risks to Delivery	Risk Rating Target (CvL)	Risk Rating Current (CvL)
Overarching	CRR 71: Agency Usage	The Trust is currently in breach of regulatory obligation regarding agency price caps, is incurring premium costs for staffing where vacancies exist, and in some circumstances this results in an adverse impact to quality and safety. Breach of IR35 regulations and potential fine from HRMC.	Monthly financial performance Performance against indicative agency ceiling Weekly reporting regarding cap compliance	The Trust is current spending in excess of the agency ceiling. The Trust breaches the agency cap for a number of roles. No agency medical staff are engaged below agency cap rates. It should be noted that this risk is mitigating some of the other risks currently raised on the Trust risk register. In particular nurse staffing, work around ED/flow and elective recovery. This clearly is not ideal but is accepted whilst those other risks persist. Agency Review meetings in place with Directorates to bring great focus on the issue. Specific review of problem medical areas.	Substantive recruitment and retention schemes Clear escalation on cascades where appropriate and available ***Risk score remains the same at 15.*** ***To note 23/02/23: plan is to review the sign off process and reinstate agency meetings***	**(3X3) - 9**	**(3X5) - 15**
Overarching	CRR 76: Underlying Financial Position	Risk to financial sustainability and regulatory impacts as a result of not achieving breakeven. Risk to providing value for money to taxpayer. Risk to service sustainability as a result of resources available to provide services.	Improved understanding of the underlying run rate, and the balancing of this risk against other service risks. Improved planning and implementation of Savings Programme schemes Mitigations for inflationary pressures as a result of wider economic position	The Trust is currently at risk of managing within resources available in future years. Current high level position – Underlying Run Rate £12m adverse System Support in 2019/20 £3.5m favourable National Savings requirement (3%) £9m adverse Reduction in Covid Income £5m adverse ERSF Risk £6.5m adverse Recurrent Impact of LA pay award £1.8m adverse In planning terms this would suggest a £30m issue entering 2023/24, pre any mitigation and/or developments. Currently setting waste reduction targets for directorates at 3% plus any historic issues. Performance against this will contribute to the Yellow figures.	2023/24 planning process Productivity review Various financial controls Output from HFMA financial sustainability checklist Waste reduction programme Elective recovery workstreams Outpatient Transformation work	**(5x1) - 1**	**(5x3) - 15**


Awaiting guidance on elective recovery funding to understand the risk in Blue, how this may be mitigated by improved performance and what this may provide to mitigate waste reduction.

Integrated Board Report - February 2023

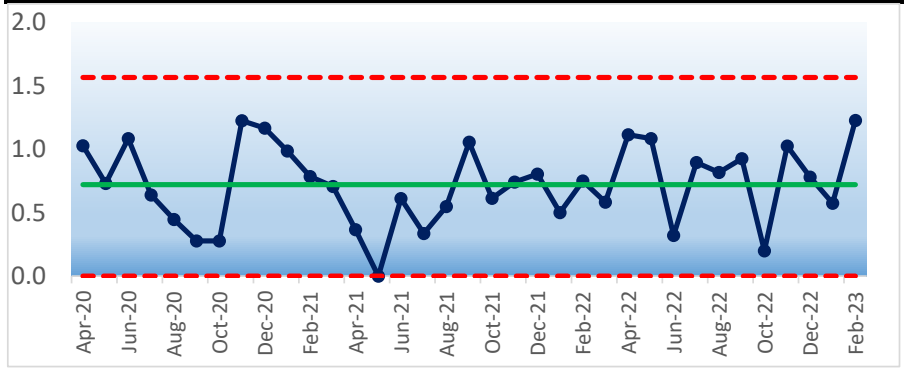
Domain 1 - Safe

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	Feb-23
Value / RAG rating	1.23

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 was a total of 44 HAPU (all categories) reported in February 2023, with 11 category 3 or above. A clinical area of concern was highlighted in February and intensive education and support delivered by the TVN team which is ongoing. Of the 11 reported pressure ulcers, 5 were assessed to be moderate harm following review by TVN, triggering the PULT process to ascertain if omissions in care led to the pressure ulcer developing or deteriorating. A further increase in mucosal device related pressure damage has been seen in February and this has been escalated to the continence practice facilitator and wider continence team to review and support clinical areas.

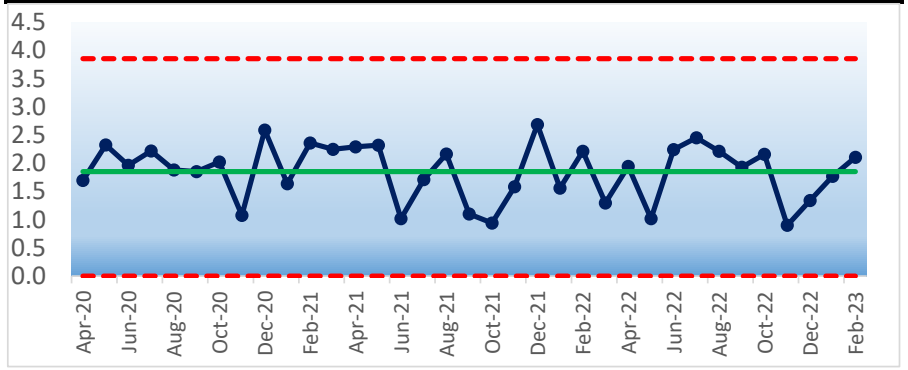
Vacancies within the TVN team have been recruited to with two external candidates joining the team by the end of May. A further vacancy for a 6-month support worker is ongoing. The successful candidate will support the existing team to review and monitor category 1 and 2 pressure ulcers (not currently reviewed by TVN) and implement preventative measures to reduce the risk of deterioration and patient harm. It is anticipated a further reduction in HAPU will be seen with the implementation of this new post.

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	Feb-23
Value / RAG rating	2.10

Indicator description

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

SPC chart



Narrative

There were 36 pressure ulcers (all categories) which developed or deteriorated in HDFT community care in February 2023. Of these, 12 were verified as category 3 or above. All 12 were assessed as low harm following holistic patient assessment by TVN or podiatry. All preventative measures were found to be in place, appropriate advice provided to patient/carers and equipment supplied if required.

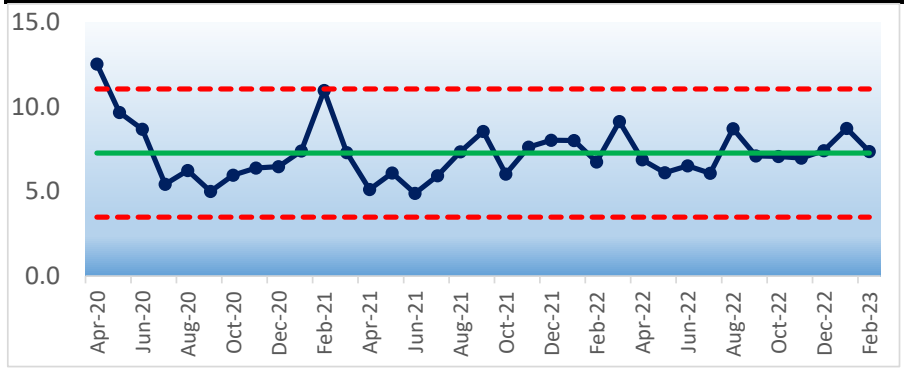
The TVN team continues to provide support and expert advice to patients receiving care from adult community services. This support also extends to those in nursing homes, GP practices and 0-19 children's services.

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	Feb-23
Value / RAG rating	7.4

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

HDFT target for lying and standing blood pressure compliance for all patients aged 65 and over has been agreed at 85%. A Trustwide report to measure compliance is being developed and Tendable provides a robust mechanism to gain assurance on each individual ward.

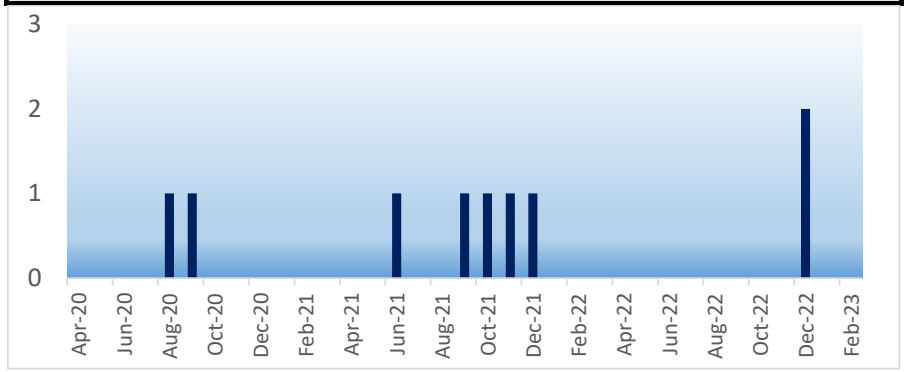
More wards are now trained in the use of falls sensors. Discussion with physiotherapy lead into having mandatory competencies for all new starters to the Trust in assessing patients for walking aids to ensure we hit the 24-hour target of a patient being assessed.

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	Feb-23
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 was 1 hospital acquired cases of C.difficile reported in February.

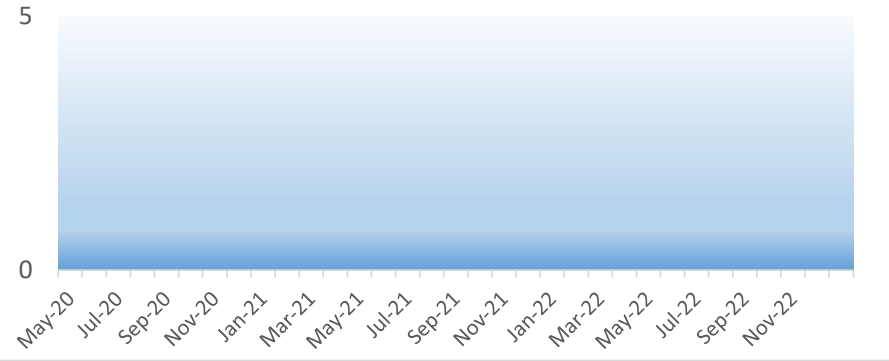
The year to date total for all hospital acquired cases is now 23, remaining below the maximum trajectory of 40 cases. RCAs have been completed and agreed with the CCG for all 23 cases - 2 of the December cases were deemed to be avoidable (due to inappropriate antibiotic prescribing) - these were the first avoidable cases reported this financial year.

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	Feb-23
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 reported in February.

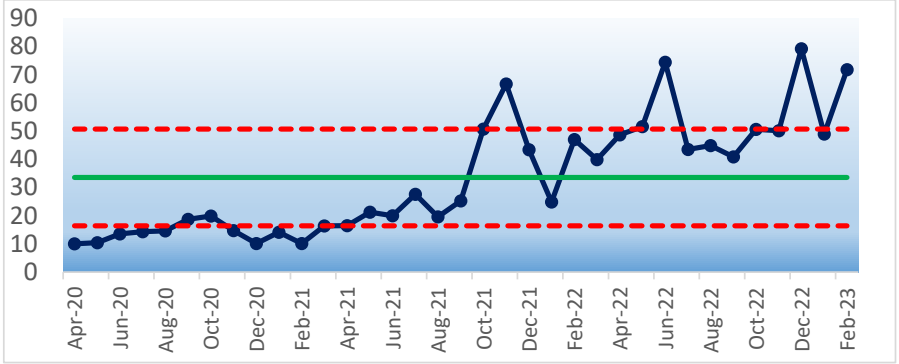
The year to date total for all hospital acquired cases is now 2. RCAs have been completed and agreed with the CCG for both cases and both were deemed to be unavoidable.

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	Feb-23
Value / RAG rating	71.8

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 February 2023, the top 5 categories for incidents were:

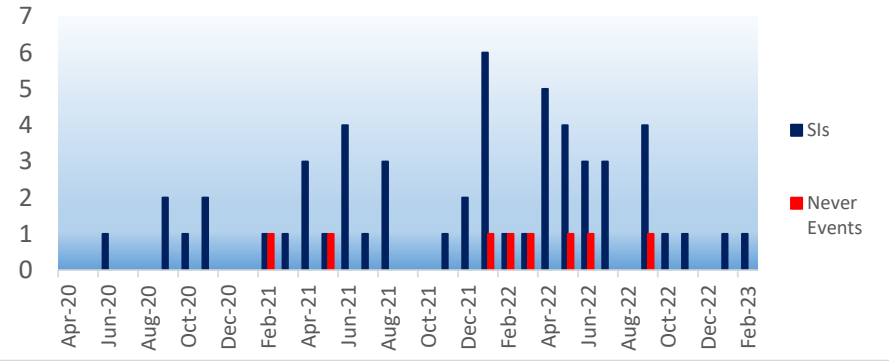
-Pressure Ulcers & Other Skin Damage (26%)
-Diagnosis, Treatments, Procedures & Tests (11%)
-Records & Consent (9%)
-Appointments, Admission, Transfer & Discharge (8%)
-Medication, IV Fluids & Medical Gases (7%)

Indicator	**1.7 - Incidents - comprehensive serious incidents (SI) and Never Events**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Feb-23
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

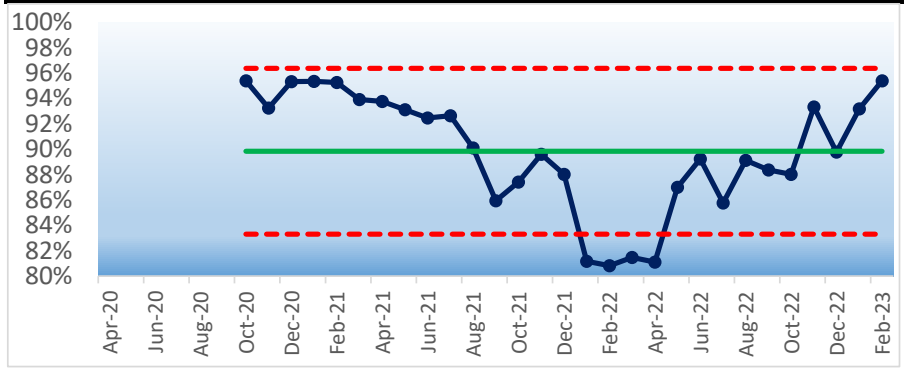
1 incident meeting the Serious Incident criteria was reported this month following 48 hour review and confirmation at Quality Summit. Investigation processes have commenced.

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	Feb-23
Value / RAG rating	95.4%

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

Improving position on fill rates continues. Recruitment and retention plans continue to be implemented with impact reflected.

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	Feb-22
Value / RAG rating	7.91

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

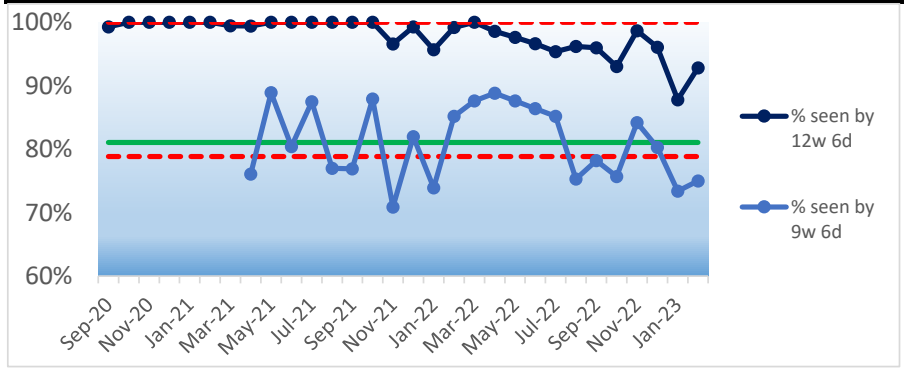
Increase in CHPPPD coincides with increased fill rates and has seen an increase this month which is positive.

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	Feb-23
Value / RAG rating	92.8%

Indicator description

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

SPC chart



Narrative

Admin issues had been identified with ensuring women are allocated to an appropraite antenatal clinic within the relevant time scales. This has now been actioned and further clinics have been created to ensure women are seen in a timely manner.

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.

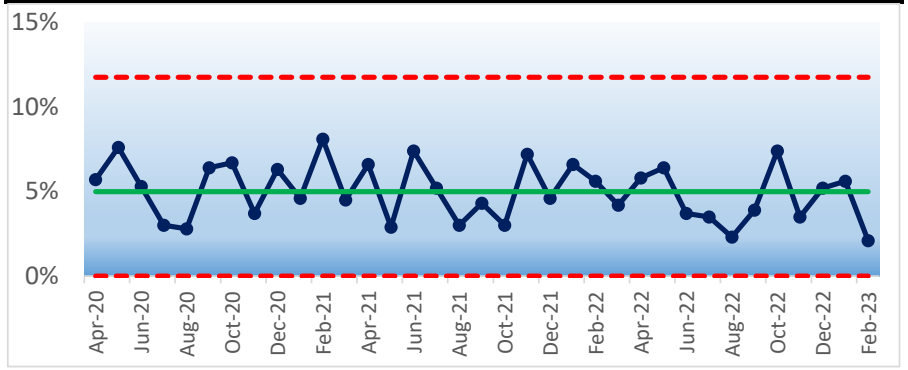
Work continues on building blocks to enable implementation of a team in quarter 1/2 of 2023/24.

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	Feb-23
Value / RAG rating	2.1%

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

Narrative
Very brief advice training in place. Small numbers so percentage does fluctuate.

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	Feb-23
Value / RAG rating	83.7%

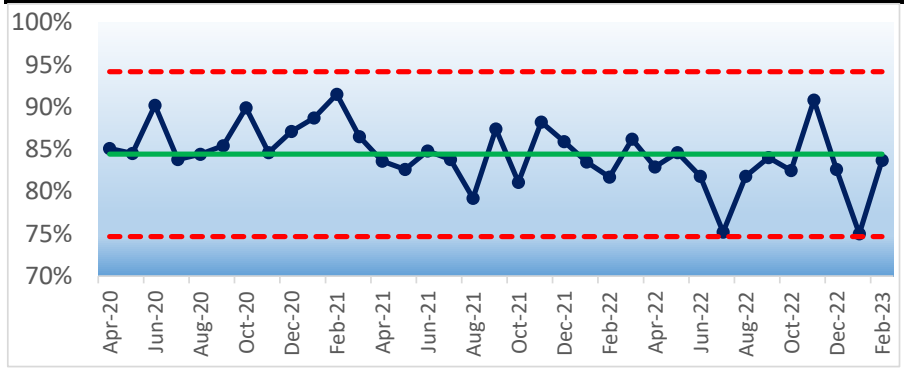
Indicator description

The % of women initiating breastfeeding

Narrative

Staff audit on-going. Number of women initiating breast feeding are significantly better than the national average. Plans are in place to develop new training once staff audit completed.

SPC chart



Indicator	**1.13 - VTE risk assessment - inpatients**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Feb-23
Value / RAG rating	93.8%

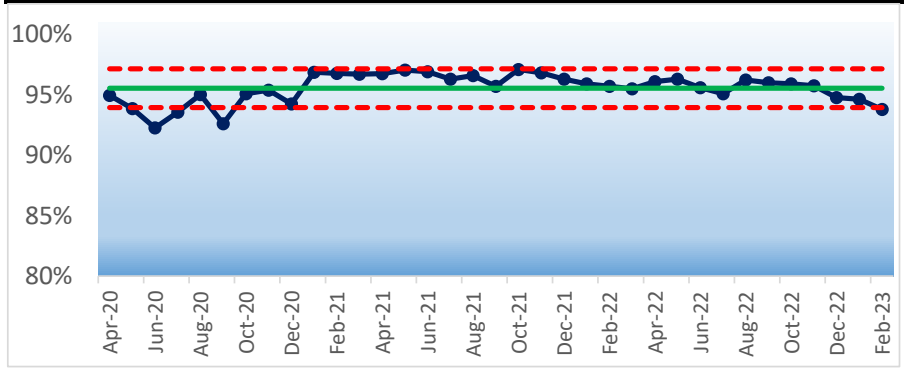
Indicator description

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

Narrative

Deterioration in compliance with this standard. Work ongoing to improve the position.

SPC chart

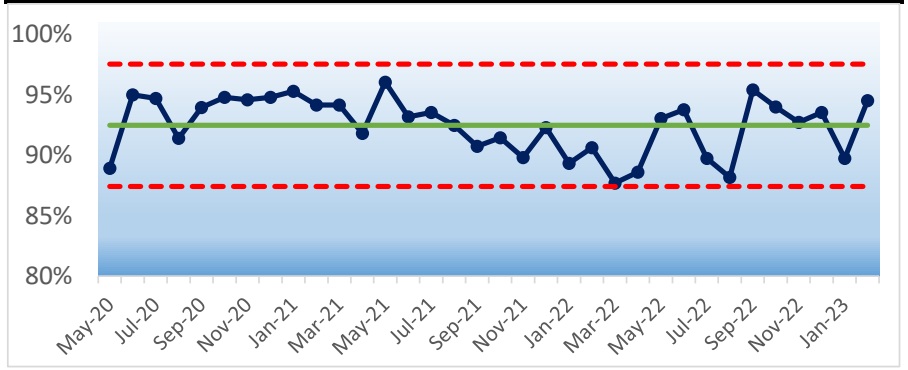


Indicator	**1.14 - Sepsis screening - inpatient wards**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Feb-23
Value / RAG rating	94.5%

Indicator description

The percentage of eligible inpatients who were screened for sepsis.

SPC chart



Narrative

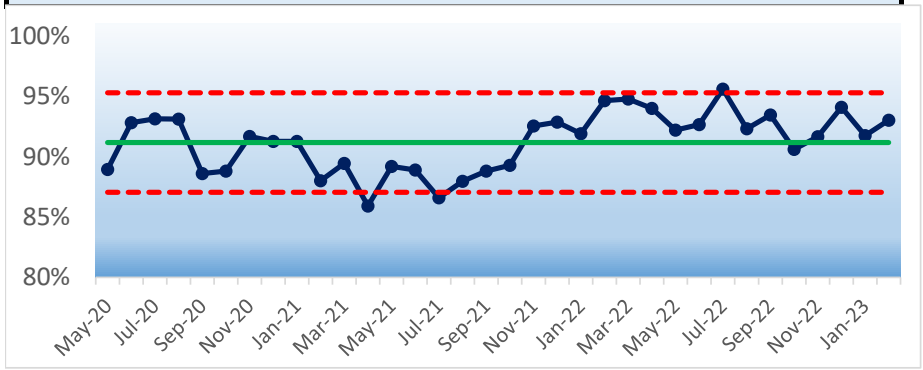
As previously reported, the reduction in compliance across January was shared with Matrons and Ward Managers to acknowledge the areas with full compliance and to also enable those areas with a reduction in compliance to refocus. Sepsis screening compliance is now also being monitored via Quality Summit.

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	Feb-23
Value / RAG rating	93.0%

Indicator description

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

SPC chart



Narrative

As previously reported, the reduction in compliance across January was shared with Matrons and Ward Managers to acknowledge the areas with full compliance and to also enable those areas with a reduction in compliance to refocus. Sepsis screening compliance is now also being monitored via Quality Summit

Sepsis screening compliance continues to be supported by the electronic flagging system, is transacted by ED nursing staff and compliance is monitored by the Matron.

Integrated Board Report - February 2023

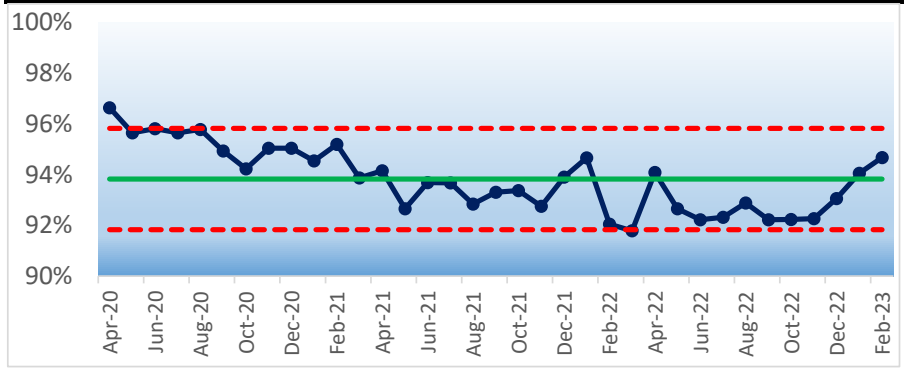
Domain 2 - Caring

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	Feb-23
Value / RAG rating	94.7%

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 over 90% which is positive. Positive comments from the FFT in February describe staff as caring, dedicated, wonderful and professional. Less positive feedback was centered around waiting times, parking, communication and signage in the hospital.

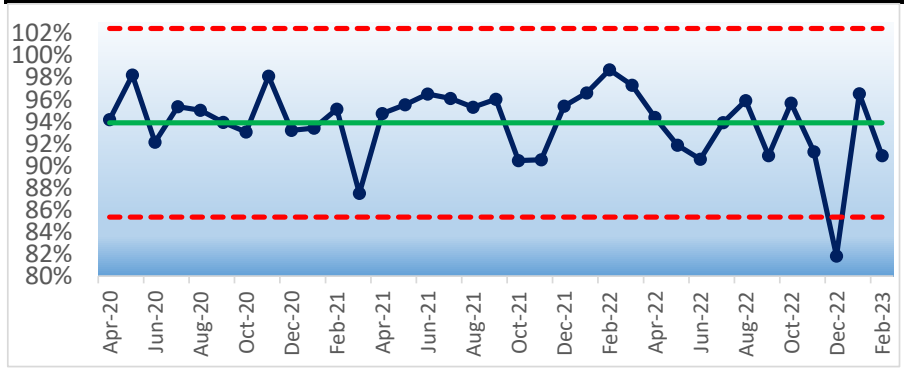
FFT response rates for ED areas remains less positive, predominantly due to waiting times and communication within the department. However they did receive a number of positive comments describing how professional, kind and compassionate staff are, recognising the ongoing pressures and challenges the department and staff are working under.

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	Feb-23
Value / RAG rating	90.9%

Indicator description

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

SPC chart



Narrative

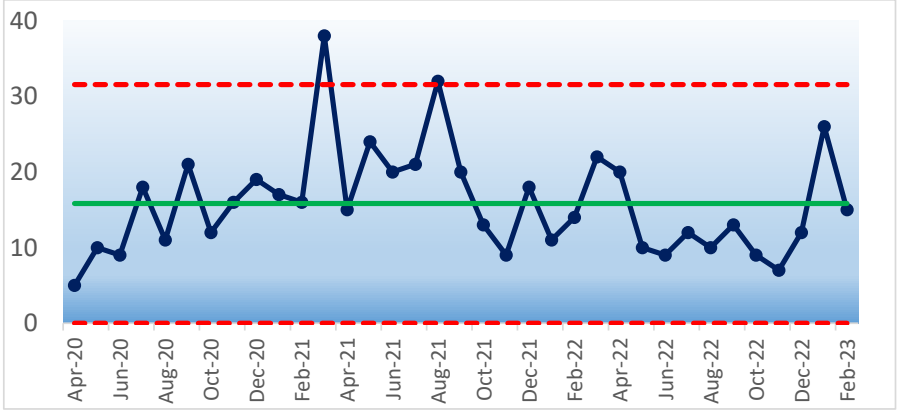
Performance against this standard continues to fluctuate but overall remains over 90% which is positive.

Indicator	**2.2.1 Complaints - numbers received**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Feb-23
Value / RAG rating	15

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

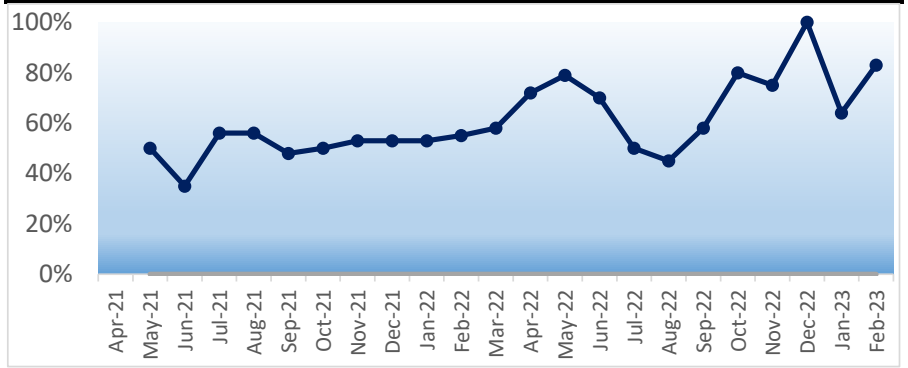
In total, there were 15 standard complaints received in February 23 (number and response rate for our KPI which is the standard complaints- 25 working days). 2 complaints came under CC Directorate. 1 complaint came under HIF, 1 complaint came under Corporate, 5 complaints came under LTUC and 6 complaints came under PSC.

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	Feb-23
Value / RAG rating	83%

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 for February was 83% (against a target trajectory of 95%). There were 12 complaints in total and 10 complaints responded to in time. 1 was responded late and 1 still outstanding .

Integrated Board Report -February 2023

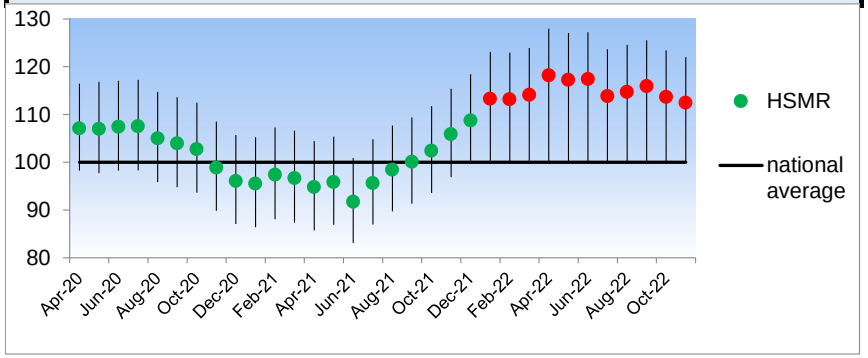
Domain 3 - Effective

Indicator	**3.1 - Hospital Standardised Mortality Ratio (HSMR)**
Executive lead	Jacqueline Andrews, Medical Director
Board Committee	Quality Committee
Reporting month	Dec-22
Value / RAG rating	111.96

Indicator description

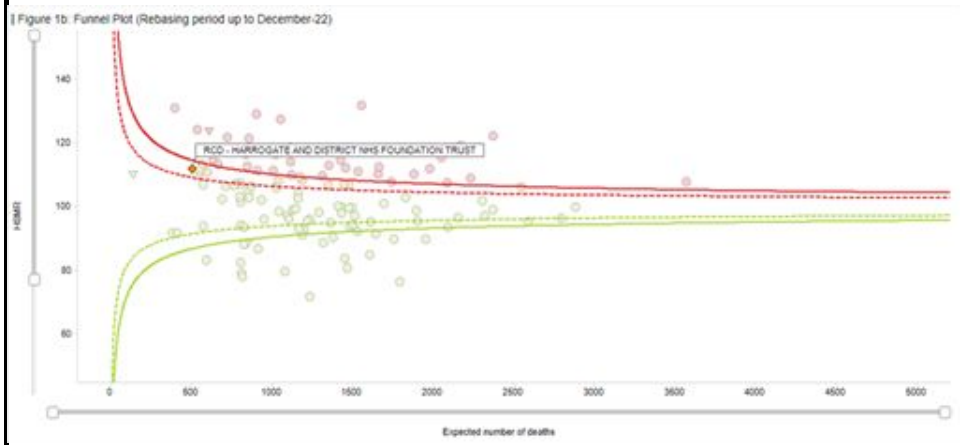
The HSMR looks at the mortality rates for 56 common diagnosis groups that account for around 80% of in-hospital deaths and standardises against various criteria including age, sex and comorbidities. The measure also makes an adjustment for palliative care.

Trend chart



Narrative

National average is 100. HDFT remains above the expected range - a deep dive with external scrutiny has been performed and no quality concerns identified. The funnel plot below shows HDFT as the diamond compared to similar Trusts (shown as a triangle) and all other Trusts.

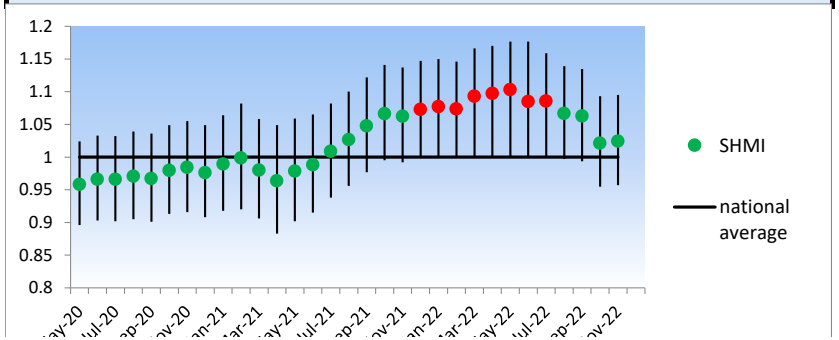


Indicator	**3.2 - Summary Hospital Mortality Index (SHMI)**
Executive lead	Jacqueline Andrews, Medical Director
Board Committee	Quality Committee
Reporting month	Nov-22
Value / RAG rating	1.024

Indicator description

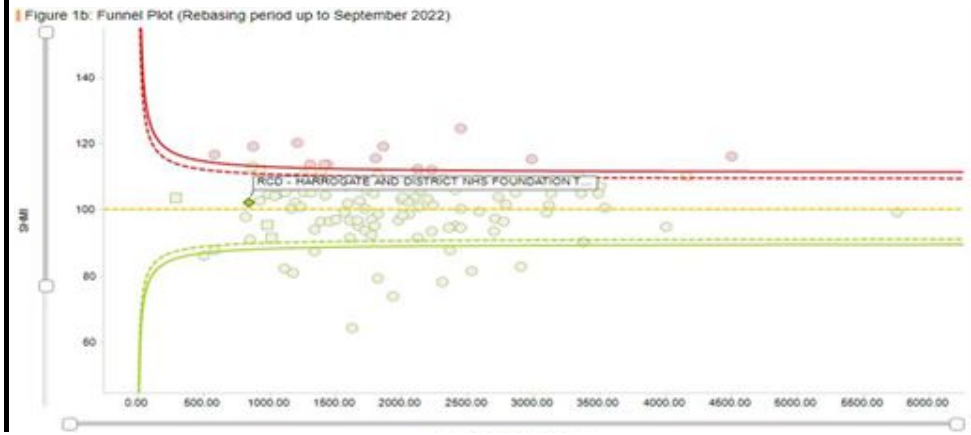
The SHMI looks at the mortality rates for all diagnoses and standardises against various criteria including age, sex and comorbidities. The measure does not make an adjustment for palliative care.

Trend chart



Narrative

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

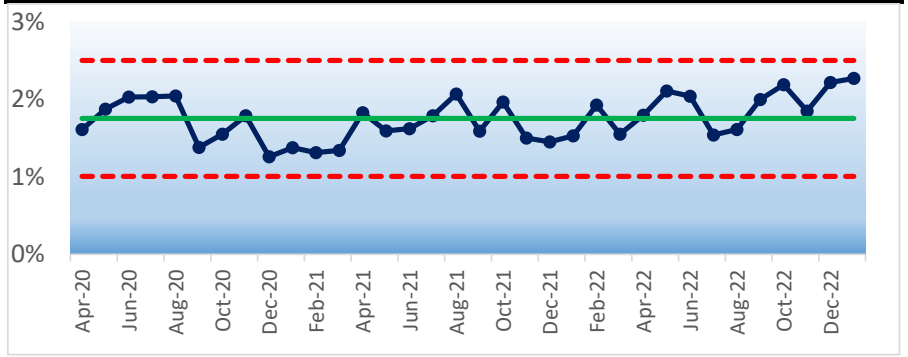


Indicator	**3.3.1 - Readmissions to the same specialty within 30 days - following elective admission**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Jan-23
Value / RAG rating	2.3%

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

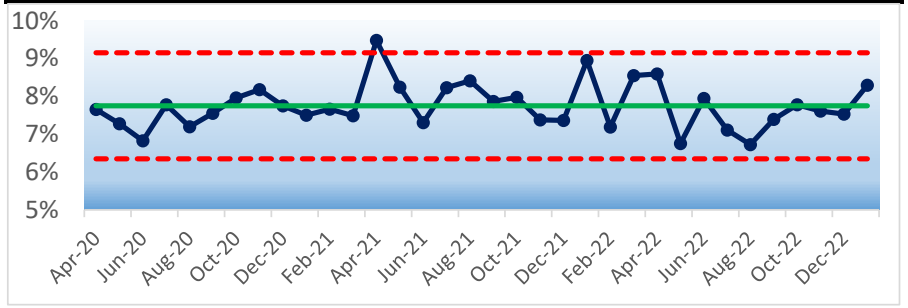
Readmissions following an elective admission increased to 2.3% in January but remain within control limits and less than national average.

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	Jan-23
Value / RAG rating	8.3%

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 8.3% in January 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

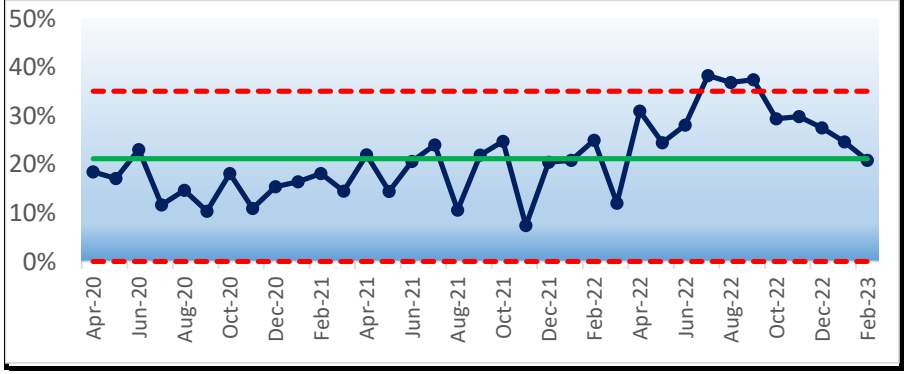
Narrative
Work on a manual methodology to provide data for this metric is underway. It is expected that by May 2023 that data for 2022/23 will be available.

Indicator	**3.5 - Delayed transfers of care**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Feb-23
Value / RAG rating	20.8%

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

21% of inpatients did not meet the criteria to reside when the snapshot was taken in February, continuing the recent improving trend but remaining higher than the historical average. The Trust have now purchased a system using funding from NHSE that allows the ward teams to electronically capture the criteria to reside of every patient. This is now rolled out across all adult wards and provides real-time information.

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

3

People and Culture Committee
25th January 2023

Title:	**Guardian of Safe Working Hours Report Q3 2022/23**
Responsible Director:	Executive Medical Director
Author:	Guardian of Safe Working Hours

Purpose of the report and summary of key issues:	The report provides the People and Culture Committee with key updates and actions since the previous update from the Guardian of Safe Working.	
BAF Risk:	AIM 1: To be an outstanding place to work	
	BAF1.1 to be an outstanding place to work	X
	BAF1.2 To be an inclusive employer where diversity is celebrated and valued	X
	AIM 2: To work with partners to deliver integrated care	
	BAF2.1 To improve population health and wellbeing, provide integrated care and to support primary care	X
	BAF2.2 To be an active partner in population health and the transformation of health inequalities	X
	AIM 3: To deliver high quality care	
	BAF3.1 and 3.4 To provide outstanding care and outstanding patient experience	X
	BAF3.2 To provide a high quality service	X
	BAF3.3 To provide high quality care to children and young people in adults community services	X
	BAF3.5 To provide high quality public health 0-19 services	X
	AIM 4: To ensure clinical and financial sustainability	
	BAF4.1 To continually improve services we provide to our population in a way that are more efficient	X
	BAF4.2 and 4.3 To provide high quality care and to be a financially sustainable organisation	X
	BAF4.4 To be financially stable to provide outstanding quality of care	X
Corporate Risks	All	
Report History:	Previous updates submitted to Public Board meetings.	
Recommendation:	The Committee is asked to note this report, and identify any areas in which further assurance is required.	

HARROGATE AND DISTRICT NHS FOUNDATION TRUST

PEOPLE AND CULTURE COMMITTEE

JANUARY 2023

3

1.0 Executive Summary

This is the Eighteenth quarterly report of the Guardian of Safe Working Hours. Its purpose is to report to the Board of Directors the state of safe working of doctors in training ('junior doctors') in relation to their working hours, gaps in rotas and their educational experience. This report covers the period 1st October to 31st December 2022 – Q3 of 2022/23.

The report provides the Board with up-dated quarterly evidence to support its assurance that the issues of safety within the Guardian's remit are in a satisfactory state.

85 exception reports were submitted in Q3, down from the high of 102 in Q2 (58 in August alone). There were 8 education exception reports submitted in Q3, bringing the total to 20 for 2022/23 year to date. This maintains the higher than usual numbers we have been seeing.

3 further breaches of contract have been reported, bringing the total number of breaches to 19, and fines totalling £2763.39 have been levied. These breaches relate to working beyond the maximum 13hr shift length, either within general surgery on SDEC or acute medicine.

There has been no regional meeting for Guardians since the last report. Trainee doctors' fora have been held jointly with the Deputy Director of Medical Education. These continue in both a face-to-face and virtual capacity on quarterly schedule.

The experience of trainee doctors – as for the whole NHS – has changed profoundly from March 2020 with the onset of the viral pandemic. This summer has seen doctors joining the workforce whose entire 'clinical' training has taken place under COVID-19 safety measures. As a result, they will have had significantly reduced clinical exposure to patients and will likely need additional support. Conversely the challenges these new FY1s faced as undergraduates has put a focus on their expectations from their employer and further increased the likelihood of an exception report being submitted. This is evidenced by the increased number of reports now being submitted.

Rota coordinators continue to report difficulties in staffing rota gaps with increasing frequency, surgical rotas seem to be particularly difficult to find cover for. However, communication to the affected teams of said staffing gaps has improved significantly and it is clear that they are working to fill these gaps.

This is the key quality assurance statement for the Board:

'The Board is advised that whilst rostered hours across the organisation are compliant, feedback suggests that workload is exceedingly high and this position is worsened by the current spike in viral illnesses. This quarter has seen further Guardian fines levied against the trust. The concerns over workload have yet to be successfully addressed.'

2.0 Introduction

All doctors in training posts at HDFT are now employed under the 2016 Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) (hereafter referred to as the New Contract). As part of the new contract, the trust has appointed a Guardian of Safe working, the primary responsibility of which is to:

1. To act as the champion of safe working hours for doctors in approved training programmes within the Trust.

2. Provide assurance to doctors and employers that doctors are safely rostered and enabled to work hours that are safe and in compliance with Schedules 3, 4 and 5 of the new terms and conditions of service.

In accordance with Schedule 6 of the new contract the Guardian of Safe Working should provide the Board with a Guardian of Safe Working Report not less than once per quarter. Its purpose is to report to the Board of Directors the state of safe working of doctors in training ('junior doctors') in relation to their working hours, gaps in rotas and their educational experience. This is the Sixteenth quarterly report of the Guardian of Safe Working Hours.

The Trust now has all junior doctors employed on the 2016 Terms and Conditions of Service (TCS) contract. These have moved to Version 5 of the contract.

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

3.0 High Level Data

3.1 Vacancy information

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

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

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

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

Fellow Posts

The trust has recently appointed a total of 6 fellows in general medicine, 2 in emergency medicine and 1 in dermatology. This is a great outcome following the feedback, in part through exception reporting, that highlighted issues with the junior medical rota and persistent staffing shortfall. These fellow posts will go some way to supporting the staffing in these areas.

Changes to Medical Curricula

Changes to several postgraduate medical curricula have come into effect during 2020-2022. Integral to many of these is a requirement for additional supervision for early year registrars. These changes to entrustability (More holistic approach to judging a trainee than simply looking at competencies – "they can do it but are they ready for the responsibility of doing it on their own"), means that in some specialties, only trainees at ST5 level or above are allowed to be left to do the role unsupervised, out-of-hours.

It is likely that Harrogate will have HEE trainee doctors rotating who are unable to fulfil out of hours commitments to the same level of independence as their predecessors. Specialties particularly at risk are obstetrics and gynaecology, and medicine. The result of this may be increased staffing requirements and/or diversion of consultant activity from elective work to emergency out of hours care.

January 2023

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

The current position is 5.8 Whole time equivalent (WTE) gaps. There should be 137 junior doctors in the trust. This increases to 166 when GP trainees are included.

The following table explains the breakdown of gaps by directorate.

	Dept	Rotates	Grade	HEE or Trust	WTE	Recruitment
LTUC	SDEC/ Acute Medicine	Aug/Feb	GPSTS	HEE	1	This post will be filled from Feb 23 (Originally advertised a LAS FY3 post to cover this gap, this was then withdrawn and was to be resubmitted as a LAS FY2, department decided against this and the advert was not resubmitted)
LTUC	Emergency Medicine	Aug/Feb	GPSTS	HEE	0.8	There is a 0.8 gap from December-January due to a trainee returning from maternity leave and changing specialties. This post will be filled from Feb 23.
LTUC	Diabetes & Endocrinology	Aug/Feb	CT1/2	HEE/ Trust	1	HEE Gap in Aug 2021, we recruited a LAS FY3 who has now gone on maternity leave. We have not received a D&E rotation for this year.
LTUC	Microbiology	Aug/Feb	ST3+	HEE	1	Current honorary trainee was due to return following maternity leave; however, they have been successful in securing a consultant post. Post remains unfilled.
CC	Dental	Sept	DCT 1/2	HEE	1	No plans to fill this post.
PSC	Anaesthetics	Aug	Fellow	Trust	1	This is due to the current fellow being on maternity leave, they are due to return mid Feb 23.

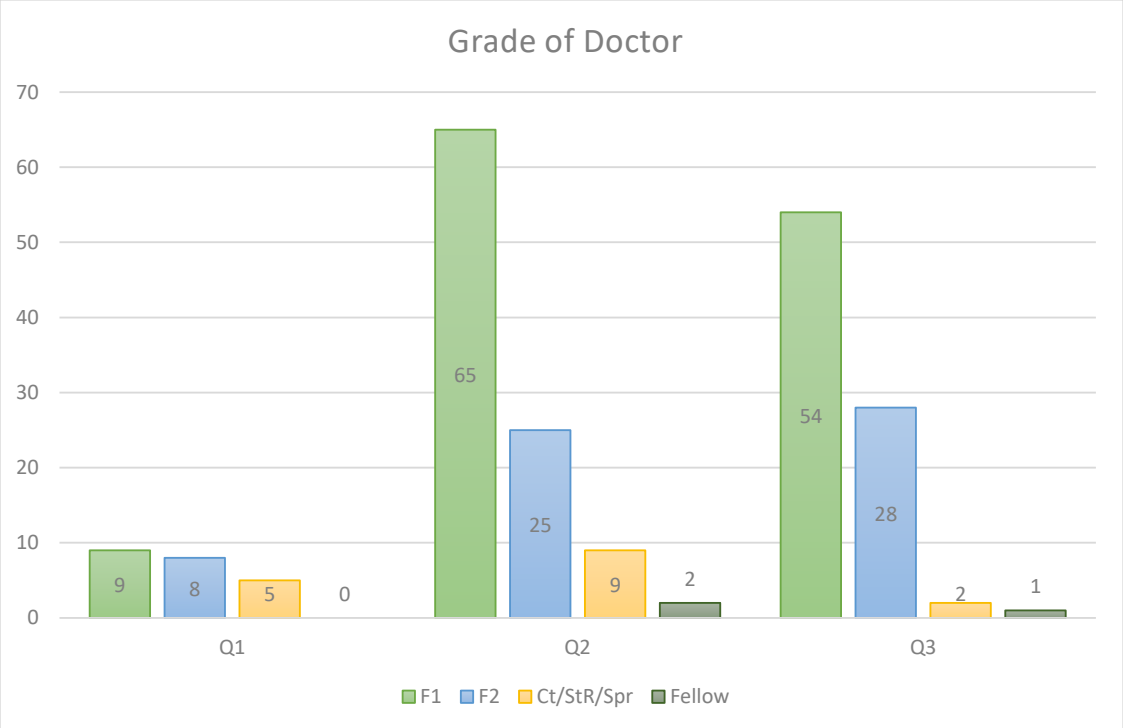
4.0 Exception Reports – Qualitative Analysis

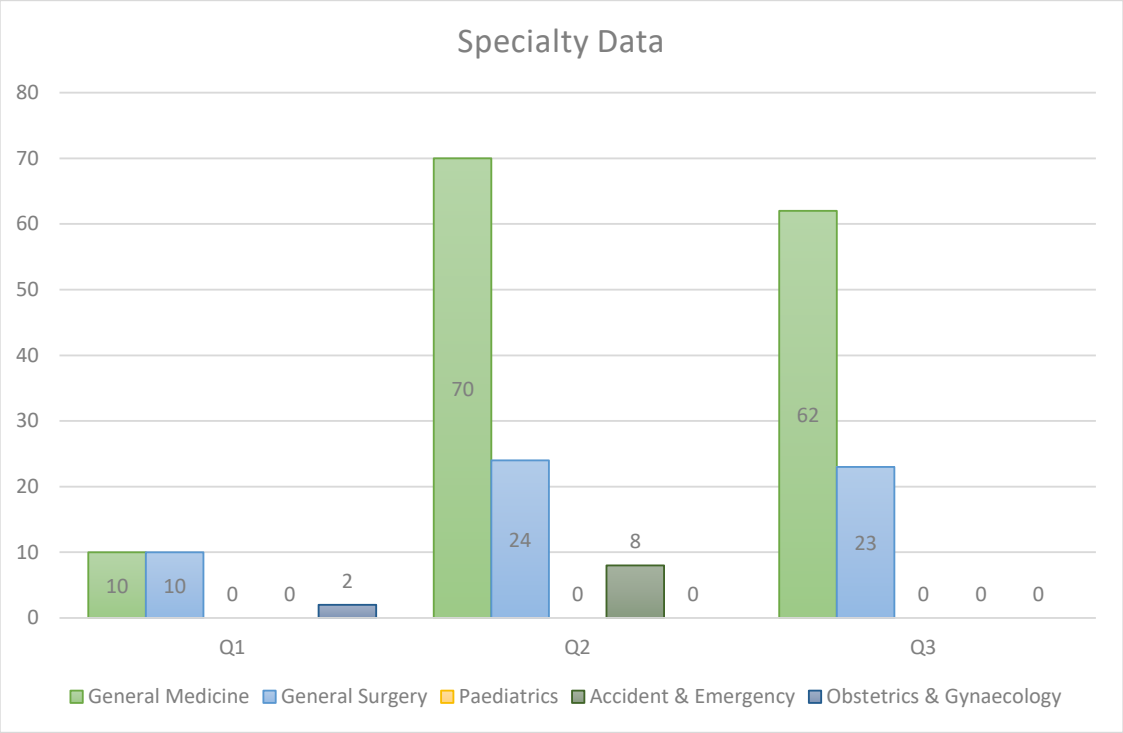
Exception reports are individual notifications to the DRS system by trainee doctors who have experienced an issue causing them to vary their working hours from the contracted work schedule. This may be repeatedly missing breaks during the day, being unable to attend scheduled teaching (either internal or external) or more likely workload requiring them to stay beyond the scheduled hours to complete tasks.

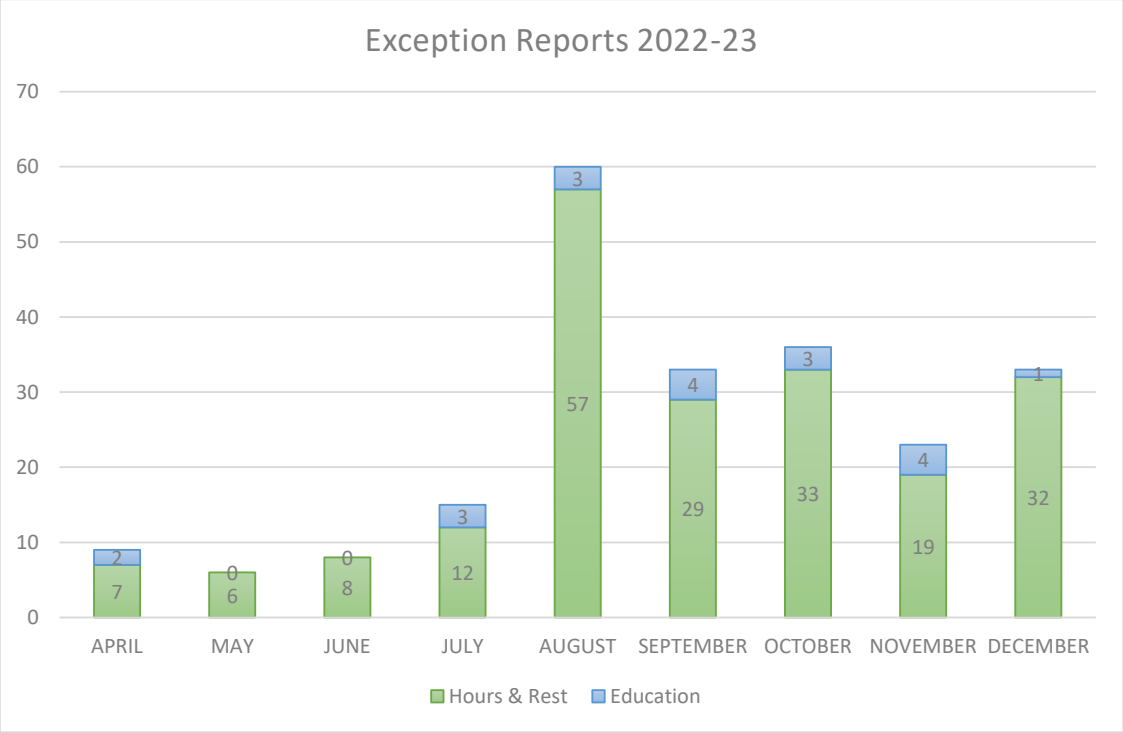
Clinical supervisors are, in most cases, poor at responding to exception reports within the required time frame. This task was added to the supervisors without consultation by the 2018 review of the New Contract and has never had an enthusiastic response. Significant effort has been put in to try and improve the status quo, most notably weekly reminder emails and participation in the supervisor workshops. Following a role change agreed in V5 of the TCS, any overdue reports must be reviewed and agreed by the Guardian – this accounts for 70% of all reports submitted.

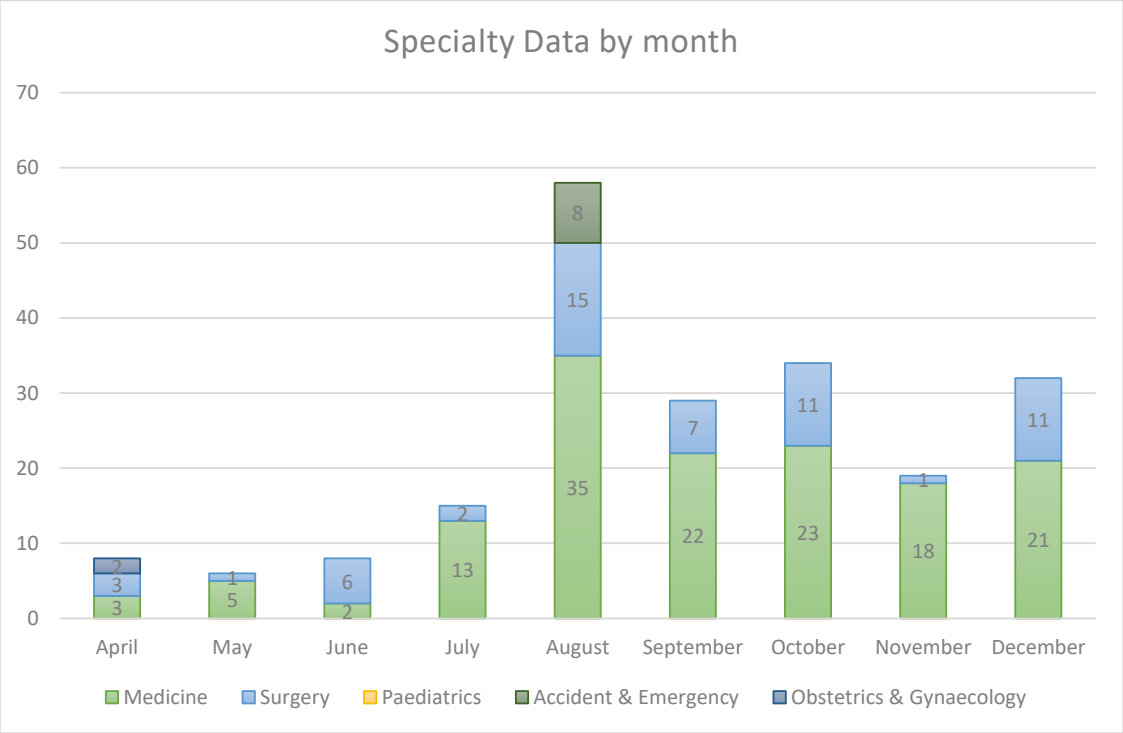
The reports quoted below were all highlighted to supervisors, directorate management and the Director of Medical Education (where appropriate) at the time of submission/review by the Guardian.

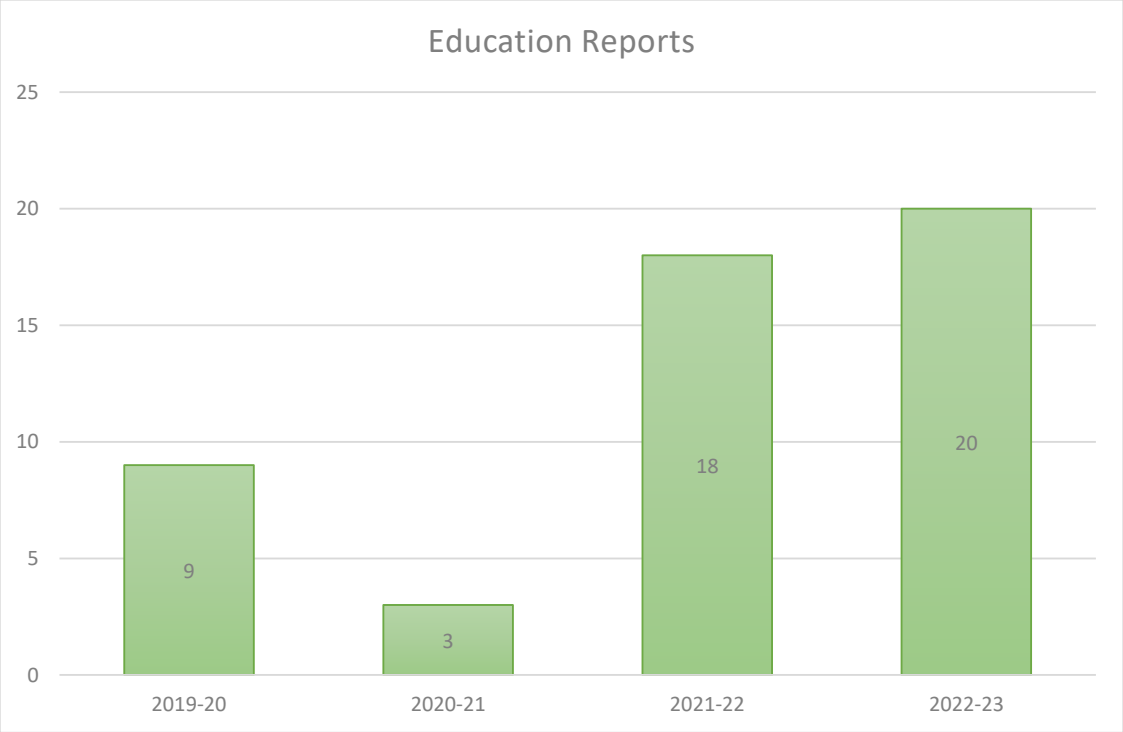
The following pages detail the breakdown of data.




Specialty Data
80
70
60
50
40
30
20
10
0
10
10
0
0
2
70
24
0
8
0
62
23
0
0
0
Q1
Q2
Q3
General Medicine
General Surgery
Paediatrics
Accident & Emergency
Obstetrics & Gynaecology


Exception Reports 2022-23
70
60
50
40
30
20
10
0
2
7
0
6
0
8
3
12
3
57
4
29
3
33
4
19
1
32
APRIL
MAY
JUNE
JULY
AUGUST
SEPTEMBER
OCTOBER
NOVEMBER
DECEMBER
Hours & Rest
Education





The increased trend in education exception reports has continued with 20 submitted so far in 2022-23, surpassing the previous peak in 2021/22. All education exception reports have been discussed with the Director of Medical Education who reviews them all. Whilst a minority are erroneously tagged as education reports, there is still a significant enough number to be concerned.

Nearly all reports are of over-working at the end of the day when clinical workload, acutely ill patients and too few colleagues demand working beyond normal hours. This is especially true in general medicine which usually accounts for 65-80% of all exception reports submitted (70% 2021-22).

There has been a marked increase in the number of exception reports being submitted since the junior doctor's rotation in August, with 58 exception reports being submitted in that month alone. Since the August change-over, 182 exception reports have been submitted, double the same period last year and alarming when compared to 220 reports for the complete 21-22 year.

It should be noted that although FY1 doctors submitted the majority of the reports, there is still a significant increase in submissions from FY2 & CT/ST doctors.

The number of exception reports submitted is known to underestimate the actual amount of routine over-working.

If a doctor has overworked their contracted hours on an occasion, then they are entitled under the TCS to over-time pay or time off in lieu. If the over-work is caused by rota gaps, then time off is not appropriate if it will compound the shortage situation. The doctor is entitled to overtime pay even if their overtime commitment followed from their own inefficiency or misjudgement. Clinical supervisors are expected to guide their trainees in efficient working, prioritising clinical activities and making timely handovers to over-night teams. The Trust will incur a small cost each month in some hours' over-time pay; but this is offset somewhat by vacant posts owing to rota gaps. But overall, the Trust is usually over-spent on medical locum costs for consultants and trainees.

4.1 Verbatim exception report excerpts

The following are verbatim excerpts from Q3 exception reports. Due to the publicly available nature of this report any names or other identifiable material have been removed.

Medicine

113215: 06 Oct 2022 Nature: Education

Working on Oakdale ward - currently two SHOs off sick. I worked with two locum SHOs but one had to leave at lunchtime. That left 2 of us to finish remaining day when minimum staffing is three juniors. Was meant to have half day release from 2-5pm this afternoon but unable to attend due to insufficient ward staffing and excess workload for number of doctors.

Steps taken to resolve

Didn't get chance to call rota team as busy in afternoon after other doctor left. They were however aware of the sickness of two SHOs on the ward.

Supervisor Comments: Not acceptable for GP trainee to miss their training. I will email rota coordinator.

For some junior doctors, attendance at regional teaching programmes is mandatory for progression through training. If attendance falls below minimum expected levels, then it is likely they will receive an adverse outcome in their annual appraisal.

113882: 10 Oct 2022 Nature: Hours & Rest

Acute frailty unit (AFU) has increased patient load by 12 patients but there is no change in the level of staffing provided i.e. Bolton ward is down to 2 juniors covering, with 1 on AFU. Due to the high acuity of patients and lack of junior doctors, I was unable to leave the ward at any point, could not attend any clinics or teaching opportunities and had to stay for approximately half an hour longer than planned.

Steps taken to resolve

Emailed Dr XX, YY, ZZ and AA. Dr XX then contacted BB and CC to raise issues. D/w Dr DD who has also flagged concerns. Suggestion so far is to contact LTUC manager of the day every day to 'deploy workforce as effectively as possible'.

Our Junior Doctors are very adept at highlighting the safety concerns they have, unfortunately the response to address them is often not as effective.

113830: 14 Oct 2022 Nature: Hours & Rest

Stayed 1.5 hour late to finish urgent jobs on the ward and make sure everything was set properly for the weekend- e.g. requesting bloods, fluids, medication etc. Had complex/unwell patients which required a lot of work- discussion with specialties, scans as well as long family discussions. Also helped more junior members of team with some of their jobs/advice. Still handed over a few things to the on call- e.g. bloods. Since we were above minimum staffing (4 juniors on the ward, min is 3) I was meant to go to clinic which is part of training. However, I didn't go, as it was so busy and I felt that if I left, my team would struggle a lot. I was also the 'most senior' person after the consultant. (This doctor is an FY2)

Steps taken to resolve

Consultant also there until very late helping with unwell patients and discussions. On the ward there 4 juniors which is above minimum staffing, however, none of us left on time- earliest someone left I think was 16:30. This is a frequent occurrence- almost daily we leave after 16:00, maybe 10-20 minutes late, so we don't exception report for that, however, it adds up over time. I think 2 reasons for that is 1) bloods are taken around 11ish frequently so they come back late /having to action them very late in the day and 2) other specialties finish at 17:00 so when we request a review, they frequently come close to 4 and we just don't leave until they finish (is easier as we know the patient rather than asking the on-call person). If the day was 8-5 (like surgical standard days), it would mean we have some breathing space to finish jobs on time, prepare discharge letters in advance to not delay discharges (Which we rarely do at the moment), as well as have some more educational time during the day-both for us (clinics) as well as having more time to spend /dedicate teaching medical students on the wards. The 8-5 is my personal opinion, not sure if it is shared by other trainees and whether it is feasible.

Sadly this report reflects the necessity to work beyond regular scheduled hours as a matter of routine to finish the required tasks.

114215: 20 Oct 2022 Nature: Hours & Rest

On Thursday Oakdale ward was covered by only two doctors (myself and an FY2), despite minimum staffing levels for our ward being three doctors. The FY2 who joined me was also my regular FY2 colleague who had picked up the shift as locum, as had noticed on the rota I was due to be the only doctor covering the ward. There was also no ACP trainee on the ward as there usually is to support us on a Thursday. As there was only two of us to review all the patients, in addition to completing tasks, it was not possible for us to complete this all on time. We consequently had to stay an hour late to finish all of the jobs. In addition to this, I had been invited by my clinical supervisor earlier in the week to join him in clinic to complete some WBAs. As there was already below minimum staffing levels on the ward and attending clinic would leave only 1 doctor on the ward, I was not able to attend this. I am also on call next week and consequently will now have my WBAs delayed by 2 weeks.

Steps taken to resolve

We contacted our rota coordinator who informed us that there were three doctors (minimum staffing) on the ward according to the rota. Unfortunately, the third doctor had not arrived nor contacted the rota team to explain that they would not be on the ward. The rota coordinator

apologised and informed us they would attempt to get some additional support for the afternoon, but this may not be possible due to the short notice.

The requirement of urgent discussions between junior doctors and the rota teams to attempt to clarify the staffing plan for that day has been previously highlighted by the Guardian

115182: 09 Nov 2022 Nature: Hours & Rest

As per the previous two days, on Wednesday Oakdale was again covered by only myself and Dr XX (FY2). In addition to covering an understaffed ward, we were both on-call for 12.5hr shifts and also each carrying a crash bleep which left the ward unstaffed whenever it went off. Having been the case for the prior two days of our shifts, we were extremely disappointed that this was again the same staffing issue which we had escalated and was still unresolved. Furthermore, by this point, the combination of being the only two doctors on the ward, also working 12.5hr shifts, and having attended 4 arrests, was consequently making us feel extremely overworked, tired, and unsafe. For our week of on-call, this dangerous staffing had now been the same and unresolved for 3/4 of our on-call days. Furthermore, on Wednesday we also began to get calls from other wards asking us to review and complete tasks for outlier patients (Nidderdale and Rowan ward). Already understaffed and struggling with our own workload on Oakdale (even more so when there was no doctor to continue jobs whilst we were away at crash calls), it was becoming an impossible task to then also have to have one of only two doctors leave the ward to go do outliers. This left only one doctor on Oakdale whilst outliers were completed. At this point, we both felt extremely overworked, tired, and unsafe. We consequently escalated to our rota coordinator again who did not appear to effectively understand the scenario we were in and asked why we could not just ""give our arrest bleep to a different doctor"" since our ward was understaffed. We consequently escalated these working conditions by sending an email to XX and Dr YY (FTPD), who escalated and forwarded our concerns to Dr ZZ and the Guardian of Safe Working.

Steps taken to resolve

We first escalated to our rota coordinator who did not appear to effectively understand the scenario we were in and asked why we could not just ""give our arrest bleep to a different doctor"" since our ward was understaffed. We consequently escalated these working conditions by sending an email to XX and Dr YY (FTPD), who escalated and forwarded our concerns to Dr ZZ and the Guardian of Safe Working.

It seems like poor rota planning to place both of the 2 ward doctors on-call at the same time, and it is clear to see the level of frustration developing with the system when concerns are not addressed, and the issues persist.

115787: 24 Nov 2022 Nature: Hours & Rest

Today the ward was staffed by three doctors including myself, an FY2 and a GPST1. Minimum staffing for Oakdale ward is three doctors so this was adequate cover for the ward round, which finished at around 12.00. However, the medical rota team had approved the FY2 to be on a half day, and the GPST1 to attend afternoon teaching from 2-4pm. I also had been arranged to deliver final year medical student teaching from 3-4pm. Consequently, from 12.00 there were only two doctors covering the ward, and from 14:00 there was myself only. As the only doctor on the ward from 2pm, my workload was not manageable, actioning jobs from the morning ward round in addition to new jobs arising on the ward and being the only doctor present for family discussions. Furthermore, at 15:00 the elderly care consultant arrived to review patients on the ward. Consequently, it was not possible for me to attend and deliver my teaching for the final year medical students, and I have had to rearrange this. I also missed my lunch break due to the level of understaffing and finished 1hr late in order to finish tasks which were unsuitable to handover.

Steps taken to resolve
Discussed with rota team who advised they would try get ward cover from 16:00, but it would not be possible to get earlier cover to enable me to leave the ward to deliver my teaching session.

These last three reports have highlighted the numerous frustrations the Junior Doctors have with their rotas.

115993: 28 Nov 2022 Nature: Hours & Rest

On Saturday I was the FY1 on-call covering Farndale. The PTWR was extremely busy with over 20 new admissions to be post-taken Consequently, the PTWR did not finish until close to 13.00, and the consultant was due to return for the afternoon PTWR at around 14:00. I therefore prioritised urgent tasks due to the short time period, to ensure patients had medication changes, scans requested, and blood test taken etc. By the time the consultant returned for the afternoon PTWR I still had outstanding tasks to complete, including specialty referrals required for same day reviews/advice. I informed the consultant who agreed these were a priority, and that I should join the afternoon PTWR once these were complete. After completing the afternoon PTWR it was close to 4pm so I decided to take my break (which I had not had by this point). At this point, the medical registrar pulled me aside and informed me that the ward nurses had been complaining that I had not completed any discharge letters for them, but that he understood why this was the case. I therefore ate my lunch completing discharge letters and got no formal break all day because of this.

Steps taken to resolve
I explained to the medical registrar why I had not completed any discharge letters, and that I had not had a break all day. He understood why this was the case and was empathetic with me, but advised I found time for a break once the letters were completed due to the complaints from the nursing staff. Unfortunately, this was not possible due to the afternoon PTWR tasks.

It goes without saying that there is significant pressure on the wards currently and it is often the most junior doctors that bear the brunt of the this, working beyond their scheduled hours, repeatedly, and with numerous challenges/additional stresses placed on them by other staffing groups. The Guardian has previously referred to the use of DATIX incident reporting as a threat aimed at ensuring “the doctors do as they are required”, and whilst this is not mentioned in this report, it is still being mentioned at the junior doctor’s forum and anecdotally in informal conversation.

117803: 31 Dec 2022 Nature: Hours & Rest

I was the long day (ward cover) SHO for the bank holiday weekend, preceded by a 3-day week due to the other bank holiday. The sheer volume of patient reviews I got handed over to do was just impossible to achieve, even with two extra registrars (who were attending sick patients) and an extra SHO just covering Bolton until 6. I came on in the morning and I had about 15 reviews to do (excluding Bolton that had another 4-5) from the weekend handover list, which a lot didn’t specify if it was a reg or an SHO, including a lot being ""review with bloods ?home" with no TTOs done which meant that should be seen and sorted before pharmacy closes at 14:30. Plus other long discussions with Leeds for patients needing transport taking very long time. This is even before people starting to get unwell/getting bleeped for other things I only managed to have a 30-minute break in the whole 12 and half hour shift (also interrupted by bleeps) and no other breaks.

Steps taken to resolve
Escalated to reg who tried to help with reviews but also had x2 chest drains to do and help acute team.

117807: 01 Jan 2023 Nature: Hours and Rest

Possibly the worst shift of my training. See exception report from 31/12 (Was long day ward cover medical SHO), naturally things got also pushed to Sunday (after discussing with the reg) as unable to complete everything the day before, in addition to extra reviews scheduled for Sunday. No extra SHO help, one extra reg on who was reviewing sick patients as well. The day was really busy with unwell patients and too many bleeps which meant I constantly being interrupted and couldn't complete a single task (a lot of them could be directed to the FY1 instead- e.g. paracetamol, death verification, double bleeping for routine fluids). Cherry on the top was when I went to review a well patient at 19:00 for? discharge and the relative asked 'Did you have a very long lunch break or something?' as they waited so long to be seen. Overall, I managed to have maybe a 20-minute break the whole day (interrupted with bleeps of course) and stayed extra another 1 hour after handover (left at 21:30) to make sure I updated the list, and all the jobs were done and nothing was missed. Again, a lot of stuff carried over the 2/1/22 which the SHO working then reported similar events to mine over the weekend.

Steps taken to resolve

I spoke to Dr XX during the day which he asked me to datix the shift which I did.

These 2 reports from the same junior doctor, relate to a weekend on-call spread around multiple bank holidays. The workload is clearly intense and this is reflected in the inability to take appropriate breaks throughout the shifts – this despite staffing numbers being higher than they normally would be. The second of these reports, resulted in a fine for the directorate.

The Guardian is hopeful that the ward reconfiguration that has taken place will help with some of the issues raised here. From conversations had with directorate leadership, the plan seems to be a balance between a team based and ward-based approach with each ward covering certain specialties. There can be no doubt this will be popular with the junior doctors.

Surgery

113670: 07 Oct 2022 Nature: Hours & Rest

On a regular day shift on Friday, we were staffed at a minimum of 2 juniors on the wards. There were a few patients that had to be assessed acutely due to their bloods being deranged which took time and made it difficult for us to stay on top of our jobs. There were also bleeps where we had to attend to patients and jobs like elective TTOs that we were made aware of towards the end of our shift that needed to be completed. Throughout the day, we were aware of how busy the long-day doctor was on SDEC and how a junior locum was even asked to stay later by the surgical coordinator to help them manage. This led to us staying late to try to complete as many jobs as possible before handing over a more manageable job list for the on-call doctor.

Steps taken to resolve

Surgical coordinator was aware with how busy SDEC was and a day junior locum was asked to stay later to help long day doctor manage.

SDEC workload remains an area of concern for the junior doctors. High patient turnover and the subsequent large number of TTOs that need to be completed during each shift is the most frequent cause of junior doctors staying past their scheduled finish time. Every time this has been exception reported by the doctor working the long day shift it has resulted in a fine for the directorate. Repeated fines for the same problem highlight a system issue that still needs to be addressed by the directorate.

113437: 08 Oct 2022 Nature: Hours & Rest

Difficult weekend of ward cover. Between 4 of us over 20 TTOs had to be written on the Saturday due to increased discharge of patients due to bed pressures. This was exceptionally difficult whilst assessing unwell patients and dealing with other ward jobs. I had to stay 2 hours extra so that jobs for patients could be sorted. Other hospitals and trusts offer TTO locus shifts on weekends that allows the normal weekend team to focus on patient care, I believe this is something that HDFT should consider.

Steps taken to resolve
Nil

113757: 09 Oct 2022 Nature: Hours & Rest

Due to the nature of the workload over the weekend -carrying on call bleep for general surgery, urology, and orthopaedic wards, covering SDEC for patients that needed to be reviewed, it meant that at the end of the weekend there were still a number of low priority jobs that needed to be done. By the end of the shift, the list had only partially been updated for general surgery and urology list we had not had time to update at all. We discharged a huge number of patients over the course of the weekend (>15 on Saturday, unsure on number on Sunday). As an on-call team we prioritised getting the medications for the TTOs through to pharmacy (as this has to be done by 2pm), and then writing the medical part of the discharge summary as soon as we had the time to do so. Many patients had outpatient follow up that needed sorting - e.g. MDT referrals, scans requesting, which couldn't be handed over to day team as the patient was being discharged. On a weekend shift it is incredibly difficult to keep up with patient reviews, TTOs, urgent scans and other urgent jobs for all surgical patients, meaning the patient list is the last thing to get looked at. To update patient lists with all bloods and scan results and plans takes a long time, and on a weekend is not feasible to do in hours.

Steps taken to resolve
We managed the urgent reviews and jobs as a team as well as we could, but it meant that there were a number of tasks that needed completing for patients that had been discharged during the day after handover, as well as updating the general surgery and urology patient lists with the weekends bloods/ investigations/ plans. We handed over the tasks that could be done by the night team, but I stayed for 2 hours to get the other tasks completed.

113903: 15 Oct 2022 Nature: Hours & Rest

Working as ward based on-call at the weekend, SDEC had 11 patients so SDEC on call F1 couldn't help with any ward jobs in the day. Very high numbers of TTOs from general surgery patients and all of the jobs for Fountains and Nidderdale meant that both the locum F3 and I stayed late doing jobs it wouldn't have been fair to hand to the night doctor like elective patient regular meds prescriptions.

Steps taken to resolve
No patient safety concerns so not escalated

116893: 10 Dec 2022 Nature: Hours & Rest

I was the surgical FY1 on-call this weekend and was balancing SDEC admissions, ward jobs and simultaneous bleeps due to being on-call. Whilst the workload in SDEC was manageable, there were a significant number of patients being discharged who required letters completed before pharmacy closed at 14:00. A large proportion of these patients were also orthopaedic patients myself and the other juniors knew nothing about as do not attend the weekend orthopaedic ward round. I therefore helped out with this and balanced this against seeing

patients on SDEC (knowing SDEC closed at 5pm). Due to the volume of work, I was unable to achieve my 1hr lunch break. Furthermore, the on-call period from 5-8pm was extremely busy and I was unable to find time to update the handover list. I therefore stayed for 30minutes after handover to update the handover list from the day.

Steps taken to resolve

None possible

These last 4 reports specifically mention the pressure of completing TTOs for patients prior to pharmacy closing – several hours before SDEC closes. This is a frustrating system issue that could be fixed by extending pharmacy opening hours at the weekends. Whilst only 4 mentions have been included in this report there were many more that could have been included.

117494: 19 Dec 2022 Nature: Hours & Rest

On Monday I was the Long Day on-call doctor covering SDEC. The day was very busy and I clerked 14 patients during the shift. At 5pm the surgical care practioners finished and handed over some incomplete patients with outstanding tasks, which added to the workload of patients I was already managing. Due to the opening hours of SDEC, I focussed on getting patients reviewed and managed to ensure all patients were seen and had beds allocated if admission was necessary prior to SDEC closing. This unfortunately meant that I had to prioritise this over completing discharge letters for patients I had already seen. Consequently, I was required to stay an hour late after handover to complete discharge letters for the patients I had seen that afternoon, in addition to updating the handover list.

Steps taken to resolve

Both myself and the twilight FY1 worked together to prioritise patients being reviewed prior to SDEC closing and worked together to complete discharge paperwork after handover.

Within surgery, SDEC remains a focal point, both from a supportive working model and the pressures faced by the junior doctors whilst working on there. Previous HEE visits have focussed on SDEC specifically and although the anticipated visit/additional measures expected in October were delayed, it remains the concern of the Guardian that not enough has been done to address the concerns raised previously by our Junior Doctors. The Guardian is aware that a lot of work has been undertaken by directorate management to engage with the junior doctors, and the feedback, although still mixed, is more positive.

5.0 Work schedule reviews and interventions

5.1 Work schedule review

A work schedule review would be undertaken to investigate any case of systematic or repeated over-working of contracted hours where the planned schedule itself is questioned. No individual work schedule review has been necessary during this quarter. The working conditions on SDEC continue to be under the spotlight both internally and externally with HEE.

5.2 Interventions

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

The rota gaps due to covid isolation/sickness have placed significant strain on the junior doctor workforce. There have been numerous days when staffing has fallen drastically short of minimum safe staffing levels, and this is often reflected in the reports submitted. While escalation processes have been more widely publicised to junior doctors, there remain a large number of exception reports that mention the attempts at conversations with the rota teams.

These highlight the issues and that they have not received the additional support they have requested – from either redeployment of workforce or senior staff "acting down".

Information collated from TempRe Liason Workforce puts the current cost of covering junior doctor rota gaps at £942k for this financial year. This figure does not include shifts paid via internal Salaries20 forms so the total figure is likely to be higher.

6.0 Fines

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

This last quarter has seen further fines levied against the trust. There have been 19 reported breaches of the TCS of the new contract caused by the Trust.

Fine number	Directorate	Total Amount	Amount within GOSW Fund
1	PSC	£ 249.48	£ 155.94
2	PSC	£ 249.48	£ 155.94
3	PSC	£ 205.94	£ 128.73
4	PSC	£ 162.40	£ 101.51
5	PSC	£ 118.86	£ 74.30
6	PSC	£ 150.64	£ 94.16
7	PSC	£ 75.32	£ 47.08
8	PSC	£ 190.68	£ 119.19
9	PSC	£ 261.51	£ 163.46
10	PSC	£ 110.34	£ 68.97
11	PSC	£ 73.56	£ 45.98
12	LTUC	£ 132.99	£ 83.13
13	LTUC	£ 110.32	£ 68.96
14	LTUC	£ 261.46	£ 163.43
15	PSC	£ 100.78	£ 63.00
16	PSC	£ 95.34	£ 59.60
17	LTUC	£ 63.56	£ 39.73
18	LTUC	£ 63.56	£ 39.73
19	LTUC	£ 87.17	£ 54.49
TOTAL		**£ 2,763.39**	**£ 1,727.34**
TOTAL DISBURSED			**£ -**
REMAINING BUDGET			**£ 1,727.34**

7.0 Meetings

There have been no regional meeting of Guardians in the previous quarter. To date, there has been no plan announced for a national meeting. In future it is anticipated that meetings will be held face to face where possible.

8.0 Junior Doctors' Forum

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

Recently conversations around overworking within surgical SDEC and on the medical wards have dominated the junior doctors' fora. At the most recent forum, several junior doctors raised concerns around the planned move of Surgical SDEC back into an SAU (Surgical Assessment Unit) on one of the surgical wards. The concerns revolved around the change in requirements on the nursing staff of these wards and whether they would be familiar with the high patient turnover and the distinctly different needs of running an SDEC/SAU model vs a regular ward. They raised the question on whether this had been factored in or whether any additional training would be scheduled.

There is concern at high level within HEE on the impact on future doctor numbers that the pandemic is having. Burn-out, mental health issues, and an increasing trend in working less than full time will all have an impact on the ability to fill trainee posts, rota gaps and overall junior doctor numbers.

9.0 Disclosure

These regular Guardian reports are submitted to Health Education England at their request and by standing consent of the Trust Board of Directors. A regional summary is assembled and discussed at each regional meeting. Guardians assume that their quarterly reports to their boards of directors are open to the public domain. The change in periodicity of reporting to the Board has disrupted the flow of reports to Health Education England.

Health Education England will receive periodical download of the entire database of exception reports for the purpose of research by the mining of big data. The Board has agreed to this. This information is collated and shared upon request.

10.0 Confidentiality

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

11.0 Care Quality Commission

The Guardian has had no contact with CQC inspectors in the previous quarter.

12.0 Extending the scope of the Guardian to the inclusion of Non-training Doctors

The Trust Board has requested that the Guardian enlarges his role: in addition to the existing role to doctors in training grades, the Guardian will embrace the remaining non-training, non-career grade doctors in his system and responsibility. The Guardian has agreed to this change, in fact it was agreed by the previous Guardian in 2020.

The Guardian can now report that fellows, of all varieties, are now able to exception report. This is a significant step forward. The feedback from this group frequently stated that they felt their input wasn't valued and that there was an inequality amongst themselves and the junior doctors they worked alongside. Although this is an improvement, this process still hasn't yet been extended to the SAS doctors within the organisation and sadly it is clear there is little interest in doing so. This remains unfortunate as this staff group have worked within the trust for a longer period of time and represent a substantial percentage of the institutional memory which is subsequently lost as a result of their exclusion.

Until such time as SAS doctors, working on the same rotas as the junior doctors, have the ability to exception report the extra hours they work, there exists an inherent inequality.

13.0 Issues arising

a) The trust continues in comparable standing to other trusts in the region. Exception report numbers have increased significantly during the last quarter.
b) There is an on-going problem of over-working and late finishes for trainee doctors owing to colleagues off sick, rota gaps and pressure of clinical work. This is especially true in General Medicine and now for surgery on SDEC.
c) Reluctance of trainees to report exceptions exists regionally and nationally.
d) Exception reports are being received and processed within the accepted time limits. There remains reluctance from supervisors in signing-off the reports. >70% are signed off by the Guardian alone.
e) There are gaps on rotas, but recruitment cycles continue.
f) No national Guardian meeting has yet been announced for 2023.
g) The Trust Board has requested that the Guardian enlarges his role in relation to SAS doctors. This was agreed in principle and although the facility has now been extended to the fellows within the organisation, no progress has been made with SAS doctors.

14.0 Actions taken to resolve issues

a) 2 further fines have been levied against the LTUC directorate and 1 against PSC during this quarter.
b) At the date of reporting, the Board of Directors is assured from the evidence that:
    i. The exception reporting system is operational for all trainees and now fellows; they are now all converted to the 2016 TCS Version 5 or equivalent.
    ii. Over-working owing to pressure of workload and rota gaps is a chronic problem in general medicine.
    iii. The Guardian can only intervene on notified problems.

15.0 Questions for consideration by the Committee

a) The Committee is asked to receive the report of Q3 2022-23 and to consider the assurances provided by the Guardian.
b) The issues around persistent overworking of juniors outlined in this report are now a significant concern and urgent action is needed by directorate management teams.
c) Significant pressure on staffing is currently being felt across the organisation and is concerning. There is evidence that support mechanisms are not working adequately.
d) The Guardian asks the board to be aware of the increasing pressures on junior medical staffing and the need for a long-term sustainable workforce model.
e) Issues of medical (and indeed all healthcare professional) workforce planning are an urgent strategic challenge to the Trust and to the entire NHS. The Trust always has vacancies in trainee doctor posts; these currently run at about 4%.

Dr Matthew Milsom

Guardian of Safe Working Hours

16th January 2023

Integrated Board Report - February 2023

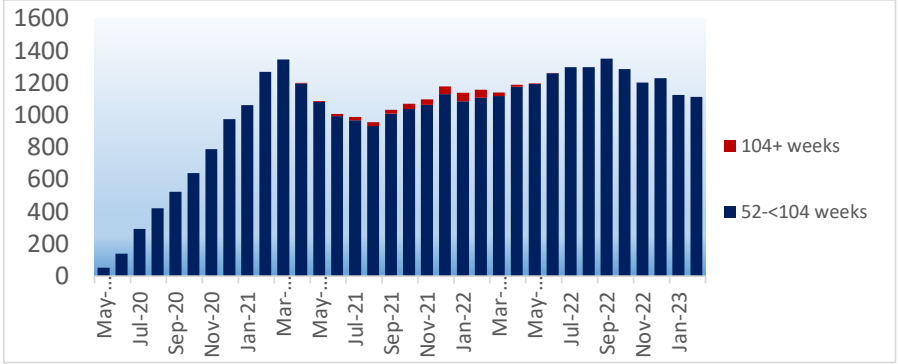
Domain 5 - Responsive

Indicator	**5.1 - RTT Incomplete pathways - 52+ weeks**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Feb-23
Value / RAG rating	1112

Indicator description

The number of incomplete pathways waiting over 52 weeks.

Trend chart



Narrative

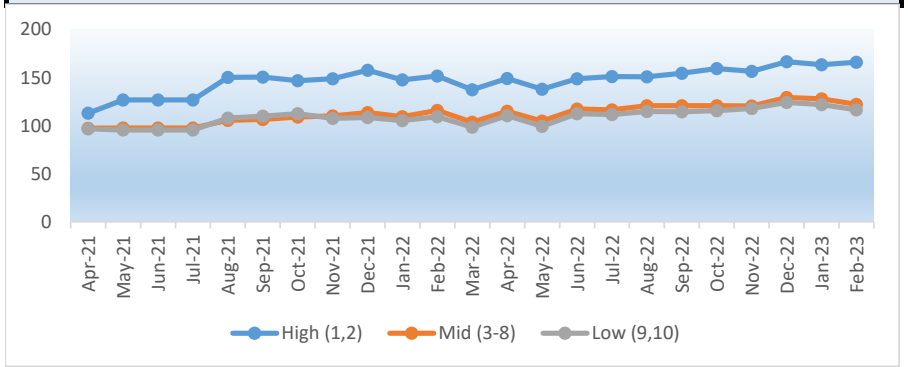
The overall RTT waiting list increased in February to 25,139 (24,846 last month). The increase was largely due to operational pressures within the Trust, including the number of Covid inpatients during the month, impacting our ability to deliver elective activity. However the focus on clearing the 78+ week waiters continues with the number of 78+ week waiters and the number of 52+ week waits both reducing in month. The Trust has reported zero 104+ week waits since Jul 22.

Indicator	**5.2 - RTT waiting times - by level of deprivation**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Feb-23
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.

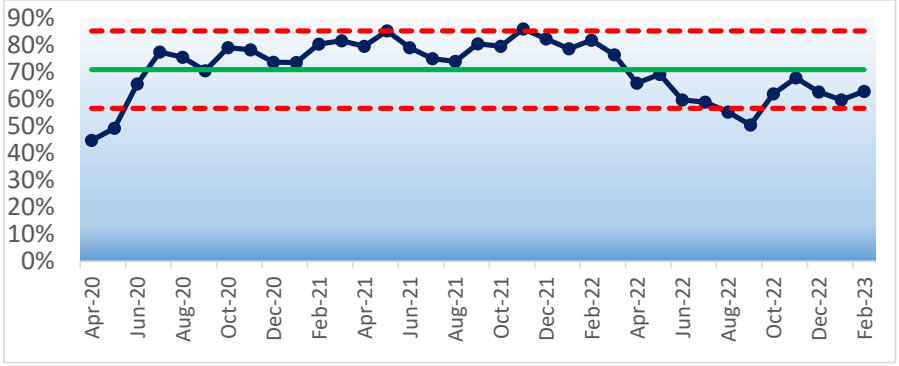
Work also continues in improving the recording of ethnicity and use of the learning disabilities flag across our clinical systems (this will improve further with the reinstatement of patient kiosks).

Indicator	**5.3 - Diagnostic waiting times - 6-week standard**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Feb-23
Value / RAG rating	62.9%

Indicator description

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

SPC chart



Narrative

Whilst the standard is not being achieved, mainly driven by a Covid-19 driven DEXA waiting list, progress in reducing long waiting patients has been made across all diagnostic modalities. CT is a high risk currently due to 1 of the 2 scanner being out of action. Additional sessions through the functional scanner are in place to mitigate.

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

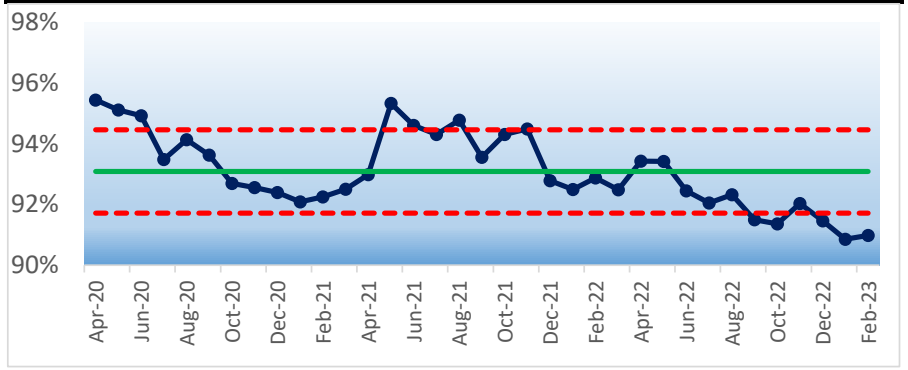
Narrative

Indicator	**5.5 - Data quality on ethnic group - inpatients**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Feb-23
Value / RAG rating	91.0%

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.

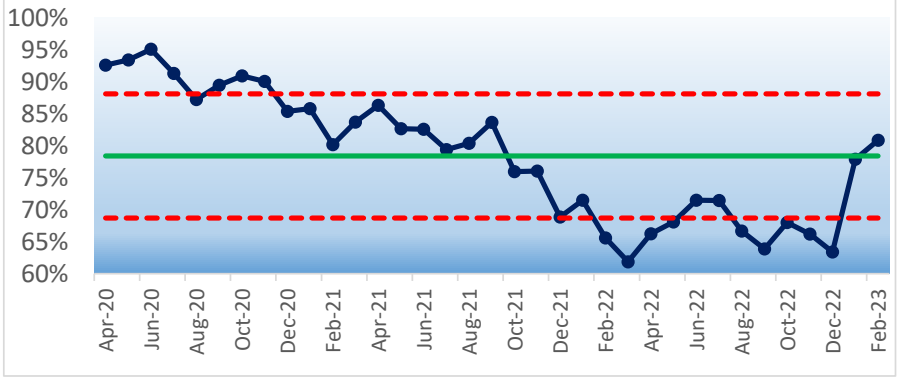
- Made contact with the lead at Central London Community NHS Trust (CLCH) who have improved their ethnicity recording rates on their patient records – they are organising a webinar to talk through their actions
- Reminded staff of the process regarding the collection of this data including reception 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. New kiosks are now ordered and expect to be implemented end of Q1 2023
- 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	Feb-23
Value / RAG rating	80.9%

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 but has seen a sustained significant improvement . Performance reflects the continuing significant pressures with high bed occupancy relating to discharge challenges and staff absenses, coupled with the current buidling works which is impacting ED capacity. The Trust continue to support the HNY system which is significantly pressured (OPEL 4) with regular diverts of ambulance patients to Harrogate - (over 1,000 YTD) this negatively impacts on HDFT's 4 hour performance and length of stay. Current work underway to improve this position includes:

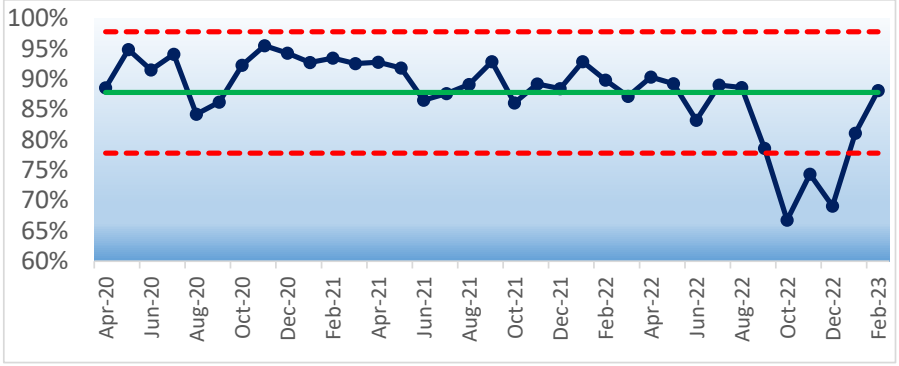
- delivering 7 day SDEC service and a direct to SDEC pathway with YAS;
- streaming of minors at the front door (now in place);
- utilising Criteria to Reside flow software to identify patients no longer requiring hospital care;
- developing a 2 hour crisis response service, expanding ARCH in-reach to ED and maximising SDEC opportunities;
- educating other specialties to avoid using ED as their triage and assessment service;
- increased GP Out of Hours provision to avoid Primary Care attendance;
- revision of infection control procedures as soon as national guidance changes to allow more rapid flow; (complete)
- implementing a 'fit to sit' area to improve flow; (complete)
- red2green methodology;
- criteria led discharge implemented;
-pharmacy attendance at board rounds;
- ward reconfiguration and specialty alignment; (complete).

Indicator	**5.7 - Ambulance handovers - % within 15 mins**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Feb-23
Value / RAG rating	88.1%

Indicator description

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

SPC chart



Narrative

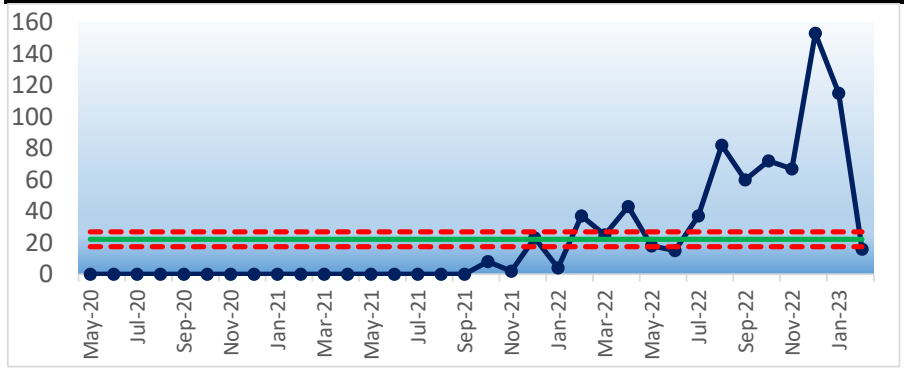
88% of ambulance handovers took place within 15 minutes in February, a continued improvement on recent months but remaining below the historical average. There were 26 over 30-minute handover breaches with 8 over 60-minutes in February. Prevention of ambulance handover delays continues to be a focus 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	Feb-23
Value / RAG rating	16

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

16 over 12 hour trolley waits were reported in February. RCAs have commenced and will be reviewed at internal quality and performance meetings.

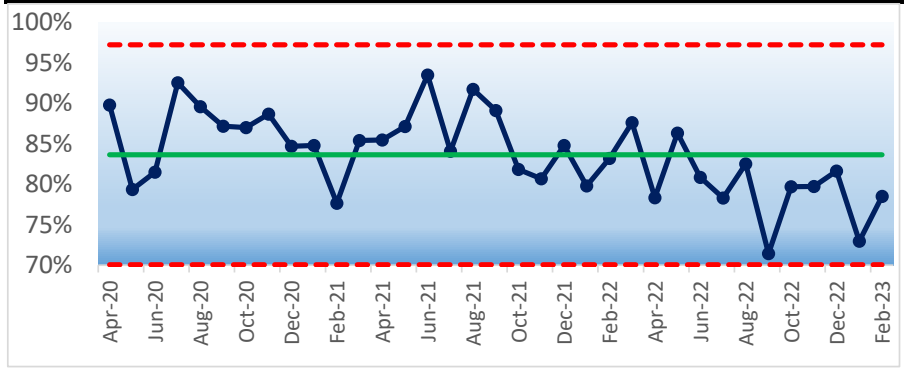
Last month, the Trust reported a position to NHS England (and within this report) of 89 over 12 hour trolley waits for the month of January. The correct figure was in fact 115. This was as a result of error in processing of the validated data. We have now reviewed these data processes and streamlined them, working with LTUC Directorate colleagues, to minimise the risk of a similar error in future. We are in the process of notifying NHS England of the error and requesting a revision of our published data.

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	Feb-23
Value / RAG rating	78.5%

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 February for the ninth consecutive month (78.5%). There were 60.5 accountable treatments (66 patients) in February with 13.0 accountable treated outside 62 days. Of the 10 accountable tumour sites treated in February, performance was below 85% for 8 (Colorectal, Gynaecology, Haematology, Head and Neck, Lung, Other, Upper GI, and Urology).

Provisional data indicates that 28.6% (4/14) of patients treated at Tertiary centres in February were transferred for treatment by day 38, compared to 47.8% (11/23) last month.

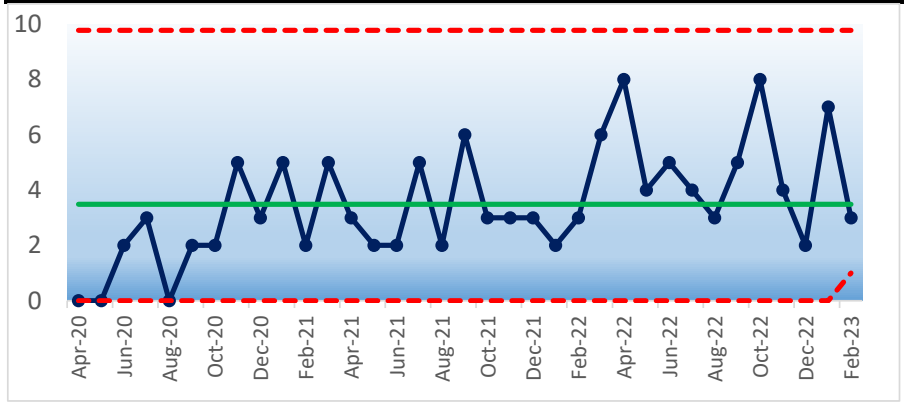
The latest published provisional data reports that national performance for the 62 day standard for all providers was at 54.4% in January. Of 143 providers, HDFT was the 24th best performing Trust. 114 of these providers had 50 or more accountable treatments, and of these, HDFT was the 14th best peforming Trust.

Indicator	**5.9.2 - Cancer - 62 day standard - number of 104 days waiters**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Feb-23
Value / RAG rating	3

Indicator description

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

SPC chart



Narrative

3 patients waited 104+ days for treatment in February (1 x Leeds Prostate; 1 x Harrogate Haematology; 1 x Harrogate Gynaecology). The delay reasons were as follows:

- Prostate: Complex pathway
- Haematology: Complex pathway
- Gynaecology: Patient choice delay to first outpatient appointment

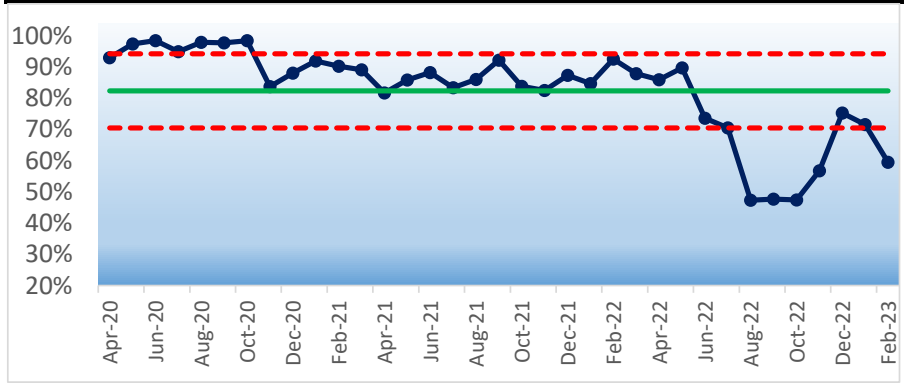
All patients have now received treatment. Following the implementation of a new cancer system in October (Somerset Cancer Registry) and the time constraints on the tracking team, it has been agreed to stand down the October, November and December breach panel meetings. This means that the patients who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

Indicator	**5.10 - Cancer - 14 days maximum wait from urgent GP referral for all urgent suspect cancer referrals**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Feb-23
Value / RAG rating	59.5%

Indicator description

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

SPC chart



Narrative

834 patients attended their first appointment for suspected cancer in February which is a similar level to last month (807). Of the 834 patients seen in February, 338 were seen outside 14 days (59.5%) which is a deterioration on recent months.

14 day capacity continues to be challenging in February with 4 suspected cancer sites below the 93% standard (Breast - 22.3%; Colorectal - 78.5%; Gynaecology - 57.7%; Skin - 2.1%). Non-cancer breast symptomatic performance was at 23.5%.

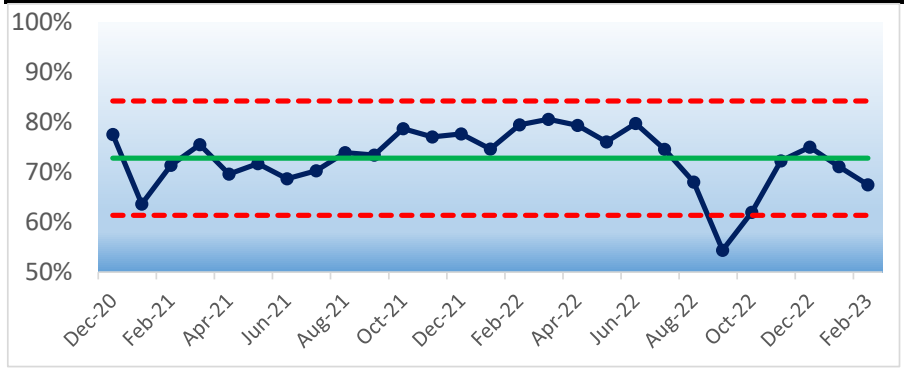
The latest published provisional data reports that national performance for the 2WW suspected cancer standard for all providers was at 81.8% in January. Of 141 providers, HDFT was the 22nd worst performing Trust. 123 of these providers had 500 or more first attendances, and of these, HDFT was the 7th worst peforming Trust.

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	Feb-23
Value / RAG rating	67.5%

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

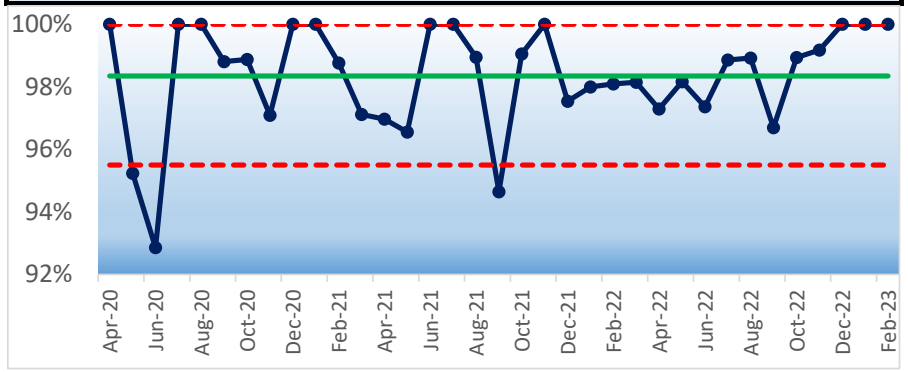
Provisional data indicates that in February combined performance for the three 28 days standards (2WW suspected cancer, 2WW non-cancer breast symptoms, Screening) continued to be below the proposed operational standard of 75% at 67.5% (2WW cancer – 71.5%; 2WW Breast Symptoms – 94.0%; Screening – 29.6%). This is a slight deterioration on last month (71.1%).

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	Feb-23
Value / RAG rating	100.0%

Indicator description

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

SPC chart



Narrative

Provisional data indicate that 83 patients received First Definitive Treatment for cancer at HDFT in February, with all treated within 31 days.

Overall performance was above the expected standard of 96%.

Indicator	**5.13 - Children's Services - 0-12 months and 2-3 years caseload**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Feb-23
Value / RAG rating	

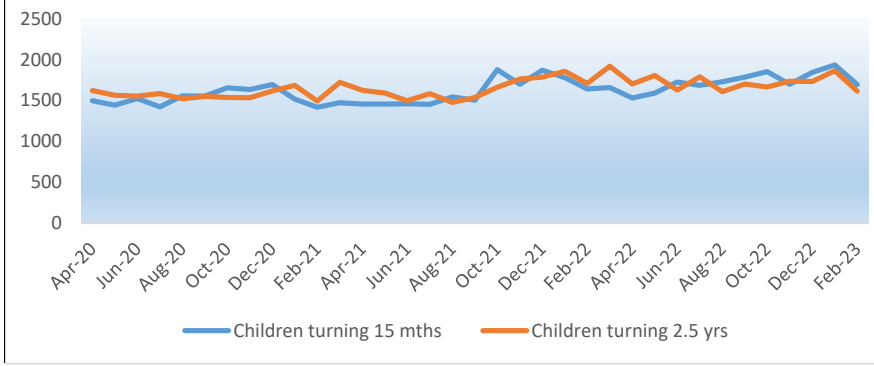
Indicator description

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

Narrative

Both caseloads decreased in February.

SPC chart

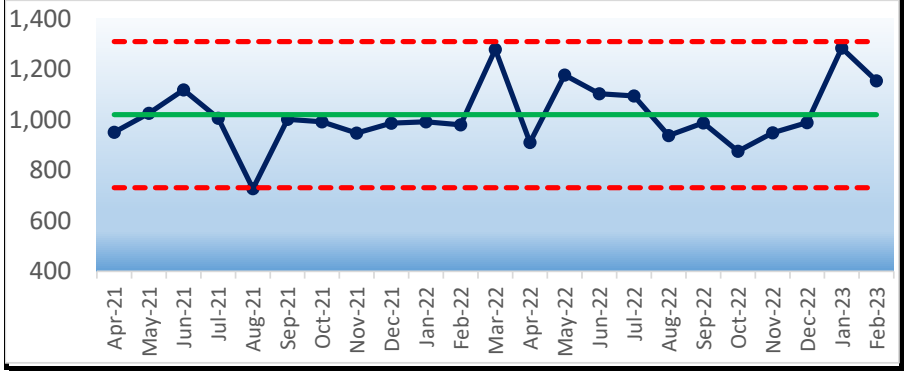


Indicator	**5.14 - Children's Services - Safeguarding caseload**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Feb-23
Value / RAG rating	1154

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	Feb-23
Value / RAG rating	91.4%

Indicator description

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

SPC chart

Narrative

91% of eligible pregnant women received an initial antenatal visit in February.

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	Feb-23
Value / RAG rating	97.5%

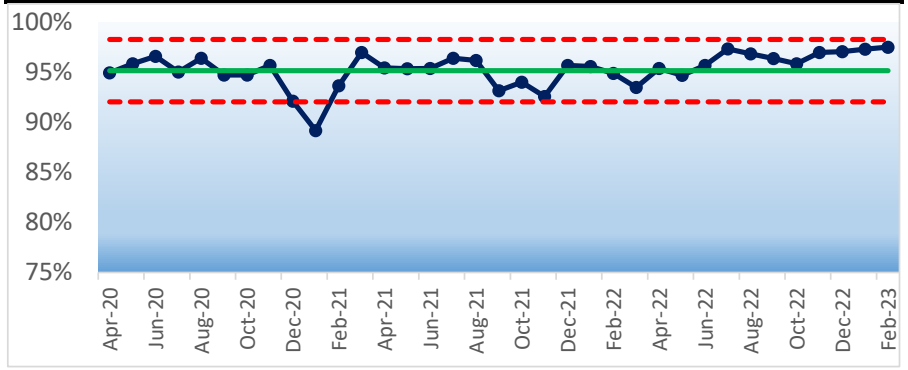
Indicator description

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

Narrative

98% of infants received a new birth visit within 10-14 days of birth during February.

SPC chart

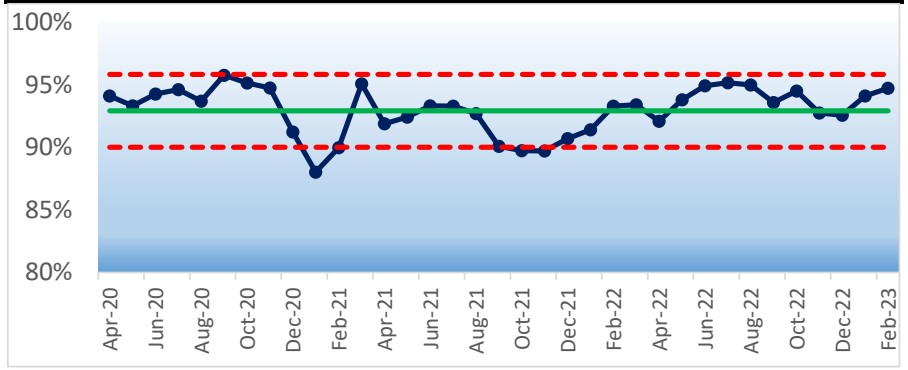


Indicator	**5.17 - Children's Services - 6-8 week visit**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Feb-23
Value / RAG rating	94.7%

Indicator description

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

SPC chart



Narrative

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

Indicator	**5.18 - Children's Services - 12 month review**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Feb-23
Value / RAG rating	96.3%

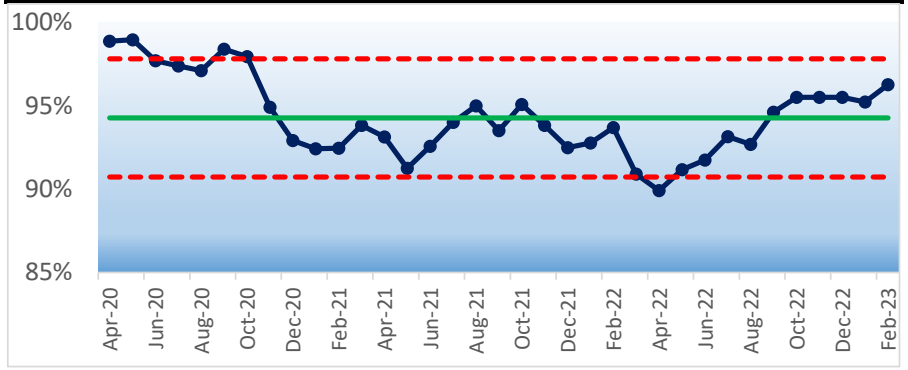
Indicator description

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 February.

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	Feb-23
Value / RAG rating	92.6%

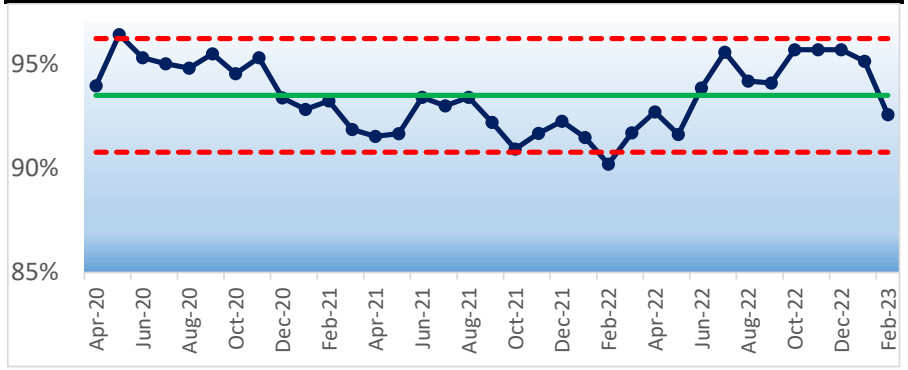
Indicator description

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

Narrative

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

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	1/2/3

Indicator description

This indicator is under development.

SPC chart

Narrative

CC Directorate have started to discuss and record OPEL levels for 0-19 Services at their Safety and Governance huddles. The position for February was:

Acute Paediatrics - Level 1
Darlington - Level 2
Durham - Level 3
Gateshead - Level 1
Immunisation DDT - Level 2
Immunisation NY - Level 3
Middlesbrough - Level 3
North Yorkshire - Level 2
Northumberland - Level 2
Safeguarding - Level 3
Stockton - Level 2
Sunderland - Level 3
Wakefield - Level 3

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

Indicator description

This indicator is under development.

SPC chart

Narrative

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

From March, the Trust has started to submit data related to this standard as part of the monthly Community Services Data Set submissions to NHS England. We are awaiting confirmation from NHS England as to how organisations wil be assessed against the standard. Provisional data suggests that the Trust continues to achieve the 2 hour standard for 100% of eligible cases in February.

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

Indicator description
This indicator is under development.

SPC chart

Narrative

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

Indicator description
This indicator is under development.

SPC chart

Narrative

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

Indicator description

This indicator is under development.

SPC chart

Narrative

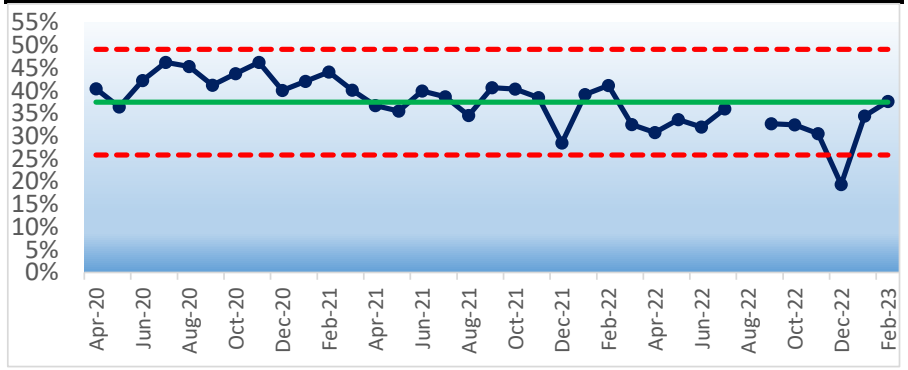
CC Directorate have started to discuss and record OPEL levels for Adult Community Services at their Safety and Governance huddles. The overall position for February remained at level 3.

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	Feb-23
Value / RAG rating	37.6%

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 Aug-22 performance.

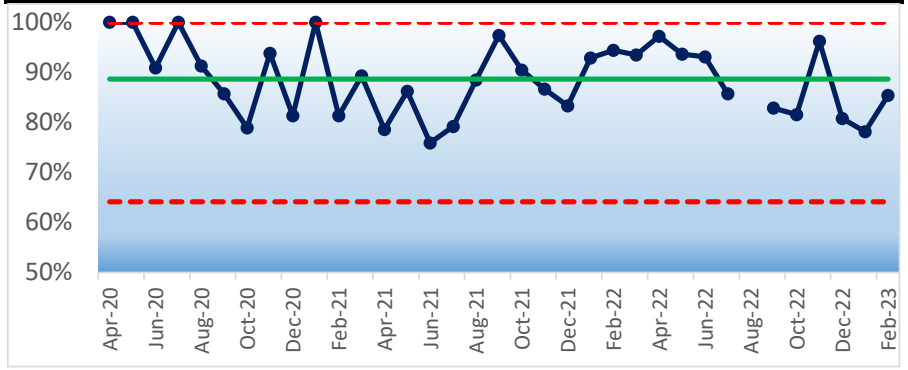
In February, 38% of urgent cases received a telephone clinical assesment within 20 minutes of call prioritisation, an improvement on recent months.

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	Feb-23
Value / RAG rating	85.4%

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 Aug-22 performance.

In February, 85% of urgent cases received a home visit within 2 hours, an increase on the previous month.

Integrated Board Report - February 2023

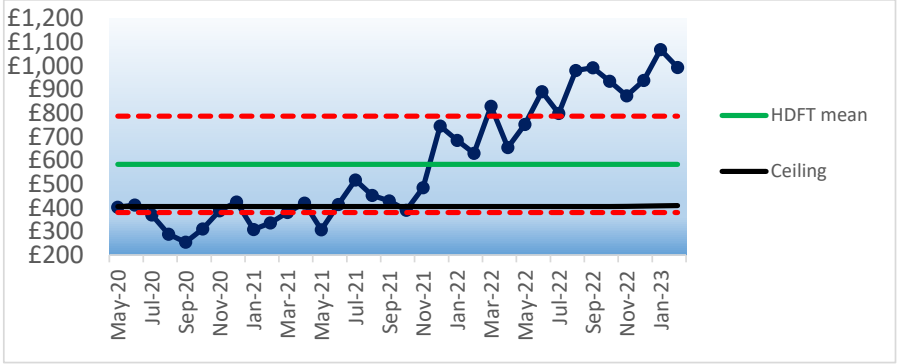
Domain 6 - Efficiency and Finance

Indicator	**6.1 - Agency spend**
Executive lead	Jordan McKie, Finance Director
Board Committee	Resources Committee
Reporting month	Feb-23
Value / RAG rating	£993

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

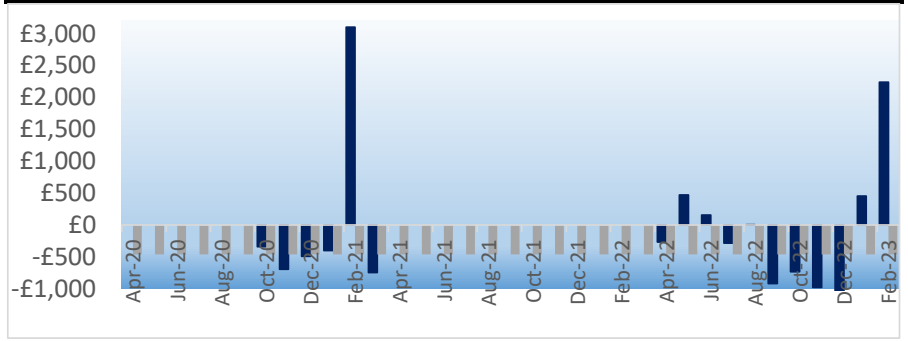
Month 11 expenditure on agency is £993k, reflecting continuing pressure in medical staffing and wards. Spend continues to be above the agency ceiling. Agency spend is being monitored via the monthly agency review meetings and directorate performance meetings.

Indicator	**6.2 - Surplus / deficit and variance to plan**
Executive lead	Jordan McKie, Finance Director
Board Committee	Resources Committee
Reporting month	Feb-23
Value / RAG rating	£2,240

Indicator description

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

Trend chart



Narrative

The reported position is £2.2k surplus in month. This takes the year to date deficit to £2.2k. The in month position reflects non-recurrent benefits and the year to date position reflects continuing pressures, mainly in pay and unachieved CIP. The Trust is forecasting to achieve plan.

Indicator	**6.3 - Capital spend**
Executive lead	Jordan McKie, Finance Director
Board Committee	Resources Committee
Reporting month	Feb-23
Value / RAG rating	£10,478

Indicator description

Cumulative Capital Expenditure by month (£'000s)

Trend chart

Narrative

Capital spend is £10,478k to month 11. The plan has been reprofiled to reflect slippage. There is risk of slippage on some schemes as we head towards year end. Ongoing discussions with the estates team and scheme leads to manage the position in particular for key schemes (EPR, TIF2) for which funding was received later in the year. Additional capital schemes to utilise potential slippage have been identified through life cycling exercise.

Indicator	**6.4 Cash balance**
Executive lead	Jordan McKie, Finance Director
Board Committee	Resources Committee
Reporting month	Feb-23
Value / RAG rating	£19,972

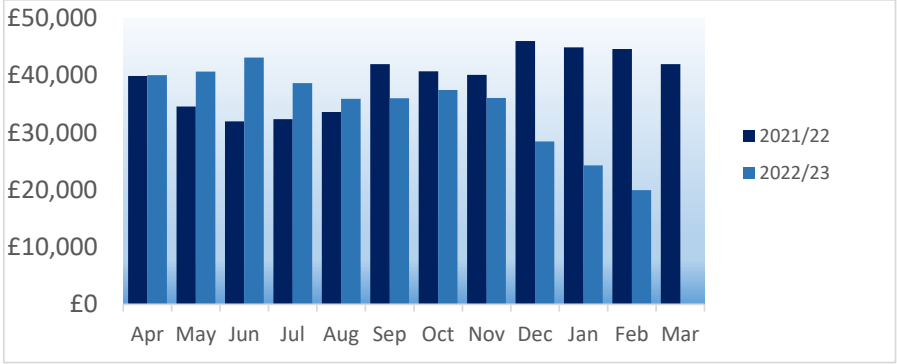
Indicator description

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	Feb-23
Value / RAG rating	153

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 153 in February, 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	Feb-23
Value / RAG rating	75

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

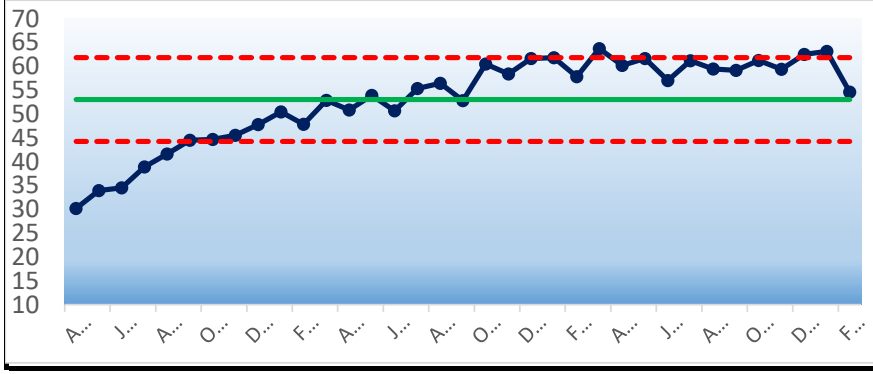
The number of long stay patients (> 21 days) was 75 in February, remaining high. This is being driven by the increase in COVID patients, COVID 'pop ups' at day 7 and patients requiring observation as COVID contacts alongside the impact of COVID on POC, residential and nursing home providers.

Indicator	**6.6 - Occupied bed days per 1,000 population**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Feb-23
Value / RAG rating	54.6

Indicator description

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

SPC chart



Narrative

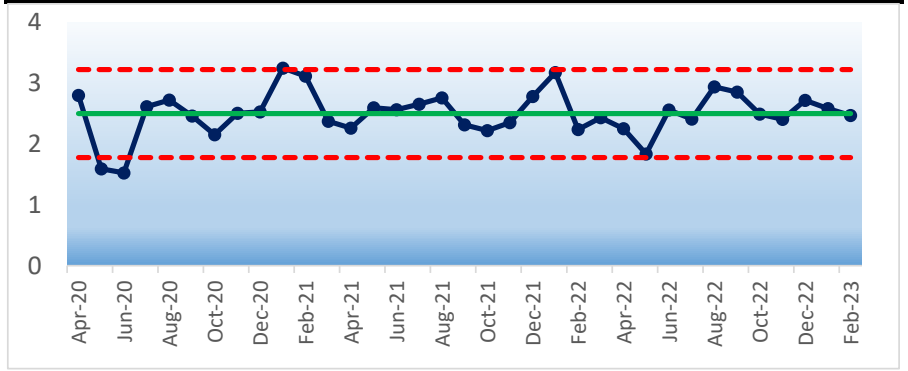
Occupied bed days per 1,000 population were at 54.6 in February. In the 2 years prior to the pandemic, occupied bed days per 1,000 population averaged 57.8, above the current level.

Indicator	**6.7.1 Length of stay - elective**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Feb-23
Value / RAG rating	2.47

Indicator description

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

SPC chart



Narrative

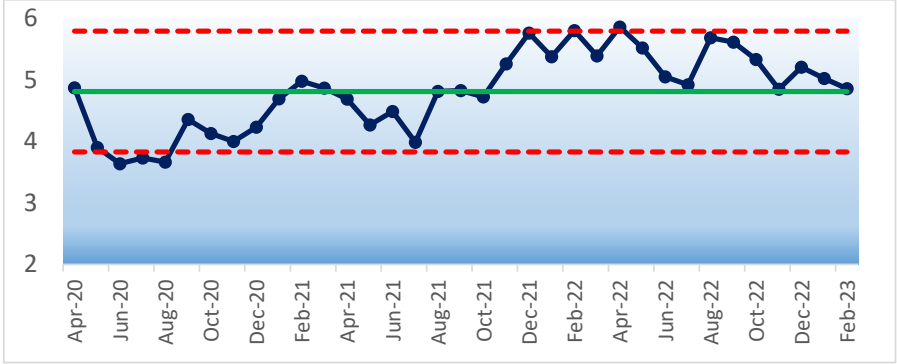
Elective length of stay decreased in February and is now below our local stretch target of 2.5 days.

Indicator	**6.7.2 Length of stay - non-elective**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Feb-23
Value / RAG rating	4.86

Indicator description

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

SPC chart



Narrative

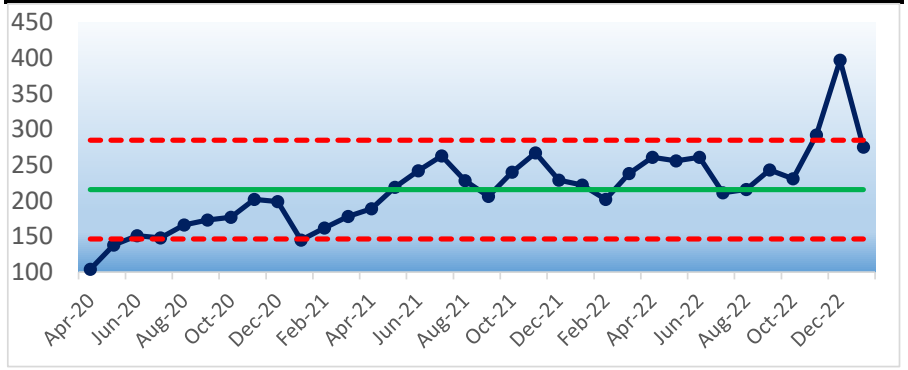
Non-Elective length of stay decreased in February but remains above our local stretch target. There is a combination of factors affecting patient flow as described in indicators 6.5.1 - 6.7.1. Primarily driven by high numbers of patients remaining with no criteria to reside and patient extended stay whilst in isolation for Covid or awaiting to be 'clear' of covid before discharge to care homes.

Indicator	**6.8 - Avoidable admissions**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Jan-23
Value / RAG rating	275

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 275 avoidable admissions in January, remaining high but a reduction on December levels. The most common diagnoses this month continue to be respiratory conditions, including influenza, and urinary tract infections. Excluding children and admissions to SDEC, the January figure was 168.

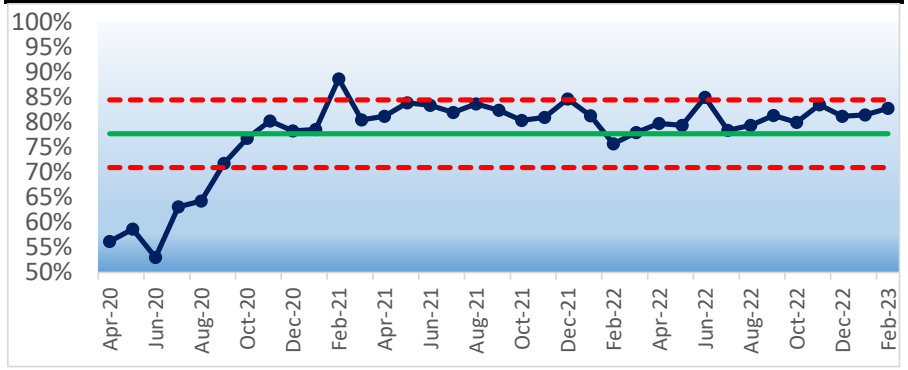
This is in line with pre-Covid levels - the average per month in 2018/19 was 270.

Indicator	**6.9 - Theatre utilisation (elective sessions)**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Feb-23
Value / RAG rating	82.8%

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 82.8% in February, remaining below the local intermediate target of 90%. There is ongoing work across the board but focussed initial work with ophthalmology colleagues to understand how we achieve GIRFT productivity within HDFT. There remains an impact from Covid-19 causing late cancellations which impact upon utilisation.

Indicator	**6.10 - Day case conversion rate**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Feb-23
Value / RAG rating	1.8%

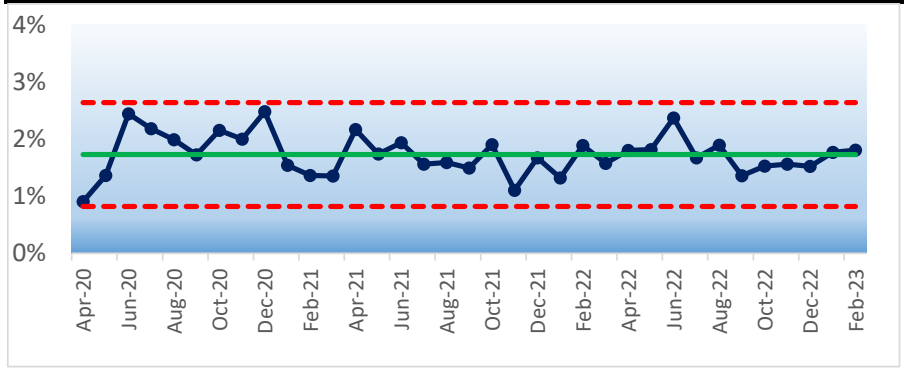
Indicator description

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

Narrative

1.8% (43 patients) of intended day cases stayed overnight or longer in February, no significant change on last month and remaining within the control limits.

SPC chart



Integrated Board Report - February 2023

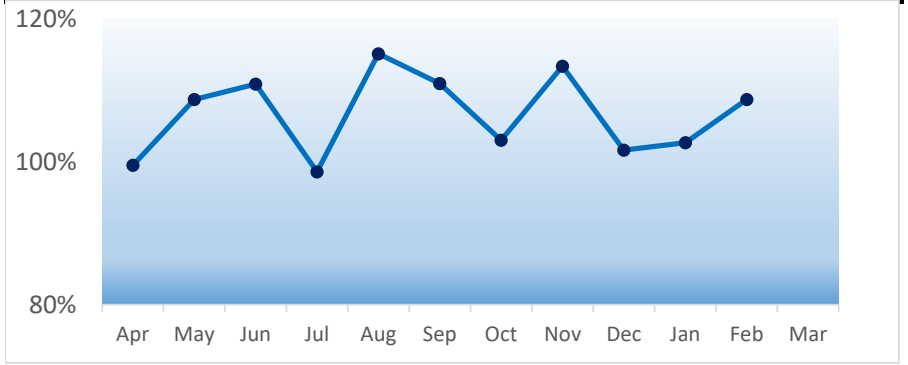
Domain 7 - Activity

Indicator	**7.1 - GP referrals against 2019/20 baseline**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Feb-23
Value / RAG rating	108.7%

Indicator description

GP referrals against 2019/20 baseline.

SPC chart



Narrative

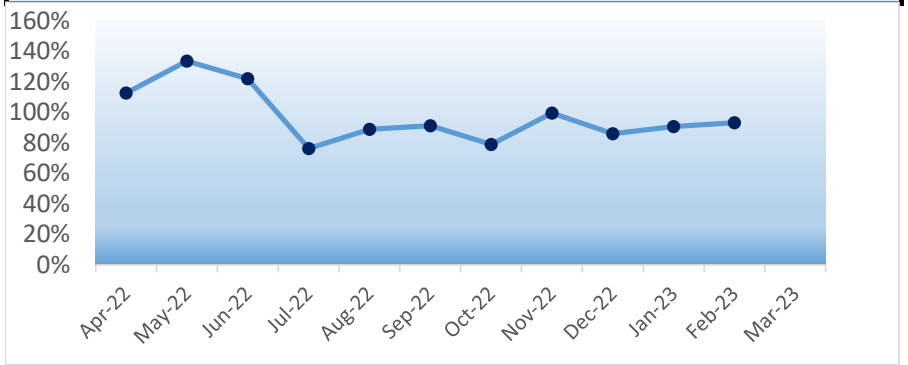
In February, GP referrals were 9% above level of the equivalent month in 2019/20.

Indicator	**7.2 - Outpatient activity (consultant led) against plan**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Feb-23
Value / RAG rating	93.1%

Indicator description

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

Trend chart



Narrative

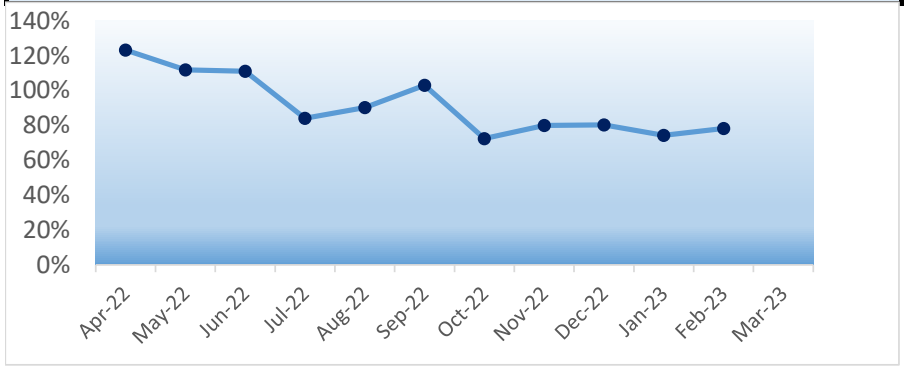
Outpatient activity was 7% below plan in February. New outpatient attendances were 24% below plan and follow up attendances were 4% above plan.

Indicator	**7.3 - Elective activity against plan**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Feb-23
Value / RAG rating	78.2%

Indicator description

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

Trend chart



Narrative

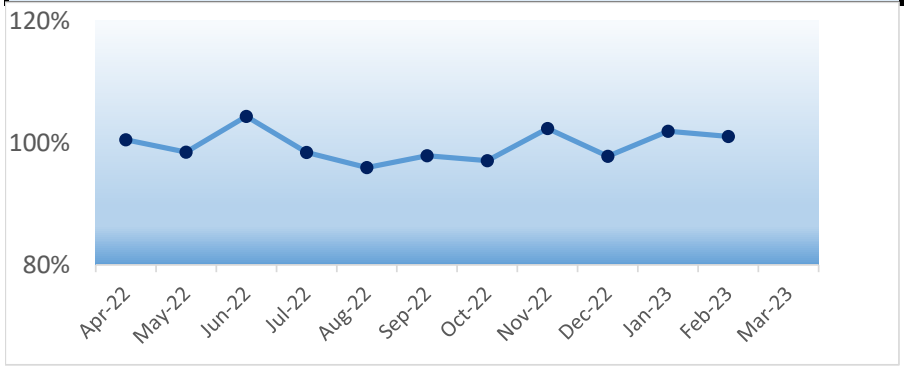
Elective admissions were 22% below plan in February. Elective day cases were 21% below plan and elective inpatients were 34% below plan. Activity continues to be affected by Covid-19. However we remain on trajectory for clearance of 78 week waiters by 31st March.

Indicator	**7.4 - Non-elective activity against plan**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Feb-23
Value / RAG rating	101.0%

Indicator description

Non-elective activity against plan.

Trend chart



Narrative

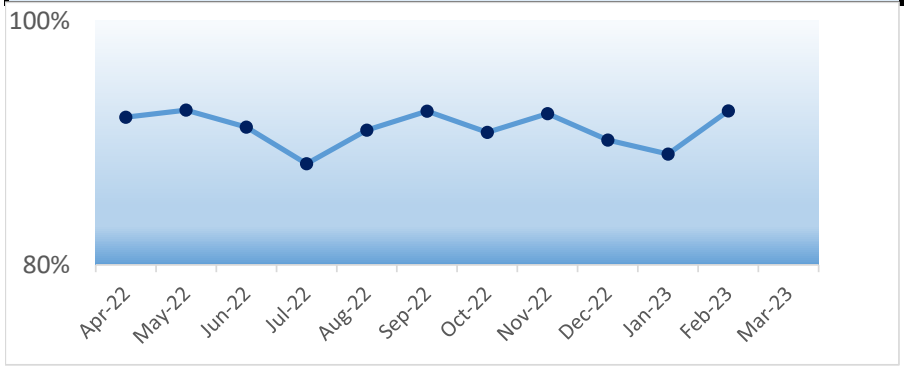
Non-elective activity was 1% above plan in February.

Indicator	**7.5 - Emergency Department attendances against plan**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Feb-23
Value / RAG rating	92.6%

Indicator description

Emergency Department attendances against plan.

Trend chart



Narrative

Emergency Department attendances were 7% below plan in February.

Integrated Board Report - February 2023

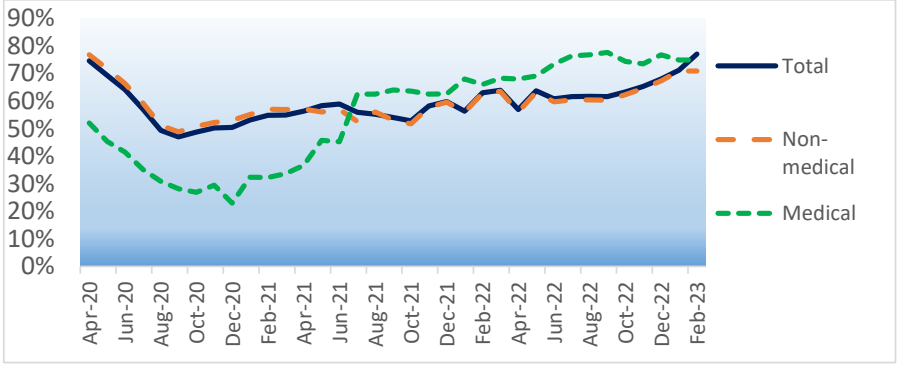
Domain 4 - Workforce

Indicator	**4.1 - Appraisal Rate - Non Medical and Medical Staff**
Executive lead	Angela Wilkinson
Board Committee	People and Culture Committee
Reporting month	Feb-23
Value / RAG rating	77.0%

Indicator description

The number of Non medical staff who have had a 4S appraisal and Medical staff who have had a Medical Staff appraisal. The Trust aims to have 90% of staff overall appraised.

SPC chart



Narrative

The appraisal rate in February is 77.0%, which is an increase in comparison to January (71.2%). Figures now exclude bank assignments.

This is a key area of focus and HR Business Partners are working with the Directorates to ensure recovery plans are in place. LTUC Directorate continue to see further significant increases in appraisal rate compared to the previous month, with an increase from 67.9% to 79.2%.

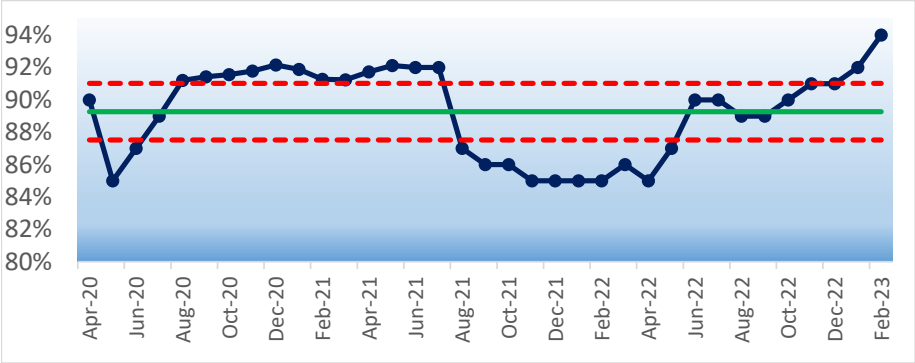
- Non-Medical appraisal % = 77.1% (previous month 70.9%)
- Medical appraisal % = 75.9% (previous month 74.8%)

Indicator	**4.2 - Mandatory training rate**
Executive lead	Angela Wilkinson
Board Committee	People and Culture Committee
Reporting month	Feb-23
Value / RAG rating	94.0%

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 February for the Mandatory Core elements of training. The overall compliance rate for substantive Trust staff is 94%, an increase of 2% since the previous month.

The Mandatory Core overall compliance for bank staff is now 81%, which has increased by 4% since last month.

The overall compliance for Mandatory core and role based training for Trust substantive is currently 89% and has increased by 2% since the previous month.

Indicator	**4.3 - Staff sickness rate**
Executive lead	Angela Wilkinson
Board Committee	People and Culture Committee
Reporting month	Feb-23
Value / RAG rating	5.0%

Indicator description

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

SPC chart

Narrative

Sickness has decreased in February from 5.2% to 5.0%. The Humber and North Yorkshire League table of sickness indicates that HDFT to be the 2nd lowest sickness levels in the region. A contributing factor to the reduction of sickness in February is a decrease in 'Cold, Cough, Flu - Influenza' and 'Chest & respiratory problems' sickness. Combining these two sickness reasons, the Trust saw a reduction of 22% compared to absences of the same reasons in January.

Sickness has decreased across all Directorates, with the exception of Corporate Services, which saw an increase from 3.5% to 3.7%, however this remains below the Trust threshold of 3.9%. CC Directorate continues to see the greatest sickness levels and has a rate of 6.1% in February. The services which have the greatest levels of sickness in February are Research and Development and the Northumberland and Gateshead localities within the 0-19 Children's services.

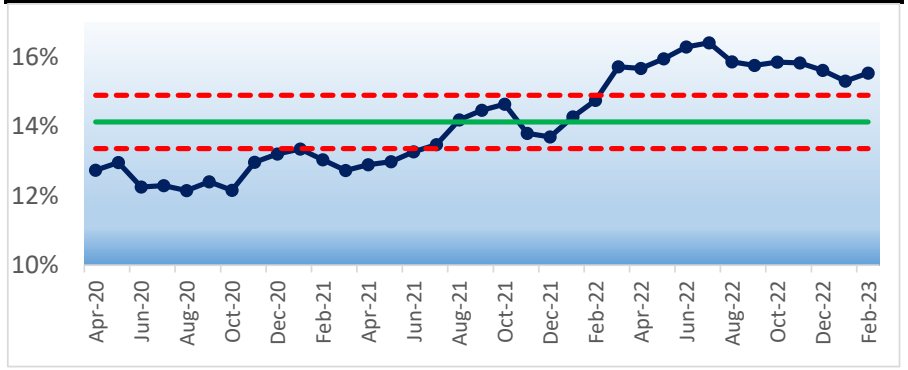
Long term sickness has decreased this month from 3.0% last month to 2.9% and short term sickness has also seen a decrease from 2.2% to 2.1%. "Anxiety/stress/depression/other psychiatric illnesses" remains the top reason for sickness this month and contributes to 31.1% of the overall sickness. 110 employees were absent due to this reason in February, (125 last month). However the overall total number of FTE days lost remains at a similar level. We continue to push Occupational Health, EAP and Wellbeing Services to support staff.

Indicator	**4.4 Staff turnover rate**
Executive lead	Angela Wilkinson
Board Committee	People and Culture Committee
Reporting month	Feb-23
Value / RAG rating	15.5%

Indicator description

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

SPC chart



Narrative

The Trust has seen a general decreasing trend for turnover since July, however February has seen a small increase compared to the previous month, from 15.3% 15.5%. (This incorporates voluntary and involuntary turnover). Voluntary turnover has increased from 11.8% last month to 12.0% in February.

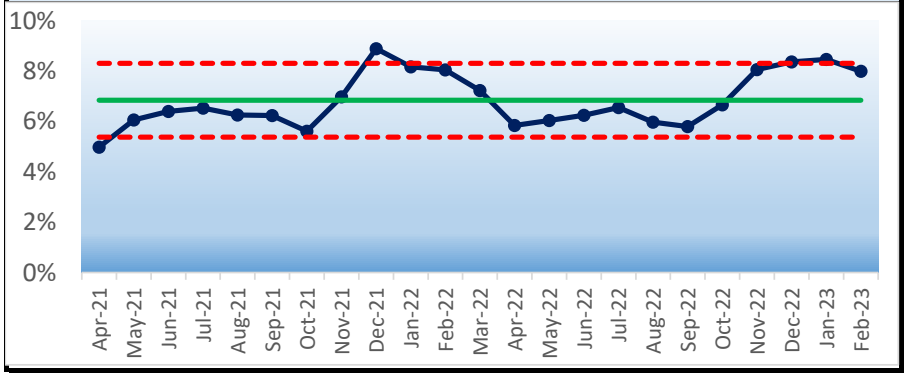
Health Visitor turnover has seen an increasing trend since October and is currently 18.9% in February. The 'Additional Clinical Services' staff group remains the staff group with the highest turnover rate, which is 18.6% in February. This remains at a similar level compared to last month. The areas with the greatest turnover within this staff group are Care Group 1, which includes Maternity Services (68.3%) and Paediatric Services (54.4%). Work is ongoing to understand reasons for leaving as part of the retention programme and to develop short, medium and long term actions to help reduce voluntary leavers.

Indicator	**4.5 - Vacancies**
Executive lead	Angela Wilkinson
Board Committee	People and Culture Committee
Reporting month	Feb-23
Value / RAG rating	8.0%

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 February is 8.0%, which is a decrease from 8.5% in the previous month. This equates to 355.90wte vacancies. The contributing factors to the decrease in vacancies this month is a decrease of 6.74wte to the budget and an increase to staff in post of 14.58wte.

LTUC Directorate has the greatest vacancy rates of 12.9% (164.21wte vacancies). The areas with the greatest vacancy rates are Granby Ward and AFU. We continue to review recruitment pipeline and processes to help mitigate vacancy rates.

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

Date	**10/01/23**	**Location**	MS Teams
Chair	**Brendan Brown**	**Minutes prepared by**	Lucy Cole
Attendees	Lucy Cole, Brendan Brown, Foluke Ajayi, Mel Pickup, Len Richards, Jonathan Coulter & Phil Wood.		
Apologies	Apologies from Julian Hartley.		

Agenda

ITEM		WHO
1	Attendance & Apologies	Chair
2	Minutes & Actions	All
3	System and operational pressures	All
4	Collaborative Report and WY HCP Report	LC
5	NSO (Chief Operating Officers and Medical Directors to join)	LR and Angie Craig
6	WYAAT Executive Development programme	Asifa Ali
7	Committee in Common – 31 January 2023 • Draft Committee in Common Agenda • Draft Infrastructure paper for CIC	LC
8	AOB	All

PREVIOUS MEETING ACTION POINTS

Category	Action	Status/Update	Lead
	See Action Log. Actions 77, 78, 81 and 82 were noted as closed. Actions 79 and 80 were noted to be covered as part of Agenda item 6. Action 71 was deferred to February given agenda requirements in January. Action 83 – Mel Pickup (MP) confirmed the contact for BTHFT was John Holden, Foluke Ajayi (FA) confirmed Katie Lister for ANHSFT, Phil Wood (PW) Jane Westmoreland for LTHT.		

By Agenda Item	Main Points and Decisions from Discussions	Agreed Actions
Minutes & Actions	The minutes from the previous meeting were accepted as a true record and the action log had no further update.	
System issues and operational pressures	MYHT • Trust remains in OPEL4 but pressure has eased compared with the previous week. Still significant demand and staff sickness and significant elective activity cancelled. BTHFT • Trust has moved to OPEL3 after a sequence of days with lower ED attendances which has alleviated the pressure in ED. Reflected that this level of pressure cannot be normalised. ANHST • Trust has moved to OPEL3 after a drop in ED attendances over a number of days. Much of the additional super surge capacity had been in ED and as a result, ED now feels less congested, and flow has improved. However, the position is still challenging with non-clinical staff supporting with flow rather than returning to the usual duties. HDFT • Previous Friday had been the most challenged day and this had elicited a greater system response, including high-levels of discharge and additional care home capacity made available with financial support from the trust to cover the first two weeks of care costs. This had previously not been identified as a blocker. LTHT • Pressure has slightly eased and flow / discharges have now started to pick up, alongside a flattening of attendance numbers. However, the trust is still operating in a high level of surge capacity and therefore is still reporting as OPEL4. Staff sickness levels related to flu and covid remain high. Preparations for a strike by YAS were underway in all trusts.	
Collaborative Report and WY HCP Report	• Pharmacy Aseptics – LC clarified the process with the group, confirming that the programme team is now working towards completion of a short form business case and undertaking value engineering to reduce the capital requirement to within the £24m allocation. LC confirmed the revised case would be taken to WYAAT CIC on 31 January 2023 with a covering paper explaining the change from the two-stage OBC / FBC process to the single stage short form case. There are no other major changes to the case and therefore, it is suggested that CEOs and Chairs take the revised case back through Boards for information rather than approval (as all Boards have approved the OBC).	

	• Pathology – LIMS. LC outlined the delay to the transfusion go live and noted that this was due to an issue with the system found during testing. CliniSys is designing a fix which has support from the blood transfusion group across WYAAT. Subject to this being acceptable in testing and to the MHRA, the module can be deployed. This has not delayed the overall deployment programme. Airedale and Bradford go live with the cellular pathology module is scheduled to take place as planned on 17 January 2023. LC noted that she would share some draft communications with CEOs to support any communications locally. • Imaging – Image sharing solution has encountered some issues in testing. Four of the six trusts are now connected to the live system. The issues have been escalated to the supplier for a formal response by today (10/1/23). A session with operational leads is taking place today to support operationalising the solution and future collaboration opportunities. • Endoscopy – nearly all the WYAAT schemes put forward for national endoscopy capital have been progressed to the national panel (excluding EUS in MYHT and CHFT). LTHT scheme has been brought forward to 22/23 with some underspend allocated to the scheme (equipment purchase). • Planned Care – LC noted that following the regional elective recovery event in York, there had been six clinical networks agreed for the high volume, low complexity (HVLC) specialties and Chairs identified. NHSE had also supported using the mutual aid funding to support clinical time for these. There had been excellent verbal feedback from the GIRFT visit from Prof. Tim Briggs.	**Action – LC to share LIMS communications with CEOs.**
NSO Next steps to progress model	*Angie Craig, David Crampsey, Stuart Shaw, Julia Nixon, Saj Azeb, John Bolton, David Birkenhead, Rob Aitchison, Jacqueline Andrews, Russell Nightingale, Mike Harvey, Trudie Davies and Richard Robinson joined the meeting.* • LR introduced the discussion noting the current operational challenges in the here and now and the future planning process for the long-term model, noting that these should be treated as separate pieces of work. • AC talked through the paper highlighting that the workforce pressures had increased since the model had been agreed in principle in April 2022. • International recruitment for medical oncologists is progressing and work is underway to develop the ACP role and pipeline. • AC noted the three part model and that the inpatient model was currently causing the most concern in terms of implementation. There was group discussion highlighting: • The need to clearly articulate the benefits of the three-part model to assure clinicians, patients, communities and OSCs that this was the right model to implement	

	• Financial analysis of the baseline needs to be completed and an understanding of any transitional costs • Staffing model must be informed by current workforce shortages and new roles, rather than a focus on recruitment of hard to fill roles • Requirement for clarity on the inpatient staffing model and the role of the acute physicians in this (using best practice from within WYAAT and other parts of the country) • Retain absolute clarity on the drivers, objectives and how we will judge success – linked to inequity of outcomes and improving cancer outcomes for the people of West Yorkshire and Harrogate • Sector model can be flexible but needs to ensure consistency and equitable distribution of resources The group agreed that: • We have an agreed model which needs to be further tested and worked through in greater detail • Parallel work needs to continue on the short-term (operational group) and long-term model (NSO Delivery Group) • A sample operational plan was required to support the Sectors to plan through the implementation of the model • A full business case was required to describe the workforce model, costs and wider impacts for patients and each organisation. • To reconvene in late February 2023 to review progress. *Angie Craig, David Crampsey, Stuart Shaw, Julia Nixon, Saj Azeb, John Bolton, David Birkenhead, Rob Aitchison, Jacqueline Andrews, Russell Nightingale, Mike Harvey, Trudie Davies and Richard Robinson left the meeting.*	**Action: AC to work with Jules Hoole on operational plan** **Action: AC to develop business case with support from LC** **Action: LC to arrange session in February.**

WYAAT Executive Development programme	*Asifa Ali joined the meeting.*
	
	• AA presented the proposal for the executive development programme, noting that this was an idea from the all-exec session in September 2022.
	• All CEOs were very supportive of the proposal noting the need to:
	  ○ Incorporate an international element of system leadership to gain insight on models outside of the UK
	  ○ Ensuring that the first cohort was a diverse group in professional groups as well as diverse in respect of protected characteristics
	  ○ Requirement for a foundational leadership element to ensure all participants are starting with a similar level of base knowledge, recognising that formal leadership development experiences will be diverse
		Action: All to identify any international leaders as potential speakers
		
		Action: AA to make amendments to the proposal to reflect inputs

	○ Ensure that organisations commit to providing the individuals with the pre-requisite time to engage in the programme, particularly for clinical colleagues ○ Consider interface opportunities with the ICB and noted that once tested, this could be expanded across sectors but that it made sense to test as WYAAT only in the first instance. ○ Organisations would identify a shortlist of candidates and then a group selection process would be undertaken to ensure an appropriately diverse cohort of leaders was selected. ○ 3-5 years to exec director was too broad a cohort and this should be targeted to the 3-year cohort. *Asifa Ali left the meeting.*	**from Programme Executive.** **Action: CEOs to discuss within their trusts and with HRDs.**
Committee in Common – 31 January 2023	• Programme Executive agreed the proposed draft agenda for WYAAT CIC. • LC gave an overview of the infrastructure paper, explaining that this was a request from the last WYAAT CIC. Paul Jones (LTHT CDIO and West Yorkshire CDIO Lead) has drafted the paper based on some work commissioned through the ICS. The paper has also been for WYAAT CIO discussion and feedback. The group confirmed it was happy for the paper to progress to CIC on 31 January.	**ACTION: LC to finalise agenda and papers for CIC.**
AOB	• None raised.	

OTHER ISSUES TO NOTE
NA

NEW RISKS/ISSUES RAISED
NA

Next Meeting	**WYAAT Programme Executive**		
Date	07/02/23	**Location**	MS Teams

Humber and North Yorkshire
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Collaborative of Acute Providers (CAP) Board Meeting
16th January 10.00 – 12.00
Via Teams

Those Present: Chris Long (CL), CEO HUTH (Chair)
Wendy Scott (WS), MD CAP
Jonathan Coulter (JC), Acting CEO, Harrogate
Matt Graham (MG), Director of Strategy, Harrogate
Andy Bertram (SB), Chief Financial Officer, York
Shaun Stacey (SS), COO (NLaG),
Peter Reading (PR), CEO, NLaG
Ivan McConnell (IMc), Director of Strategic Development, NLaG
Shaun Jones Locality Director, NHSE,

In Attendance: Carla Mitchell, (CM) Executive Assistant (Note Taker)
Shauna McMahon (SM) Chief Information Officer
Kate Wood (KW) Chief Medical Officer (NLaG)
Lynnette Smith (LS)
Mel Lilley (ML)

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1 Apologies:
Simon Morritt, CEO Y&STFT
Michelle Cady (MC), Director of Strategy and Planning, HUTH

2 Minutes from last meeting
The Minutes from 19th December were approved

3 Action Log
The Action Log will be updated for the next meeting. No further items/actions to note.

4 CAP Governance
<u>Draft Operating Model/TOR for a Committee in Common/Joint Working Agreement</u>
Trust governance leads have been meeting with Hill Dickinson to develop a CAP JWA and TOR for the CIC. WS shared these along with a draft CAP operating model document. WS wished to socialise these with this group so that any amendments can be made prior to finalising in readiness for sharing at Trust Boards.

WS asked the Board if they were agreeable with the joint working agreement and its content and to advise if there is anything omitted or

PR confirmed that he has met with IMc and Helen Harris (Trust Governance Director NLaG) to discuss the Joint Working Agreement. Following their discussions, they had a number of concerns about the legal wording. PR offered to support WS to review this, particularly in light of the developments between HUTH and NLaG.

He also advised that the CAP Operating Model needs to establish principals based on the vision discussed at the last meeting. A CAP work programme should be attached and amended each year.

IMc suggested a small working group to work through the details and think through the wiring diagram as relationships are quite complicated. WS confirmed that she was happy to take this discussion offline and have further discussions.

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CL concluded that the principals of the Draft Operating Model/TOR for a Committee in Common/Joint Working Agreement were confirmed as agreed however the details within need to be reviewed based on these conversations. **WS to work with PR, IMc and Robert McGough to meet/discuss and finalise the documents.** **WS/PR/IMc**

5 CAP Corporate Workstreams

AB shared a draft summary of the potential CAP non clinical work streams for 2023/24.

WS noted this month's highlight report on existing workstreams S Eames has asked the CAP to undertake a piece of work relating to Learning Disability and Autism patients on the waiting list. Dr Kate Wood is chairing the first meeting of a group to start this work this week. This will then feed into the ICB Population Health work programme.

In terms of other elements of focus, AB advised that Digital and Workforce are significant programmes of work that have comprehensive ICB work programmes. Trust Workforce leads are part of these work programmes. CAP work is also focused on strategy and planning and CAP OD.

Other potential areas of work that CAP might to take forward relate to procurement and efficiencies exploring areas where the Trusts are already working together and where the there are opportunities to do further work. (Edd James to discuss procurement further under item 7).

The SHYPS Pathology Collaborative is already live (Scarborough, Hull and York Pathology service (SHYPS)). AB advised that a major system standardisation project is underway and is expected to be complete by summer 23. AB noted that there is a significant savings programme being mapped out post-system standardisation and therefore it makes sense to link to the collaborative going forward. AB added that Pharmacy Procurement is a potential new programme and that there are real opportunity here for savings.

AB advised that York, HUTH and NLaG have appointed Edd James as the Collaborative Director of Procurement which is a significant part of the work to align procurement functions and there is a significant saving programme attached to this work.

In terms of other programme work streams, AB added that the work needs to start with a stocktake looking at all possible saving opportunities across the ICS and then this can be presented back to CAP Board. He noted that there is already a digital pharmacy procurement network across the Yorkshire footprint therefore it is proposed that a stocktake is undertaken, documented and that pharmacy leads are asked if there are any further opportunities to explore.

AB confirmed that efficiency fits into a significant number of these procurement collaborative's and there are a number of programmes of work that are financed directly within the ICB and Place that needs to be picked up. He added that the plan is to try and pick up what work is out there and what opportunities there are to unlock things as we progress the schemes, pull together a work programme and have leads do a stocktake.

MG added a note of caution that 2 years ago Harrogate were looking at changing to a shared pharmacy function across WYATT and N Yorkshire but because the market wouldn't support it, it was decided not to take this forward therefore this should be

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reviewed before putting lots of time and money into considering this again. AB agreed and added that the important thing for a collaborative is to understand this work and have a directory of everything that has and is happening in relation to efficiency work. He has suggested a template approach for ease and clarity which can capture what we have done in the past and what we intend to do.

AB to look at a template and capture of efficiency and procurement activity **AB**

6 Operational Planning 23/24

LS shared the 2023/24 Operational Planning Guidance and priorities, 2023/24 Operational Planning headlines and what preparations are being undertaken for ICB planning requirements 2023/24. LS shared the Operational Planning core tasks and headline ambitions for recovery and added that the ICS has stepped up a fortnightly steering group to oversee the plans, compromising of Place Directors, collaborative reps and BI support.

In terms of the current position, she noted that the Trusts have each taken a different approach to planning, using different modelling tools and different approaches to calculating expected demand. She confirmed that the group will look for a more streamlined approach for future planning rounds. Early indications are that there is likely to be a delivery gap between the capacity available and the activity expectations of the system/national ask.

LS advised that the next steps will be to share acute planning assumptions with place and other collaborative leads and ICB colleagues to support the triangulation of demand, to inform Trust plans.
Operational Planning workshops are being arranged w/c 6 Feb with all partners, coordinated via the ICB so that mutual confirm and challenge discussions can be undertaken to test out planning assumptions prior to the draft submission.

LS advised that the final plan needs to be submitted to the ICS on the 16th March and then the ICB submission is due to on 31th March.

SJ noted that the expectations around elective recovery and the elective element of the contract reverting back to a tariff based approach, is a distinctive shift. SJ shared performance headlines and everyone acknowledged the challenges associated with current performance vs the requirements in the operational plan. Further guidance in relation to Maternity, Primary Care Assess and Workforce are anticipated.

SJ concluded that there are 31 objectives set out in the planning guidance and a nominated planning lead has been identified for each.
He added that there are overlaps which he will share after this meeting but noted that work is underway to work through these and a meeting with SE tomorrow is to be held in order to recognise where all the leadership elements are to come from. **SJ**

The Board acknowledged and supported the approach to planning and thanked LS for a helpful update.

7 Procurement Business Case Update

EJ attended the CAP Board to give an overview of the Procurement business case that has been developed and is due to go to Trust Boards. As part of this EJ is looking for

investment in procurement workforce and activities – invest to save. EJ asked how regularly this forum would like to receive updates on this work. **WS**

WS confirmed that a monthly update could be incorporated into the integrated highlight report. WS to send the template to EJ.

EJ shared the procurement financial position across HuTH, NLaG, Y&S Trust and discussed the headline spend in detail per Trust and across the collaborative. EJ added that all data collected so far points to an administrative function that is not delivering the strategic aims and not supporting Trusts in the way that is required.

EJ advised that he has collated feedback from stakeholders and suppliers and shared the headlines with the Board. EJ highlighted the key issues that have been uncovered:

- Quality of procurement data is poor which affects data driven decision making and value for money.
- The 3 Trusts work on different systems which makes the sharing and visibility of data difficult
- Appropriate and skilled resource is not in place across procurement e.g. no data analyst or clinical procurement specialist
- There is no link between our corporate strategies and what we expect our suppliers to deliver

EJ shared the benefits identified as a result of implementing the business case recommendations and gave the details of the financial and non-financial benefits. He highlighted that to date 1.1m of benefit has been identified and advised how that could be achieved and what investment would be required to secure/release it. He added that he is looking to ask the CAP Board for increases from each partner Trust of 253k for pay, 110k non-pay and 44k for Capital.

PR commented that there is a huge amount of savings that can be identified by involving clinicians in procurement discussions, therefore what clinical leadership has EJ engaged with? EJ confirmed that he has a governance structure that puts a procurement board in place that has clinical involvement that then feeds up to the Trust Boards. This is to ensure that clinical preferences can be challenged therefore someone with a clinical knowledge and background is crucial.

KW added that visibility of 'everything' and having straight forward discussions on value for money and other resources is key and by taking a slower approach around engagement, will aid success. KW offered her support should EJ require it.

A discussion ensued and the proposal for investment was acknowledged by the CAP Board recognising that the business case will need to be agreed via Trust Boards. AB wished to add that this will be a significant contribution to the efficiency programme and that he is a big supporter of the proposal.

8 EPR Update

SM gave a brief overview of the EPR work. She wished to note that this is not just a digital programme, it is a business transformational piece of work that enables how we operate and run our services.

SM is working with digital CIO's and having productive conversations but added that we need to be cognisant that with NHS match funding, it is a 130m investment into our area.

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This is significant amount of money and whilst this is positive more thought is required around how we plan and implement any new EPR. SM noted that in terms of what the 'models' may look like, these conversations have yet to be had. Each Trust needs to be involved in order to work through existing digital programmes, what investment is required and what capacity could be freed up without asking for more funding to support the EPR work.

SM advised that at the Feb CAP Board she would like to discuss EPR in more detail, in particular what is the role of CAP? SM asked how much of the standardised pathways do the 4 Trusts want to see. Do we understand the full financial opportunities we have? Is there a way we might think on this differently in terms of investment? How does CAP see its role, as this will affect all acute Trusts within the next 2 years?

A discussion ensued and it was agreed that it would be really helpful for the CAP Board to have a clear view of what the benefits of a new EPR might be as well as how this can be realised and the potential risks as this is a significant investment and programme of work. **SM will present in more detail at the next CAP Board** **SM**

7

WS advised that SE is keen that CAP holds the ring on the EPR work and that there is clarity around governance processes. Discussions and key decisions made at CAP will then feed into the ICB Digital Committee.

9 Community Diagnostic Centres (CDC)

IMc advised that he has prepared a summary of the current status of the CDC programme that he will share after the CAP Board. IMC confirmed that the CDC programme to date is nationally coordinated and is managed via a team from the ICS led by C O'Neil. **IMc**

IMc shared that there is a £36m ICS allocation funding for the programme. Funding allocations need to be spent during 23/24 and 24/25, with central pressure on spend being undertaken in 23/24.

The ICS has asked for an additional £18m increasing funding levels to £54m. IMc gave the details of the proposed spend that £10m has been committed, (£4m on equipment and £6m on a spoke business case), that leaves £26m or £44m to spend. There are an additional 2 business cases that sit with NHSE that are indicative business cases drafted by the ICS team. This relates to Scarborough £15m and approx. £24m for a scheme for Scunthorpe to build hubs. He noted that there is a technical definition of what goes into a hub in terms of diagnostics.

A discussion ensued of is this the right funding allocation? Concern was shown that there is no prioritisation matrix to support this, just an investment criteria. How do we spend all the allocation? IMc added that there is a governance group chaired by C O'Neil and that Jane Hazelgrove is involved, however it is not clear who it doing the accounting and signing off of decisions. He also noted that this work needs to align with the local authority town centre work as part of the anchor piece

SMc added that she has met with imaging leads and the network imaging group regarding the imaging strategy. She noted that there needs to be one for HUTH and NLaG and the wider system. She advised that within the capital we need to look at linking up the imaging and that there are people already looking at a demo of *share plus*

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which allows you to take patients in any from the acute providers or community into the registering plasticity in order to able to read the diagnostics quickly.

IMc alerted that workforce plans in the existing business Case is for the CDC's and not the impact so consequences have not been considered in the business cases.

MG advised that in terms of the decision making piece, each Trust has a rep on the group that is involved in drafting the business case. This then goes through internal governance and then to the Exec group in the ICB for sign off.

SMc highlighted that *Intelerad* is that not the same thing as share plus and that there are a number of people not seeing this as the solution. More discussions are required and digital folks have been asked to explore. SMc added that we need to be mindful of how we manage of all of the systems coming in as it is the ongoing revenue and the people you need to employ to manage these systems.

It was discussed and agreed that the diagnostic piece within the Business Case needs development and that the gap between investment requirements needs to be managed and joined up. There needs to be an overview of everything including what is our strategic and capital investment, what it is we would like to see and how the CDC capital investment will support the delivery of this.

IMc added that there is now 12 months to sort therefore we need to think through how best to spend the £36m v £54m and work through what has already been committed to and who takes the decisions.

CL concluded that the CAP should take on the leadership of the CDC agenda and that this is tied into the Diagnostic and Elective Recovery work and the elective landscape work. Doing this is significant and means that the CAP will work closely with 'PLACE' but that we have a single diagnostic strategy for the area that ties into our plans and elective work. **CL to discuss with SE.** **CL**

10 Finance and Procurement Update

AB shared the Month 8 key headlines and noted that the variance position within the system envelope is £12.3m for the wider ICB

AB attended an ICB Directors meeting today where the month 9 position was discussed. He advised that the position has not materially moved from the month 8 summaries and that the pressure on the Trusts relates to the opening of extra beds and being able to deliver efficiency programmes. From the ICB perspective the prescribing of Continuing Healthcare is putting pressure in the system however on a positive, there is now clarity that funding is coming to support the pay award and some of the issues that have affected members are coming to resolution i.e. ERF issues.

AB confirmed that the position now is that we need to transact as much as possible into month 10 so we can all see what the size of the ask is as we move to the end of the financial year.

AB concluded that we are on track to balance but there are several millions of pressure that people are dealing with to get us to the end of the year. Work is ongoing to understand the underlying work and he is still waiting for the final financial allocations/details. AB will share the ICB overview when available.

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11 78 Weeks Update

WS/LS presented an update on the Elective Recovery 78 week position. WS highlighted that at the last regional meeting, the message is clear that we must address the situation to minimise 78 week breaches at the end of March and offer more mutual aid to each other. This is absolutely key and non-negotiable.

ML highlighted the current Y&S position and noted that they are on track for achieving the revised and agreed position/trajectory however industrial action and the need to cancel activity will have an impact.
She confirmed that the volume of cancellations are still being collated and the number of derogations are still being reviewed. ML shared the details of further cancellations this week as a result of industrial action.

Key surgical specialties that are of significant concern re long wait breaches are Urology, Gynaecology, Orthopaedics, Upper GI and Colorectal. These are all off their weekly trajectory as a result of cancellations. Upper GI, Colorectal and Maxillofacial remain the biggest areas of risk.

LS confirmed that additional elective support has been committed by regional and national team, Both offers are being formulated to sign off at the end of next week. She added that they are undertaking a number of executive led meetings Chaired by Simon Morritt, particularly with the high risk specialty teams in order to have direct CEO and Executive oversight of delivery. LS advised that the second validation letters have been sent to non-admitted long wait patients with no TCI, but this has only resulted in a very small % who want to come off the waiting list.

LS advised that the ask from the system is to deliver the actions agreed via the tier 1 systems. LS shared the thematic issues, what actions are in place and what the asks are of partners i.e. mutual aid.

A discussion ensued regarding admin staff and the fact that an inability to recruit has impacted on the ability to book patients and to validate the waiting list.

KW raised the issue of clinical networks and an expectation that clinicians look at the collective problem - what support is being provided into the clinical networks to enable them to work together to collectively address issues vs Trusts doing this at Trust level. LS confirmed there are ambitions to launch 8 clinical networks, 3 have started and a number of people have offered to lead these networks. There is not any funding at this stage to resource the networks properly and there is a cost associated if we backfill staff that release. We need to make decisions about CAPs commitment to resource these networks.

SJ concluded that 78 weeks is the highest priority linked to the national strategy and that there cannot be any 78 week waiters at the end of March therefore all options for mutual aid need to be maximised.

PR added that mobilising the clinicians and networking productivity in the collaborative is critical and if WS needs investment, he would rather put this into clinical time to release clinicians than lesser benefits. WS and KW to work up together. **WS/KW**

12 Programme Highlight Reports

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WS advised that the key highlight from the combined report was the 78 week position which was covered earlier in the meeting.

WS noted that the CAP team are starting to build a more robust programme highlight report which will be shared monthly at this meeting.

13 Any Other Business

WS confirmed that the next Trust Board OD session has been rearranged for Friday 24th March and a hold has been placed in Trust Board member diaries. An agenda will be worked up closer to the time.

Date and Time of the Next Meeting

27.02.23
10.00 – 12.00 via teams