	TRUST 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 4 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) was reduced to a 9 last month and removed from Trust register for monitoring at directorate level. In May 6 new risks (Hot water, Call bells, Diagnostic scan, CT, Colorectal wait times, Prosthetic infections) were raised to exec review with one accepted onto the Trust Register. 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	22nd May 2023						

Strategic Ambition	Corporate Risk ID	Principle Risk	Key Targets	Current Position (May 2023)	Plans to Improve Control and Risks to Delivery	Original Risk (CvL)	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	<u>Trust wide position:</u> Registered nurse vacancies have increased in April by 17.93wte. This is due to an increase in budget for the new financial year by 20.46wte. Staff in post has increased by 2.53wte. CSW vacancies have decreased in April to 72.00wte, which is a great reduction in comparison to the previous month. The reason for the decrease is predominantly due to a decrease in the 2023/24 budget by 29.49wte. Staff in post has also increased by 7.72wte this month and is also a factor in the decrease of vacancies. <u>Registered Nurses</u> **Month** / **Vacancy WTE** / **Vacancy %** Apr 23 — 183.94 — 10.06% Mar 23 — 166.01 — 9.18% Feb 23 — 161.88 — 8.95% Jan 23 — 166.01 — 9.17% Dec 22 — 151.64 — 8.45% Nov 22 — 145.41 — 8.17% Oct 22 — 94.21 — 5.42%	Focused work on additional roles to support nursing, business case being produced. □ Additional 200k secured via NHSE for ongoing International Recruitment □ Business case in process for Apprenticeship programmes to support development to registrant across nursing, midwifery and AHPs Updated review of the impact of additional funded beds on vacancy position will lead to an initial deterioration as plans are recalibrated to factor increased vacancy position. The increase in RN vacancies this month is due to the budget increasing by 20.46wte compared to the previous month. HCSW position improved by the International Nurses who are awaiting their PIN post OSCE. This will start to	**4 x 3 12**	**4 x 2 8**	**4 X 4 16**

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<tr><td>Sep 22</td><td>82.07</td><td>5.03%</td></tr>
<tr><td>Aug 22</td><td>75.54</td><td>4.71%</td></tr>
<tr><td>Jul 22</td><td>69.03</td><td>4.34%</td></tr>
<tr><td>Jun 22</td><td>64.19</td><td>4.04%</td></tr>
<tr><td>May 22</td><td>66.64</td><td>4.19%</td></tr>
<tr><td>Apr 22</td><td>58.80</td><td>3.71%</td></tr>
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<u>CSWs (Trust Wide ‘Support Workers’ and ‘Maternity Support Workers’ as defined by ESR occupation code. This includes administrative support with patient contact, e.g. Ward Clerks)</u>
<table>
<tr><th>Month</th><th>Vacancy WTE</th><th>Vacancy %</th></tr>
<tr><td>Apr 23</td><td>72.00</td><td>13.32%</td></tr>
<tr><td>Mar 23</td><td>109.20</td><td>19.16%</td></tr>
<tr><td>Feb 23</td><td>116.85</td><td>20.50%</td></tr>
<tr><td>Jan 23</td><td>127.07</td><td>22.14%</td></tr>
<tr><td>Dec 22</td><td>125.89</td><td>22.49%</td></tr>
<tr><td>Nov 22</td><td>115.87</td><td>21.13%</td></tr>
<tr><td>Oct 22</td><td>99.01</td><td>18.61%</td></tr>
<tr><td>Sep 22</td><td>83.46</td><td>16.02%</td></tr>
<tr><td>Aug 22</td><td>86.39</td><td>16.27%</td></tr>
<tr><td>Jul 22</td><td>77.43</td><td>14.83%</td></tr>
<tr><td>Jun 22</td><td>66.86</td><td>12.82%</td></tr>
<tr><td>May 22</td><td>59.86</td><td>11.69%</td></tr>
<tr><td>Apr 22</td><td>69.44</td><td>13.48%</td></tr>
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</td>
<td>positively impact the RN vacancy position next month. Initially impacting the HCSW position.

<u>Summary</u>

The principle risk and key targets to be reviewed to establish performance indicators to be met. Vacancy rates increasing due to a larger budget and the creation of additional posts does not reflect actual staffing levels. Staffing may have increased, however additional posts will report an increase in vacancy. The Trust is to establish the target.

The risk remains at 16, if the trajectory continues this is likely to reduce next month.</td>
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<tr>
<td>An Environment that promotes wellbeing</td>
<td>CRR75: Health and Safety</td>
<td>CHS1
CHS2
CHS3
CHS4
CHS8</td>
<td>See indicators below</td>
<td>Overall Position for CRR75</td>
<td>Summary position for CRR75</td>
<td>4 x 5 (20)</td>
<td>2 x 4 (8)</td>
<td>4 x 4 (16)</td>
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<tr>
<td></td>
<td>CRR75: Health and Safety</td>
<td>CHS1 Identification and management of risk.
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.</td>
<td>Risk assessments
Hazards Identification

Replacement of the existing SALUS risk management system, to ensure all have access to the relevant risk assessments.

And that the new risk management system is monitored at a local, directorate and Executive level to ensure that risks have been identified and resulting action has been taken to eliminate or mitigate the risk.

Trust H&S team to ensure that a consistent approach and appropriate standards of</td>
<td>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.

• 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.

• Further meetings held with EVOTIX to identify project management support provided by them and expectation on HDFT. Draft Implementation pack and project timeline produced.</td>
<td>H&S team is reviewing current risk assessment provision. Temporary control measures are being created where possible.

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.

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.
Additional work done with Wards and Departments (in particular HIF) on risk identification and controls

<u>Summary</u></td>
<td>4 x 5 (20)</td>
<td>4 x 2 (8)</td>
<td>4 x 3 (16)</td>
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			assessment are conducted across the Trust / HIF. Centralized system to ensure timely reviews are made, and where appropriate changes are made allowing the sharing of best practice, updated guidance and response to changes in legislation.	• 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. Risk areas have now been identified, currently being reviewed by H&S team in conjunction with HIF staff – new standard risk assessments being produced. • Still awaiting decision on use of existing money that was assigned for H&S admin role. • EVOTIX have provided updated costs based on 300 licensed users (with unlimited access users) at £30,457.75, awaiting confirmation of cost based on 250 users	Updates show risk assessment and hazard identification is underway. Once completed an audit will be required to confirm if the assessments are consistent and to an appropriate standard. The replacement of SALUS will address remaining key targets.			
		CHS2: HDH Goods yard 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.	• Suitable and sufficient risk assessment completed relating to the use of the goods yard and access to the loading bay area. • Control measures identified in the assessment are implemented to ensure that the likelihood of pedestrians being struck by vehicles is reduced so far as is reasonably practicable. • Capital programme to implement permanent physical changes to the area is complete, including entrance barrier, marked / protected walkways. • Unauthorised persons prevented from accessing the goods yard either via the road entrance or from within HDH. • Unauthorised access to the stores / estates are is prevented from within HDH.	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. • Matter still outstanding for Environment Board 24/1/23 as to whether the work can be included in the 23/24 Capital programme. OUTSTANDING • Costs of replacement goods ramp doors is being priced as part of Backlog maintenance work. Approximately £20-30k – to be included in 2023/24 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. Part of HIF top ten risk review and part of current HIF Security review Summary Mitigations have been put into place and all remaining plans require cptial investment. Risk level remains unchanged until Capital investment secured. The target date for this is June 2023.	**4 x 4 (16)**	**2 x 4 (8)**	**3 x 4 (12)**
		CHS3 – Managing the risk of injury from fire Organisational risk to compliance with legislative requirements, with the risk of major injuries, fatality, or permanent disability to employees, patients and	• Updated Fire Safety Policy and associated management protocols • Appointment of competent Fire Manager and Authorising Engineer. • Suitable and sufficient fire risk assessment completed for all areas of HDH, Ripon Community Hospital, Selby Minor Injuries, and any other	- 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.	• Review of all current fire provisions by HIF and the H&S team • Review of HDH fire compartmentation being carried out, to result in action plan for required remedial work. • 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	**4 x 5 (20)**	**2 x 5 (10)**	**3 x 5 (15)**

		others, and the unauthorised access of persons to restricted areas of the hospital through the loading bay entrance.	buildings owned or leased by the Trust / HIF. • Implementation of appropriate evacuation procedures. • Suitable training provided to all employees. • Provision and maintenance of fire mitigation measures and alarms. • Review of all compartmentation and fire doors at HDH. With an action plan in place to carry out identified remedial work. • Timely assessment of the impact of contractors, construction work and other ad hoc activities, so that temporary measures can be implemented and reflected in existing assessments or evacuation procedures. • Clear communication of fire procedures to all relevant employees, patients and others. • Audits and reviews of the above conditions at appropriate intervals.	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 to 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. As part of Backlog Maintenance report – HDH site Fire Alarm system has been identified as being in need of urgent investment, Protec have provided a quotation in excess of £1.6m to replace the existing fire alarm due to large parts of the system being obsolete In response to concerns raised in medical records, resources have been directed to carry out immediate risk assessment and carry out remedial action (notably repair / replacement of fire doors)	/ 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) • 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 and Management SOP now approved • Fire risk assessments continue to be produced and reviewed by Mark Cox, additional training requirements being identified. • Ad hoc training being provided including, training sessions throughout April for evacuation equipment in Strayside, and evacuation training for staff located around Herriots Summary All work remains ongoing The target date for this risk was April 23. KRIs are defined, Trust to establish when work will be completed. Although a number of actions underway the likelihood has not been reduced yet.			
		CHS4 – Control of contractors / construction work 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.	• Agreed procedures in place for the appointment of contractors working on Trust premises, and the health and safety requirements of the contractors. • Contractor activities and construction work assessed to identify new hazards to Trust employees, patients and others as a result of the work, to ensure new control measures can be implemented or existing controls (risk assessment, fire assessment) can be modified to eliminate / mitigate the new level of risk. • Regular communication with contractors to ensure agreed health and safety controls are being implemented and that any changes are identified in a timely manner and appropriate actions taken.	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. 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.	• Review of all current contractor procedures required by HIF / H&S team / Planning. • 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. • Trust / HIF decision regarding the role of Principal Designer – Discussed at February Environment Board to identify all current appointed Principal Designers – ensure current legal compliance PD List now produced • 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. • Letter to be sent to contractors providing a grace period for them to join RESET • New Contractor induction draft now completed, being reviewed. • 100+ contractors have been identified, now split into groups that will have detailed requirements placed on them, including RESET, recorded contractor review etc…	**4 x 5 (20)**	**2 x 4 (8)**	**3 x 4 (12)**

			• Trust takes appropriate steps to ensure compliance with it legal duties as required by the Construction (Design and Management) Regulations 2015, in particular: • Ensure that sufficient time and other resources are allocated to ensure all projects can be carried out, so far as is reasonably practicable, without risks to the health or safety of any person affected by the project. • Appoint a Principal Designer and Principal Contractor as soon as is reasonably practicable	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 Head of Estates / Head of H&S have approved format of O&M Manuals to be provided by Breathe and included in H&S File to allow planned/informed future maintenance/refurbishment work. Ongoing issues with breathe regarding plantrooms – action taken to suspend work for short period due to theatre leaks / disruption.	• Additional recruitment to the Estates team to include contractor administration and monitoring. • Security / General Office arranging for photographic identification for contractors at HDH site Summary Actions to address personal vetting in progress. Appointment of a PD in progress. Target date was April 23. To meet KPIs, data is required to show outcome of assessments and mitigation / control required.			
		CHS8 – RAAC Roofing at HDH 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.	• Plan showing the location of every RAAC plank with unique identifier – to support surveying and ultimately to record plank condition • Survey of every plank to determine: Deflection / Spalling / Cracking / Water Ingress / non-standard planks. • To undertake and annual survey of every plank; or more frequently as advised by your structural engineer • Regular progress reports to board and sub committees of the current position on RAAC Plans and the Risks • Inform Staff of the presence of RAAC Planks, the issues, and actions to take in the event of: Deflection; Spalling; Cracking; Water Ingress; Dust/Debris; and/or Noises within the structure • Be part of a communications approach led by NHS England, cognisant of: SCOSS Guidance; Duty of Candour; and duties under the Health and Safety at Work etc. Act 1974 • Adopt the West Suffolk Action Cards	• 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 REQUIRED REGARDING OCCUPANCY OF THESE AREAS UNITIL REMEDIAL TAKEN. Decision taken 23/12/22 – access prohibited to all areas apart from x2 areas in DSU, ongoing risk accepted against operational loss • 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, WORK COMPLETE • 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 TO BE COMPLETED Weekend 25th March • Silverdale side room / SDEC Secretaries office – Minor fire stopping work to be completed. • DSU ophthalmic waiting area – WORK TO BE COMPLETED Weekend 18th March • Therapy Services corridor (Head of Physio office). Work was to be carried out starting Friday 17th March, however this has been delayed due to operational demands. Work now to be completed starting Friday 31st March • Deflection survey by WSP continuing, delays occurred due to availability of WSP staff and W&L staff (who are removing/replacing ceiling to allow access). • 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 • Difficulties in progressing work due to W&L staffing issues, have been balanced against risk to delay in ED work.	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 Business Case being developed to implement RAAC eradication plan, including additional funding from NHSE Summary Works are being carried out with a large number of works completed. The overall risk will remain to an extent until works are completed. Consideration is to be given now, on how completed work has mitigated the risk and prioritise the key targets to reduce the risk.. The target date was April 23.	**4 x 4 16**	**2 x 4 (8)**	**3 x 4 (12)**

			• EPRR to have undertaken a desktop evacuation plan within the last 12 months; and every subsequent 12 months • Strategic plan in place to identify remedial action needed, with long term plan to eliminate RAAC from site by 2035. • Quarterly reporting of progress against this action plan to NHSE, (IIMARCH Reporting as appropriate) • Attendance at RAAC support group (North of England RAAC Programme Board)	• ALL initial RAAC emergency work is complete • Awaiting results of full deflection survey work being completed by WSP • Letter has been sent to all Community landlords requesting information of any RAAC within community estate – responses now arriving and being collated. • Meeting between Trust and Regional EPRR regarding response to RAAC happening 21/4/23 Business Case being developed to implement RAAC eradication plan, including additional funding from NHSE				

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	22nd May 2023						

Strategic Ambition	Corporate Risk ID	Principle Risk	Key Targets	Current Position (May 2023)	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, however data shows positive trajectory.						
Initial Date of Assessment	1st July 2022								
Last Reviewed	22nd May 2023								

Strategic Ambition	Corporate Risk ID	Principle Risk	Key Targets	Current Position (May 2023)	Plans to Improve Control and Risks to Delivery	Initial Risk (CvL)	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 - potential increase in lapses in delivery of safe and effective care to patients and service users -	**Staff Engagement – Survey Scores** Inpulse engagement scores National Staff survey scores: Engagement, morale, **Turnover – Target 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)	Financial supports for colleagues Wellbeing fund of 0.5 million provided to upgrade working environment. 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. 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. **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	• **Staff Engagement increase** - All Directorates instructed to achieve 90% Appraisal compliance. • **Turnover reduction** - 26% of leavers cited Work/Life Balance as their reason for leaving. - Changes have been made to the NHS Pension Scheme to support the attraction of new colleagues, and also to help to retain experienced staff. - Work underway to develop career pathways, utilising the apprenticeship levy as a major lever for affecting improvements. - Equality & Diversity and Inclusion work plan in place to reduce workplace inequalities and increase inclusion – actions in place for WDES and WRES, plus active staff networks across all protected characteristics. - To minimise turnover on grounds of dissatisfaction with pay - financial support in - Last Opinion – exit interview questionnaire in place to gather improved levels of data around the reasons for colleagues leaving the Trust • **Sickness Absence reduction**	**(4 x 3) 12**	**(4 x 3) 12**	**(4x4) 16**

			Sickness – Target 3.9% HDFT are 9h lowest for sickness absence levels out of 31 Trusts in NEY league table. **Appraisals – Target 90%** **Vacancy Rate**	- 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 decrease from 15.54% to 15.44% as at 31 March 2023. **Sickness – Target 3.9%** • Sickness has decreased to 4.57% as at 31 March from 4.98% in February 2023%. **Appraisals – Target 90%** • Appraisal Rates have seen an increase in March to 81.98% from 77.04% in February 2023. **Vacancy Rate** • Vacancy rate has remained static at 8.0% as at 31 March 2023, which equates to 355.85 vacancies **Sickness Absence** HDFT are 9h lowest for sickness absence levels out of 31 Trusts in NEY league table.	- Sickness absence policy and procedures in place and line managers actively supported by the Operational HR Team in managing this. - - Fair & Just Culture project underway working with TU colleagues to improve employee relations processes, communications and timescales. • **Vacancy Rate reduction** - Workforce planning underway, in conjunction with Activity and Finance Planning to ensure robust understanding of workforce requirements over 23/24 and beyond. - International recruitment plans in place t - Agile working policies under review to ensure attraction of new recruits. - Plans for increased use of apprenticeships - Disability Confident scheme level 2 achieved to promote the Trust as an equal opportunities employer. - Care Leavers scheme signed up to – expanding pool of available candidates. Point of difference – At Our Best Making HDFT the Best Place to Work branding to be developed. **Summary** Indicators will continuously fluctuate, with many factors. The current trajectory is positive overall. This will continue to be monitored against targets. The target date is June 2024			

	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 are increasing, last month to 760. Longest wait has also increased. 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 and 78 week waits are noted. Finally ED 4 is at a 12 with data showing continuous improvement. A wide range of mitigation is in place including a pilot of new streaming pathways.					
Initial Date of Assessment	1st July 2022							
Last Reviewed	22nd May 2023							

Strategic Ambition	Corporate Risk ID	Principle Risk	Key Targets	Current Position (December 2022)	Plans to Improve Control and Risks to Delivery	Initial Risk (CvL	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) Waiting list would have to be reduced to 120 and longest wait to 13 weeks Baseline capacity would need to meet the referral rate.	• Numbers on the waiting list: 940 • Longest wait: 59 weeks • April 43 assessments against plan of 40. We have modelled the impact of the funded WLI's for 2023/24 and it will only slow the growth of the waiting list. The best case scenario for referral numbers into the service would see the waiting list continue to grow to 1253 by March 24. The projected wait for assessment by March 24 would be 31 months. Commissioners have stated they do not have recurrent 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.** It has been highlighted that non-recurrent 12month funding is very difficult for the service to manage, taking into account lead in times to secure additional capacity, train staff and national shortages in psychologists etc. This would not address the underlying mismatch between demand and capacity. A proposal to increase capacity by a further 10 assessments per month plus embed a new referral pathway will be taken through the ICB approvals process, with our ICB contract manager supportive of the proposal. This funding will be insufficient to improve the waiting times but will allow for testing as to whether the new referral pathway and early help support offered could avoid a proportion of assessment requests progressing through formal assessment. An Autism Assessment team workshop on 13/4/23 has developed the detailed action plan around mobilisation for the proposal.	In order to reduce the waiting list we would need to increase the service capacity to 90 assessments per month with the additional staffing costing £490k full year effect. The modelling has been shared at the CC Resources Review Meeting and has been escalated to the place ICB meeting with Execs as it was felt HDFT could no longer carry all the risk of these waits and there is currently no agreed plan to provide the resources required to address. Summary With the funding outcome unable to address the risk, a decision will need to be made for making plans to introduce permanent staff and make arrangements for the cost of this.	**4 x 3 12**	**(4 x 2) 8**	**(4X4) - 16**
Person Centred, Integrated Care, Strong Partnerships	CRR41: RTT	Risk to patient safety, performance, financial performance, and reputation	92% 18 week incomplete performance standard 52+ Waits		**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.	**(3x4) - 12**	**(3x2) - 6**	**(3x4) - 12**

		due to increasing waiting times across a number of specialties, including as a result of the impact of Covid 19 (added 13/03/2020)	78+ Waits (zero by March 23) 104+ Waits (zero by July 22) RTT to meet constitutional standards, Reduction in waiting list size	<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>Sep-22</th><th></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></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></td></tr><tr><td>> 65 weeks</td><td>499</td><td>461</td><td>463</td><td>471</td><td>500</td><td>519</td><td></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></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></td></tr><tr><td></td><td>Oct-22</td><td>Nov-22</td><td>Dec-22</td><td>Jan-23</td><td>Feb-23</td><td>Mar-23</td><td>Apr-23</td></tr><tr><td>Total incomplete RTT pathways</td><td>25,437</td><td>25,388</td><td>24,951</td><td>24,854</td><td>25,139</td><td>25,504</td><td>25,591</td></tr><tr><td>> 52 weeks</td><td>1,285</td><td>1,201</td><td>1,228</td><td>1,186</td><td>1,112</td><td>997</td><td>998</td></tr><tr><td>> 65 weeks</td><td>477</td><td>401</td><td>477</td><td>399</td><td>362</td><td>193</td><td>202</td></tr><tr><td>> 78 weeks</td><td>112</td><td>100</td><td>118</td><td>101</td><td>65</td><td>0</td><td>0*</td></tr><tr><td>> 104 weeks</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></td><td></td><td colspan="6">*reported zero, 5 patients with treatment dates over 78 weeks</td></tr></table> **104+ week waiters** HDFT currently have no 104 week patient waits **78 week waiters (clearance target March 2023**) Zero position achieved by end of March 23. A number of patients remain over 78 weeks who have chosen to do so – they have dates for treatment compatible with their choice. 201 patients on waiting list between 65-77 weeks (T&O, Community Dental, Maxillofacial and Gynaecology account for 75%) **Additional theatre lists at a weekend** - Awaiting confirmation from commissioners around funding of waiting list initiative into next financial year for Community Dentistry - Staffing in theatres continues to be challenging with vacancies sickness - The independent sector support is continuing 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. - RTT 92nd percentile at 45 weeks **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. • LUNA - supported validation tool has gone live although some further work is ongoing to enable the AI element. • Pilot of text validation exercise goes live 18th April with other trusts seeing a significant reduction in patients waiting following this. • The RTT team has been supported by x2 RTT agency validators, who have been in post since w/c 2nd January. They have reviewed just over 1,800 pathways with a removal rate of 13.9% so far. • The RTT team continue to review all appointments without an RTT outcome and review our data quality reports, prior to their submission deadline of the 17th of each month to ensure the monthly RTT submission is as accurate as possible. • Weekly elective recovery meetings are ongoing, with directorates implementing an equivalent at service level. • 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	There are currently 22 new starters in the workforce pipeline. Additional capacity will become available for treating patients through the Wharefdale theatres (TIF1 Scheme)- however the timelines for this opening have slipped into 23-24 Limited access to an interim solution through a vanguard theatre at Wharfedale is being progressed to impact quarter 3 2022/3. The independent sector support is being increased with circa 500 cases being delivered in this way. None treatment RTT waiting over 52 weeks is minimal currently with only Gastroenterology, Neurology and specialist gender endocrinology-having patients waiting this long. Recovery plans in gastroenterology and neurology are currently in development. Summary The plans and in place have reduced the longest waits. Total incomplete RTT pathways >52 weeks is reducing. Target is March 2024 and the trajectory is expected to meet this.			
Best Quality, Safest Care	CRR61: ED 4-hour Standard	Risk of increased morbidity/	A&E 4 hour standard	**4 hour performance** The national target for the 4 hour standard has been reduced from 95% to 76% until March 2024. HDFT hope to exceed this target and our local target for the 4 hour standard is 81%.	• Support streaming with outreach work to improve streaming pathways to HDFT		

		mortality for patients due to failure to meet the 4 hour standard.	(below 95% in August 2022) 12 hour DTA breaches (82 in August 2022) Ambulance Handovers (15 over 30 minute handover breaches and 2 over 60 minute in August 2022) A&E 4 hour target to be met, 6 hour breaches <102 per month and 0 x 12 hour breaches		specialties, however getting buy in from other departments has been a challenge • Capital works ongoing to reconfigure ED to support new ways of working that will improve performance (ambulance RIAT bay) • AFU now relocated to Swaledale with the net increase of 8 patient spaces including frailty SDEC further enhancing flow out of the ED • The plans for improvement in performance are likely to take 3-6 months to address the different elements contributing to poor performance. **Summary** **Ambulance handover breaches** There has been a significant reduction in the time that patients are waiting to be handed over from ambulance crews to the ED team. The improvement correlates with the opening of the ambulance RIAT bay. 0 60+ min HO reported for April, the reduction in 30+ HO and 12 hour waits show April 2023 was a good month in terms of performance on all three metrics. There was a significant reduction in handover delays and patients in the department for over 12 hours, however there is still work to do to eliminate these long waits completely.	**4 x 3 12**	**(4x2) - 8**	**(4x4) – 12**

	June 22	**July 22**	**Aug 22**	**Sept 22**	**Oct 22**	**Nov 22**	**Dec 22**	**Jan 23**	**Feb 23**	**March 23**	**April 23**	***May 23 (so far)***
Type 1 + 3 combined	**72%**	**71%**	**67%**	**64%**	**68%**	**66%**	**63%**	**72%**	**81%**	**78%**	**83%**	***80%***

12 hour waits

	12 Hour DTA	**12 Hour total wait**
June 22	15	
July 22	37	219
August 22	82	346
September 22	60	286
October 22	72	247
November 22	67	224
December 22	165	431
January 23	115	143
February 23	16	68
March 23	45	141
April 23	4	30

	May 22	**June 22**	**July 22**	**Aug 22**	**Sept 22**	**Oct 22**	**Nov 22**	**Dec 22**	**Jan 23**	**Feb 23**	**March 23**	**April 23**
York ambulance diverts*	66	83	72	65	68	59	70	86	49	70	72	**132**

*Excluding YO51 postcodes as Boroughbridge patients come under HDFT

	30 Min HO (including 60+ mins)	**60+ Min HO**
June 22	30	1
July 22	14	2
August 22	16	2
September 22	77	25
October 22	42	41
November 22	79	28
December 22	183	97
January 23	80	39
February 23	26	9

				March 23 39 18 **April 23** 2 0 • Ambulance RIAT bay opened and our number of handover delays has significantly reduced • The bank holidays in May have led to increased pressure on the department and this has been reflected in the department's performance.				

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	22nd May 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. Underlying Financial risk (CRR76) is a High Level risk scoring 15.					
Initial Date of Assessment	1st July 2022							
Last Reviewed	22nd May 2023							

Strategic Ambition	Corporate Risk ID	Principle Risk	Key Targets	Current Position (December 2022)	Plans to Improve Control and Risks to Delivery	Initial rating (CvL)	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 Reduced use of temporary staffing to cover only in extreme circumstances.	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. Agency review being incorporated into directorate performance reviews. Over £100 per hour staff being collated for Leadership team review and Chief Executive oversight as per agency cap rules. **Summary** It should be noted that this risk is mitigating some of the other risks currently raised on the Trust risk register. In particular nurse staffing, work around ED/flow and elective recovery. This clearly is not ideal but is accepted whilst those other risks persist.	Substantive recruitment and retention schemes, including international recruitment, nursing apprenticeships, etc. Nurse rostering oversight work to ensure staff being utilised well and minimise unnecessary agency usage. Implementation of medical e-rostering during 2023/24. Clear escalation on cascades where appropriate and available.	**(5x3) 15**	**(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	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	The Trust is currently at risk of managing within resources available in future years. The 2023/24 planning round has resulted in a number of non recurrent items which result in a £6m surplus plan for the Trust. This is described in the table below, alongside the current underlying risk. **2023/24** / **2024/25** Incl. Surge and Stretch: 6,000 / - Incl. Surge: - / - HDFT Operational Plan: -11,000 / -19,100	2023/24 planning process Productivity review Resource Review and Directorate Governance processes Various financial controls Output from HFMA financial sustainability checklist Waste reduction programme Elective recovery workstreams Outpatient Transformation work Actions associated with Agency Risk	**(5x3) - 15**	**(5x1) - 1**	**(5x3) - 15**

		available to provide services.	Mitigations for inflationary pressures as a result of wider economic position	The above is dependent on the achievement of a 3% savings programme recurrently, so there is added risk to the above. Key risks which drive this position relate to … a. Elective Recovery b. Acute Flow c. Temporary Staffing d. Efficiency requirement All combining for more material underlying financial risk. This can be seen in the month 1 position, where no surge funding has been released and the impact of the stretch target being seen. As a result a £1.7m deficit was reported. The new Care Group structure has allowed better focus on the issues within directorates. Following Resource Review sessions it is clear there is 5 areas for focus – 1. Momentum in relation to the efficiency programme, with a month 1 adverse variance of £540k. 2. Ensuring that pressures within the Maternity and Breast, General Surgery, Urology and Vascular Care groups are brought back into budgets. This includes ensuring budgets are drawn down appropriately, and any non recurrent issues are resolved rapidly. 3. There are contract areas within Childrens services which have pressures as a result of non recurrent expenditure linked to payback clauses within contracts. 4. The Emergency Medicine Care Group is a key area of focus for Long Term and Unscheduled Care, with a number of issues underpinning this. 5. Elective Recovery performance, and in particular the impact of baseline changes and coding to reflect Trust activity. Finally, the Trust has a pressure of £89k associated with strike claims from the April Junior Doctor Strike alone. March claims were accounted for in 2022/23, so are not part of this year's position. The direct cumulative cost of these strikes is £193k for 1,229 hours claimed.	**Summary** The five areas of focus are to be reviewed with key targets to asses if these areas of focus will enable mitigation and control.			

Integrated Board Report - April 2023

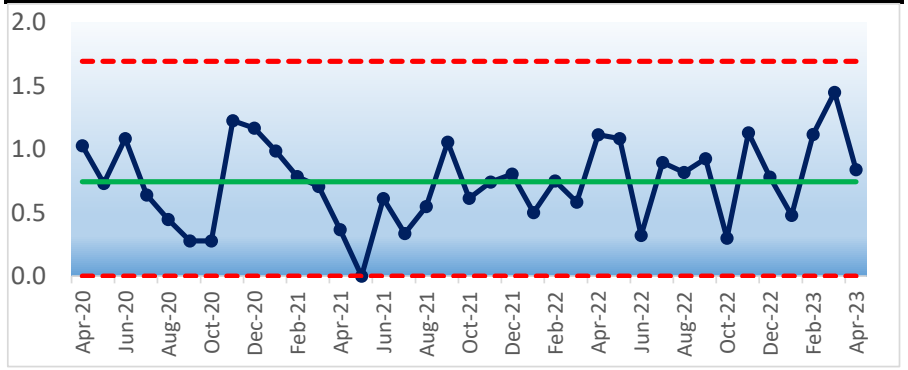
Domain 1 - Safe

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	Apr-23
Value / RAG rating	0.84

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 30 HAPU (all categories) reported in April 2023 , which is a significant decrease from March 2023 (52), with 7 category 3 or above, a decrease from March 2023 (14). Of the 7 reported pressure ulcers, 1 was assessed to be moderate harm following review by TVN or podiatry, triggering the PULT process to ascertain if omissions in care led to the pressure ulcer developing or deteriorating.

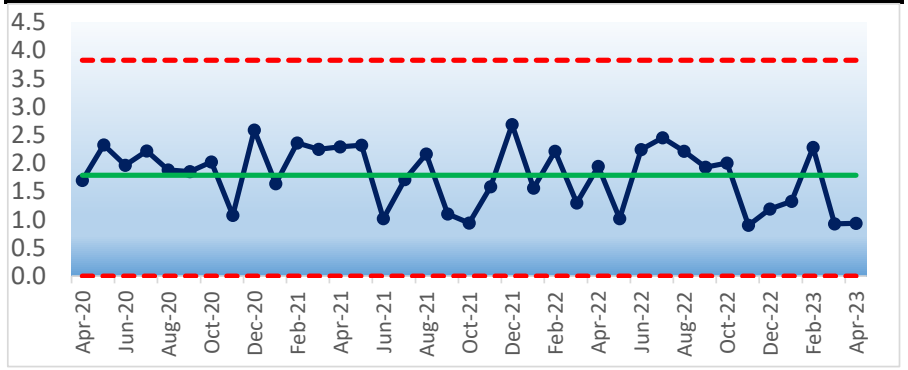
The new quality assurance process for reviewing pressure ulcers acquired in HDFT care was launched on 1st April 2023 and now includes the involvement of Directorate Heads of Nursing and Quality Assurance leads (QAL). Learning identified through this process is monitored by QAL to ensure robust and meaningful action plans are implemented to improve quality of care. Interventions put in place by the TVN over the last 12 months are showing positive and consistent improvements to pressure ulcer figures across the acute trust, including the standardisation of slide sheets and ad hoc teaching at ward level. The team will be fully established by the end of June 2023 and ongoing quality improvement work is planned to focus of preventing pressure ulcers, rather than treating. We remain committed and motivated to continue to improve outcomes for those patients accessing HDFT services.

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	Apr-23
Value / RAG rating	0.94

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 34 pressure ulcers (all categories) which developed or deteriorated in HDFT community care in April 2023 (up from 29 in March 2023). Of 34 CAPU, 6 were verified as category 3 or above. Of the 6 reported pressure ulcers, 1 was 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, with one awaiting decision by podiatry.

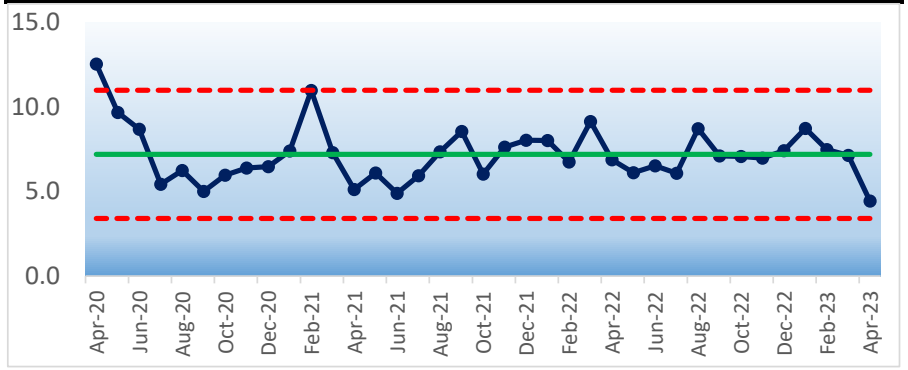
The TVN team continues to provide support and expert advice to patients receiving care from adult community services. This support also extends to those in nursing homes, GP practices and 0-19 children's services.

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	Apr-23
Value / RAG rating	4.4

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

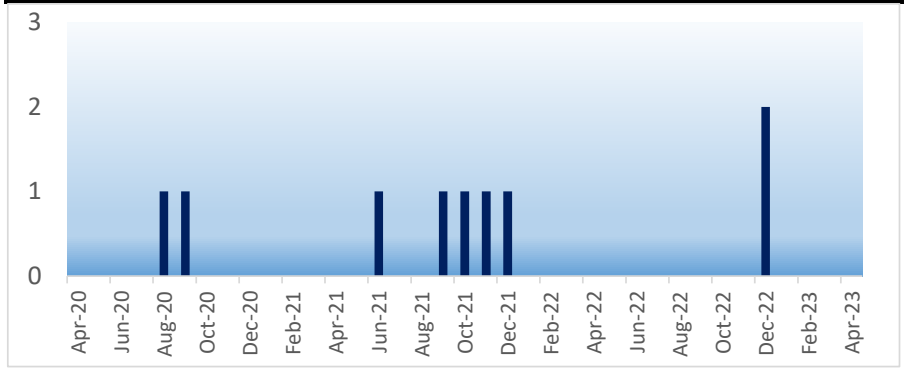
Falls continue to decrease, lowest point on the SPC chart since April 2020. As previously reported, the Trust has implemented a target of 85% compliance with lying and standing blood pressure recorded for all patients aged 65 and over. In order to support monitoring, a new report is in development that will be sent to ward managers and matrons daily regarding outstanding patients who require a lying and standing blood pressure.

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	Apr-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 2023/24 has not yet been confirmed. The trajectory for 2022/23 was a maximum of 40 hospital acquired cases - including avoidable, unavoidable and indeterminable causes.

Trend chart



Narrative

There were 2 hospital acquired cases of C.difficile reported in April. RCAs have been completed and agreed with the CCG and both cases were deemed to be unavoidable with no lapses in care.

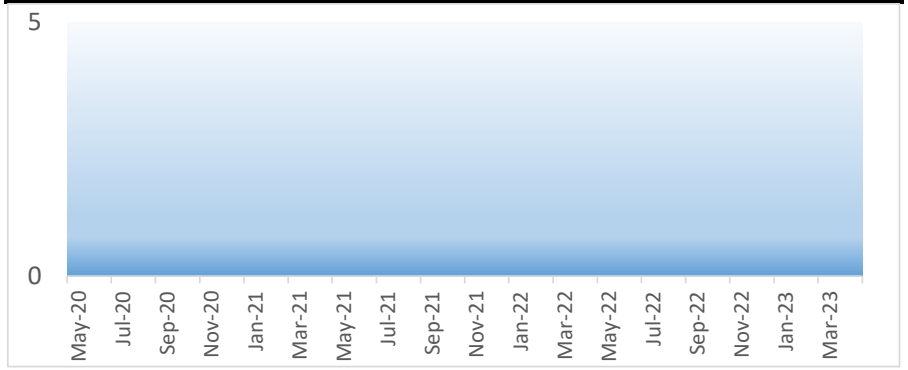
The remaining RCAs for the 2022/23 cases have also been completed and agreed with the CCG. The final position for 2022/23 was 27 hospital acquired cases in total, with 2 cases deemed to be avoidable (due to inappropriate antibiotic prescribing) and 25 cases deemed to be unavoidable. 1 case was removed as it was determined to be community acquired as part of the review process.

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	Apr-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 April.

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	Apr-23
Value / RAG rating	112.5

Indicator description

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

SPC chart

Narrative

The ratio of low harm incidents continues to increase. In April 2023 there were 900 no or low harm incidents reported and 8 moderate harm and above. This gives a ratio of 112 (i.e. 112 low and no harm incidents reported for every moderate and above incident).

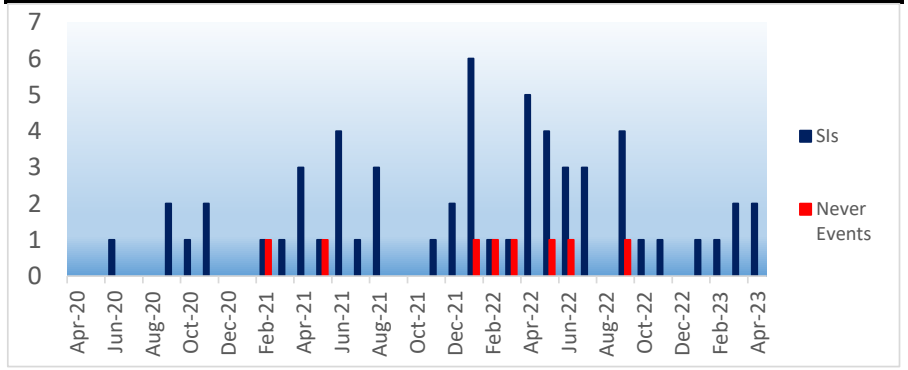
This compares to a ratio of 92 in March 2023.

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	Apr-23
Value / RAG rating	2 (SI), 0 (Never Events)

Indicator description

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

Trend chart



Narrative

2 Incidents deemed to meet the Serious Incident threshold have been declared in April and investigation processes are underway.

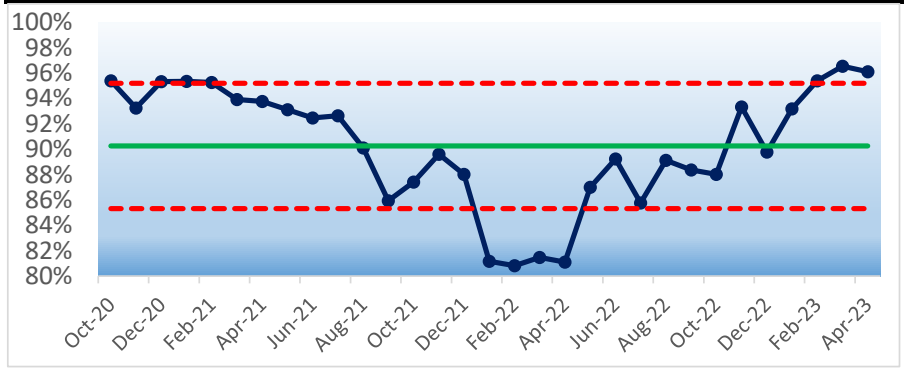
The serious incidents data now includes HSIB (Healthcare Safety Investigation Branch) investigated serious incidents, with effect from April 2023.

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	Apr-23
Value / RAG rating	96.1%

Indicator description

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

SPC chart



Narrative

With the agency cascade now fully embedded and improved NHSP fill following the introduction of the new base rates, we are seeing increased fill particularly on day shifts.

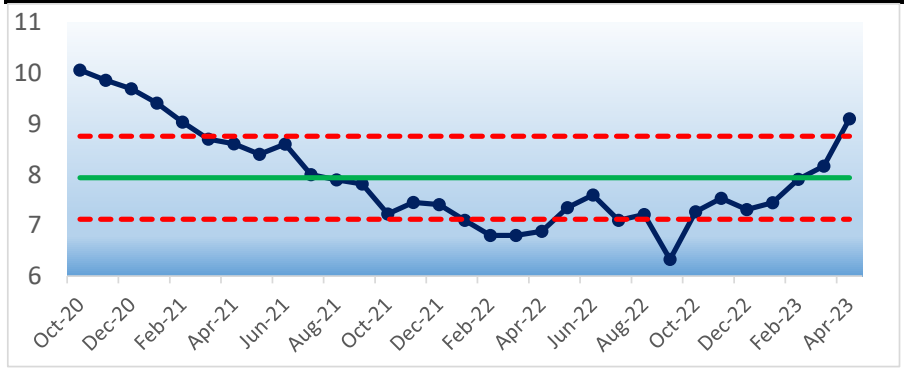
The data also shows increased fill generated by enhanced care HCSW's.

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	Apr-22
Value / RAG rating	9.10

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

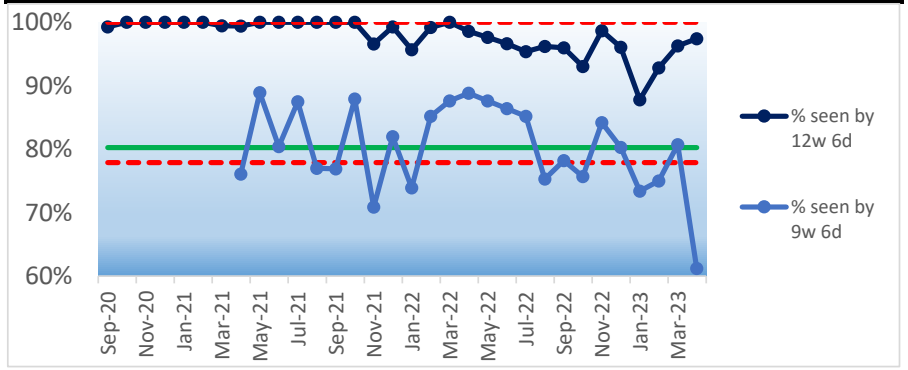
The current data correlates with the fill rates that are being achieved via improved NHSP fill rates. It also is reflective of the increased use of Enhanced Care support workers. This is alongside the increased International Recruits. The caveat being that the reduced occupancy within Critical Care and Paediatrics can cause a skew in data.

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	Apr-23
Value / RAG rating	97.4%

Indicator description

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

SPC chart



Narrative

There has recently been issues with the allocation of women to appropriate clinics following a change in the admin staff who book the clinics. This issue has been identified and an action plan is in place. This includes developing the standard operating procedures to guide the staff in the appropriate allocation of women to clinics. The staff who previously worked in this area have been asked to provide oversight and guidance to the new staff in post. There is senior oversight of the progress on the action plan. Work is planned to review clinics in the future to ensure appropriate allocation has been achieved.

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

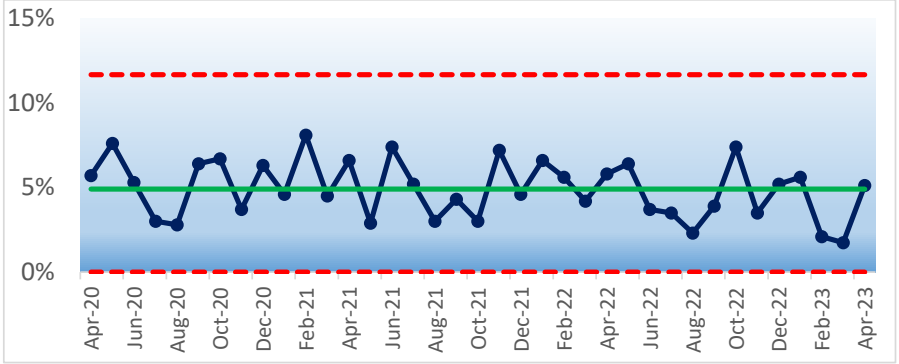
We continue to review the implementation of the Continuity of Care Team. The Trust provides continuity during the antenatal and postnatal periods but not intrapartum at the present time.

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	Apr-23
Value / RAG rating	5.1%

Indicator description

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

SPC chart



Narrative

There has been natural variation in the number of women smoking at the time of giving birth. The numbers of women are very small therefore a difference of one or two women shows as a large variation in percentage. During the month of April, 10 women were identified to be smoking at booking, all of these women were referred to stop smoking services.

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	Apr-23
Value / RAG rating	88.0%

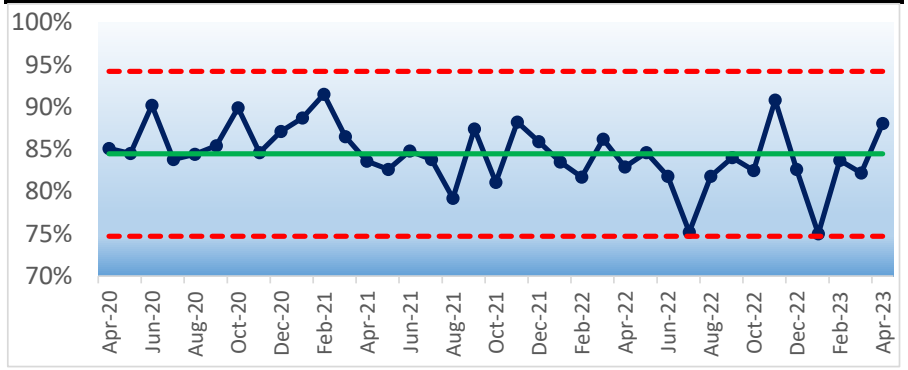
Indicator description

The % of women initiating breastfeeding

Narrative

The number of women initiating breastfeeding following giving birth remains high and within HDFT normal variation.

SPC chart

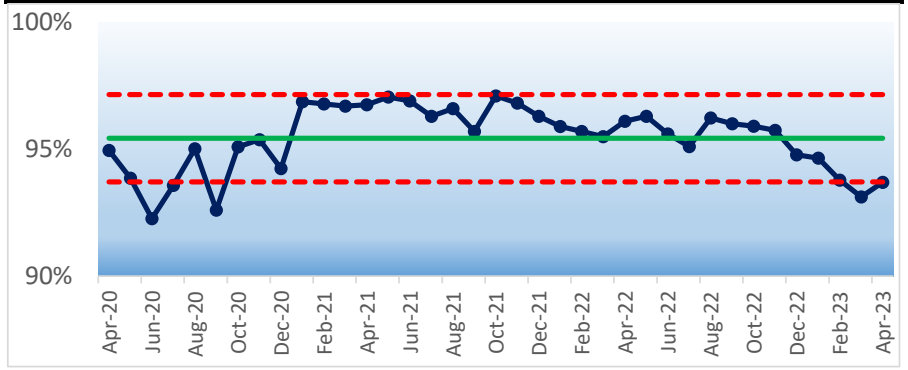


Indicator	**1.13 - VTE risk assessment - inpatients**
Executive lead	Jacqueline Andrews, Medical Director
Board Committee	Quality Committee
Reporting month	Apr-23
Value / RAG rating	93.7%

Indicator description

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

SPC chart



Narrative

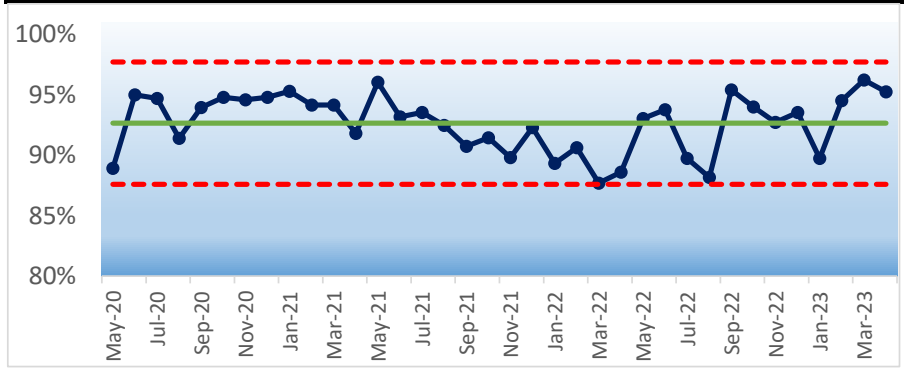
Slight improvement in the position but work continues to improve consistency in the assessment rates.

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	Apr-23
Value / RAG rating	95.2%

Indicator description

The percentage of eligible inpatients who were screened for sepsis.

SPC chart



Narrative

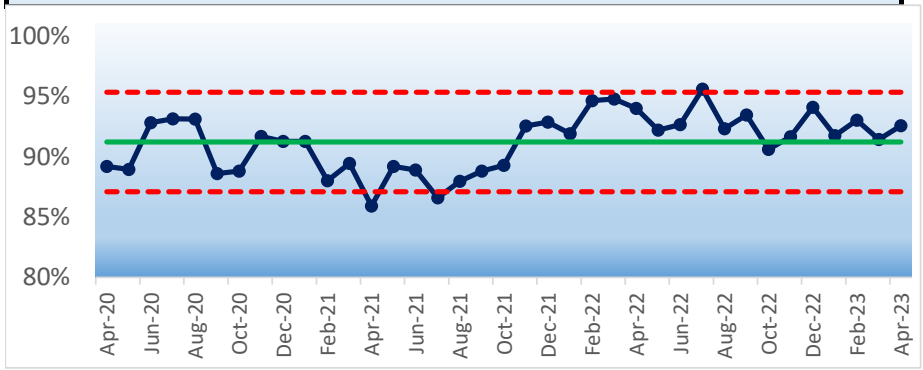
Performance remains above 95%. We continue to maintain a focus on this and datix any omissions so we learn ,understand and improve.

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	Apr-23
Value / RAG rating	92.6%

Indicator description

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

SPC chart



Narrative

Improved performance on last month and remains above 90%. 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 - April 2023

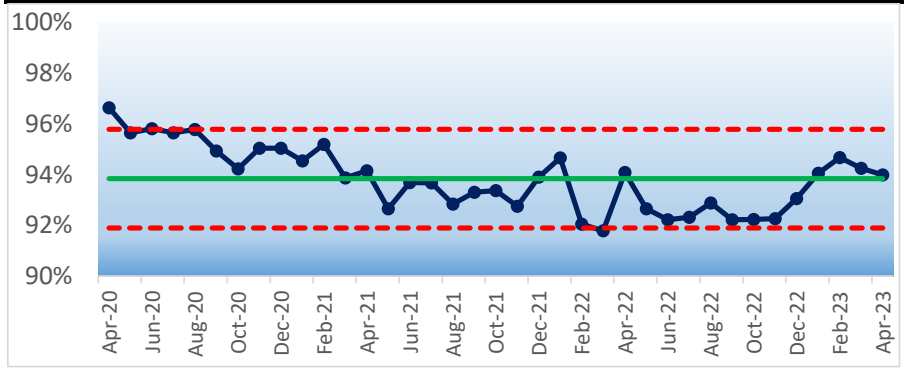
Domain 2 - Caring

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	Apr-23
Value / RAG rating	94.0%

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 a steady increase has been seen since November 2022, with the response rate for Q4 remaining over 94%.

Positive comments from the FFT in April describe staff as professional, compassionate, gracious and hard working. Patient care was described as skilful, outstanding and procedures were well explained to patients.

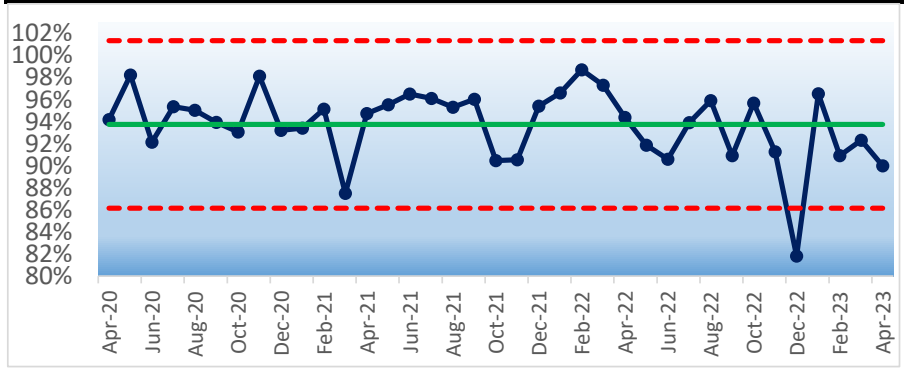
Less positive feedback was once again themed around waiting times, communication and signage in the hospital.

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	Apr-23
Value / RAG rating	90.0%

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

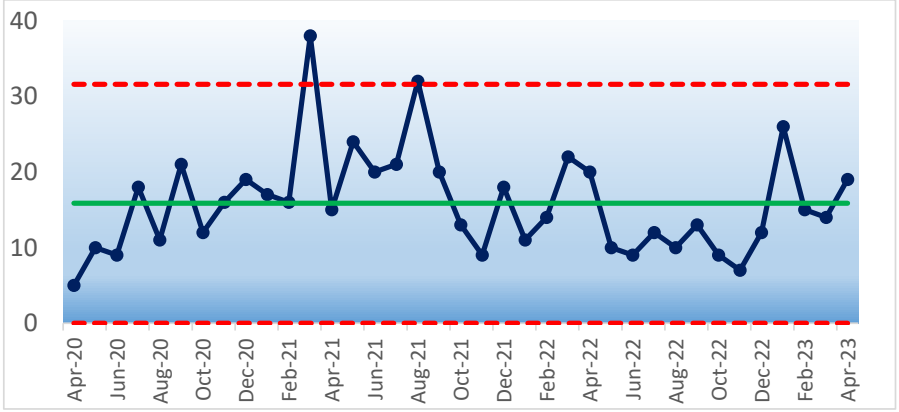
Performance against this standard continues to fluctuate but overall remains over 90% which is positive.

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	Apr-23
Value / RAG rating	19

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

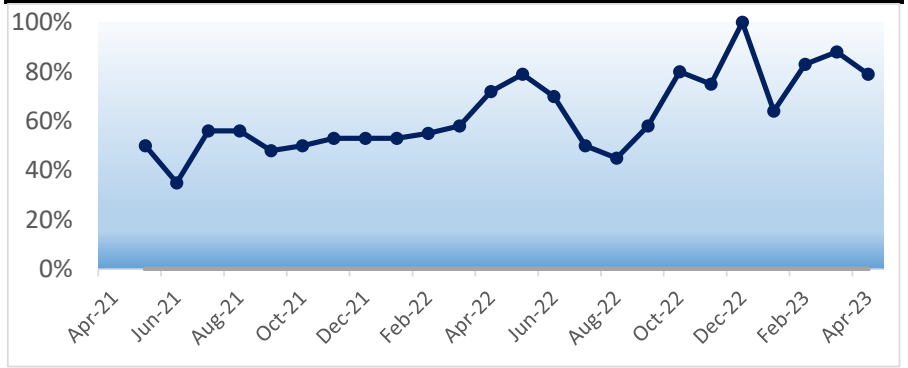
In total, there were 19 standard complaints received in April. 2 complaints came under Community and Children's Directorate, 11 complaints came under Long Term and Unscheduled Care (LTUC) and 6 under Planned and Surgical Care (PSC). In addition, there were 2 multi-agency complaints received, both for LTUC and there were no complaints requiring a resolution meeting.

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	Apr-23
Value / RAG rating	79%

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 April was 79% which is a slight decrease from 83% in March. Mitigation is being put in place to ensure the position improves. 14 complaints were due a response in total, of which 11 complaints were responded to in time.

Integrated Board Report -April 2023

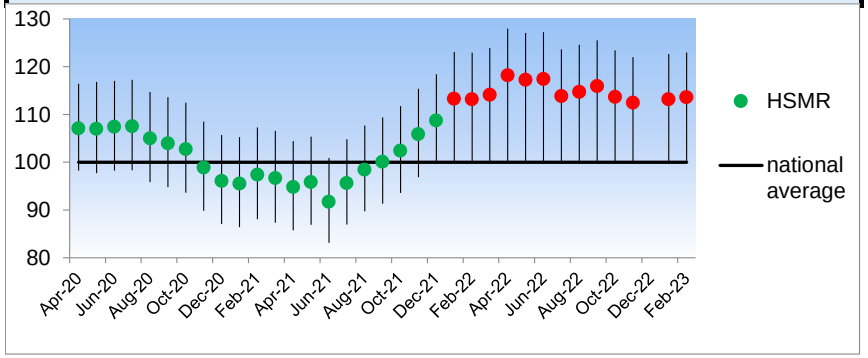
Domain 3 - Effective

Indicator	**3.1 - Hospital Standardised Mortality Ratio (HSMR)**
Executive lead	Jacqueline Andrews, Medical Director
Board Committee	Quality Committee
Reporting month	Feb-22
Value / RAG rating	113.59

Indicator description

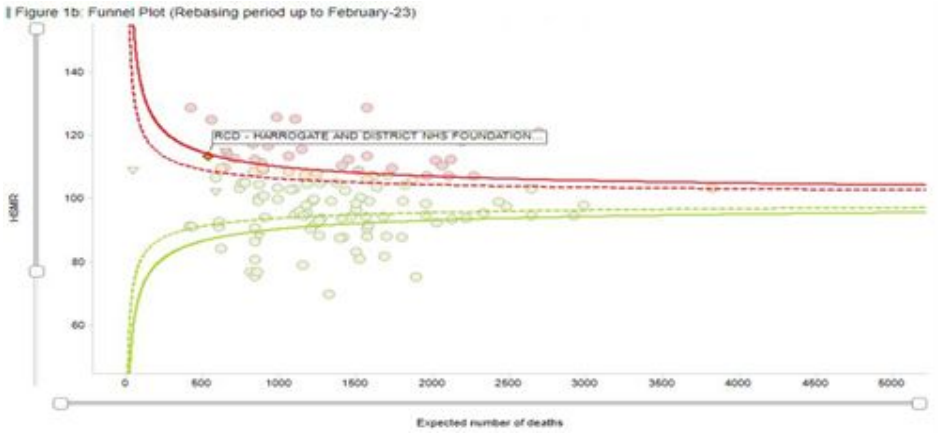
The HSMR looks at the mortality rates for 56 common diagnosis groups that account for around 80% of in-hospital deaths and standardises against various criteria including age, sex and comorbidities. The measure also makes an adjustment for palliative care.

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.

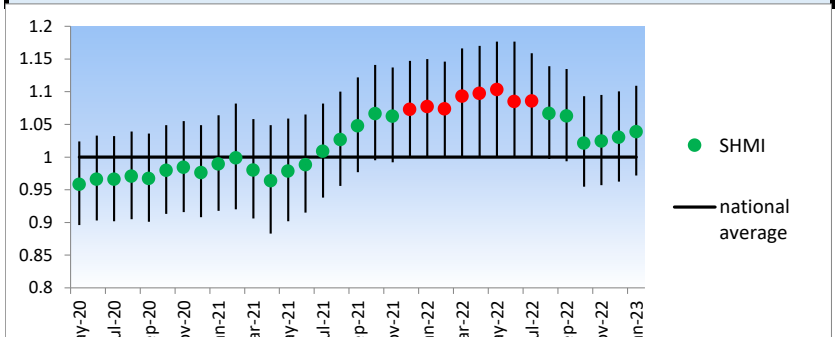


Indicator	**3.2 - Summary Hospital Mortality Index (SHMI)**
Executive lead	Jacqueline Andrews, Medical Director
Board Committee	Quality Committee
Reporting month	Jan-22
Value / RAG rating	1.039

Indicator description

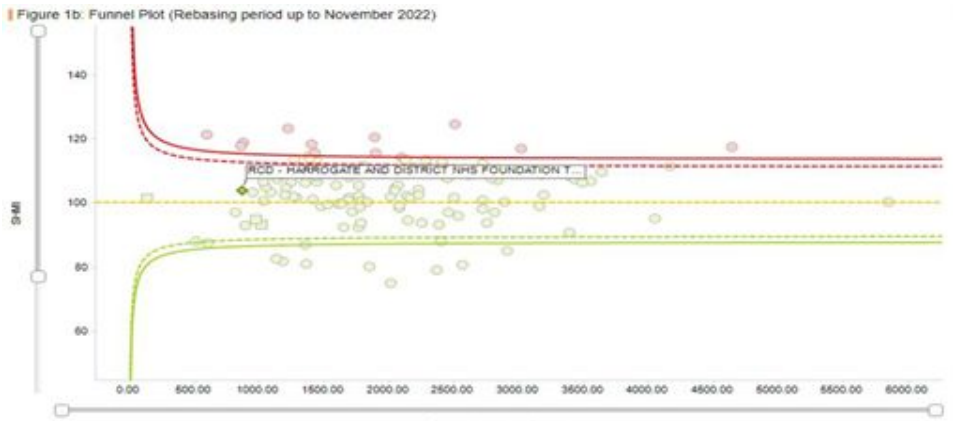
The SHMI looks at the mortality rates for all diagnoses and standardises against various criteria including age, sex and comorbidities. The measure does not make an adjustment for palliative care.

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.

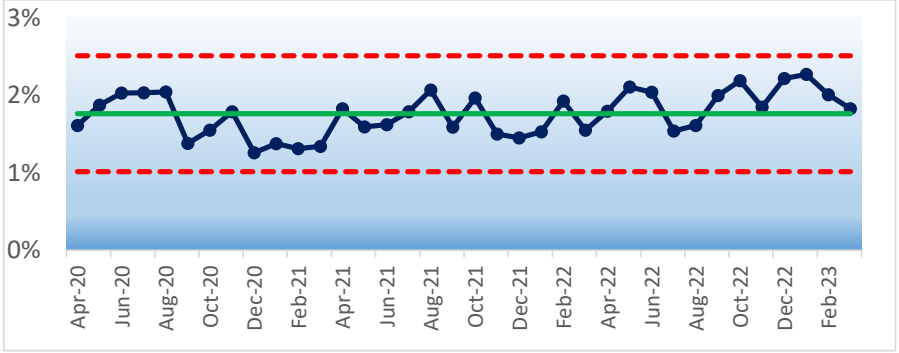


Indicator	**3.3.1 - Readmissions to the same specialty within 30 days - following elective admission**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Mar-23
Value / RAG rating	1.8%

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

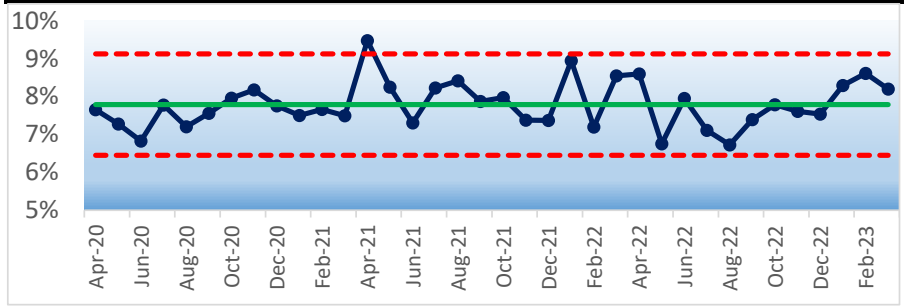
Readmissions following an elective admission decreased to 1.8% in March and remain within control limits and less than national average.

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	Mar-23
Value / RAG rating	8.2%

Indicator description

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

SPC chart



Narrative

Readmissions following a non-elective admission decreased to 8.2% in March and remain within the control limits.

Indicator	**3.4 - Returns to theatre**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Mar-23
Value / RAG rating	7

Indicator description

The number of patients who were unexpectedly returned to theatre within 30 days of their original surgery. This data is reported a month behind so that any recent returns to theatre are captured in the data.

SPC chart

Narrative

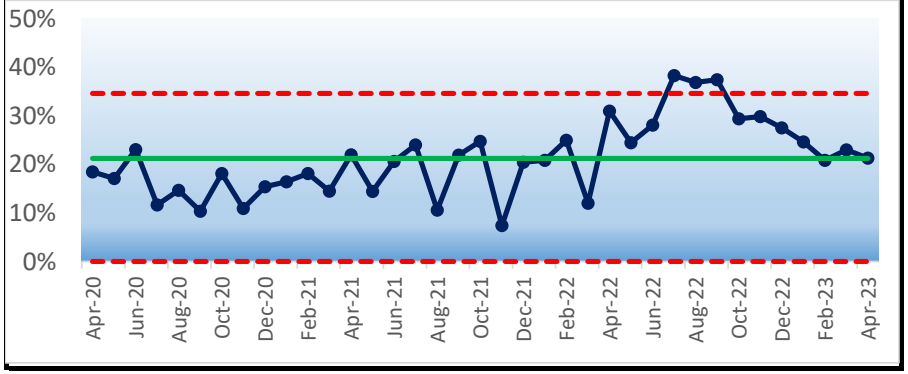
A process has been developed that will allow us to report on this metric going forward. March data has been reviewed and 7 cases of unexpected returns to theatre within 30 days were identified.

Indicator	**3.5 - Delayed transfers of care**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Apr-23
Value / RAG rating	21.3%

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 April, remaining higher than the historical average.

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 aiming to 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 recent months.

Harrogate and District NHS Foundation Trust

3

Board Meeting Held in Public
31st May 2023

Title:	Learning from Deaths Quarterly Report 4: January-March 2023
Responsible Director:	Executive Medical Director
Author:	Deputy Medical Director for Quality and Safety

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

Board Meeting Held in Public

31st May 2023

Learning from Deaths Quarterly Report 4

Executive Medical Director

1.0 Executive Summary

Crude mortality rates for the trust continue to oscillate around national trends.

Standardised mortality rates had been rising since mid-2021, in particular for the HSMR. The rates seem to have stabilised and appear to be falling, especially the SHMI.

21 cases have undergone a structured judgement review since the last report. Median score for overall care was “good”. One case was identified as delivering poor overall care, and this had been investigated through normal governance mechanisms and learning identified will be shared with the team involved.

The HDFT Medical Examiner Office is now ready for the statutory introduction of the Medical Examiner function in April 2024.

Harrogate and District NHS Foundation Trust

2.0 Introduction

Although mortality data represents a very small percentage of all trust activity, it is important that it is monitored and examined appropriately. This report aims to triangulate mortality indices with other markers of quality of care, in particular that provided by structured judgemental reviews (SJRs) of medical notes.

3.0 Findings

3.1 Crude Mortality Data

The crude mortality rate for admissions gives a long-term view of trust mortality. In total, 242 deaths were recorded in Q4, up from 225 in the Q3. An increase in Q4 is expected as the seasonal effects of influenza and RSV emerge, in addition to the continued Covid prevalence. This data is not risk-adjusted so takes no account of the unique characteristics of individual admissions. Comparison with the national mortality rate is also shown where data is available (shown in the darker blue line in Figures 1 and 2). This demonstrates that the peaks and troughs we see in HDFT are often mirrored at the national level. Figure 2 gives a "zoomed in" view of data from the last 2 years.

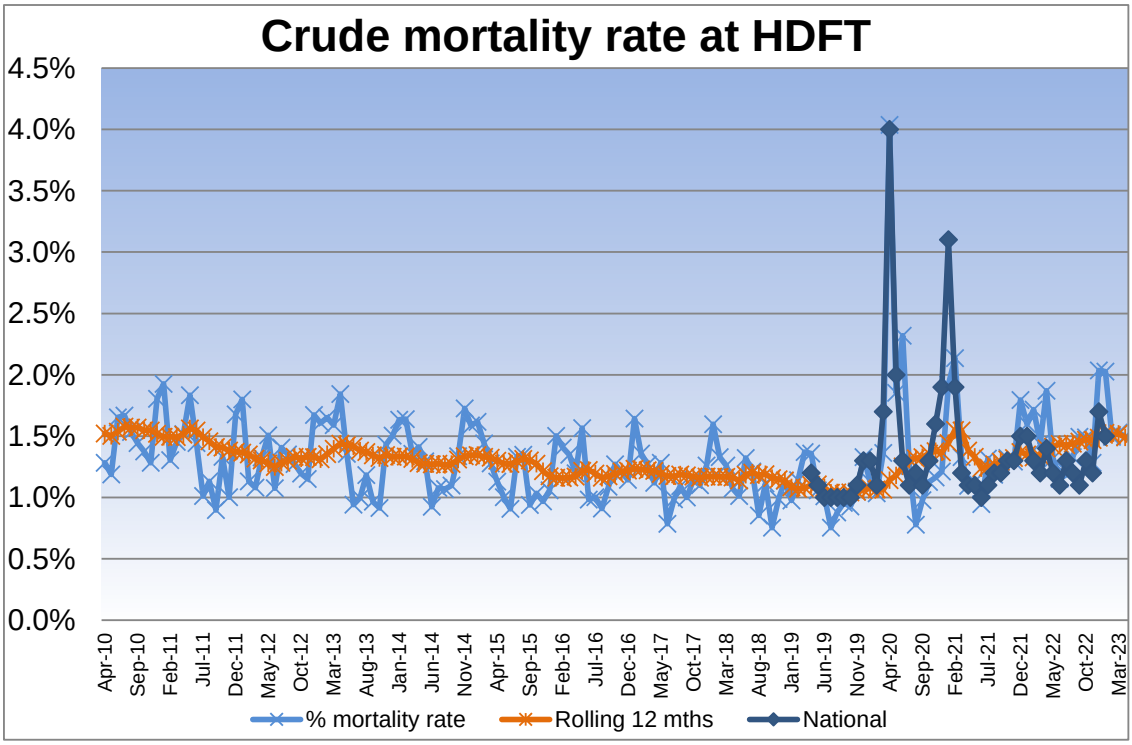


Figure 1: Crude mortality rates over the last 13 years (%deaths per qualifying episode)

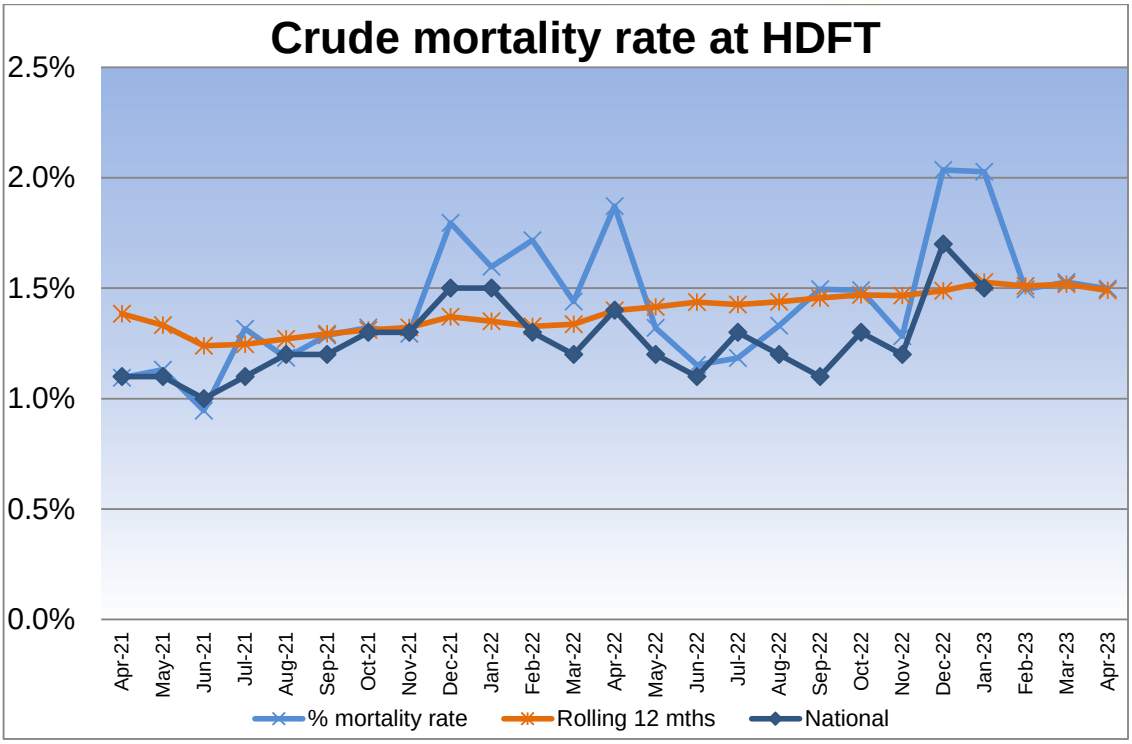


Figure 2: Expanded crude mortality rates over the last 2 years (%deaths per hospital episode)

3.2 Standardised Mortality Rates (HSMR and SHMI)

3.2.1 HSMR

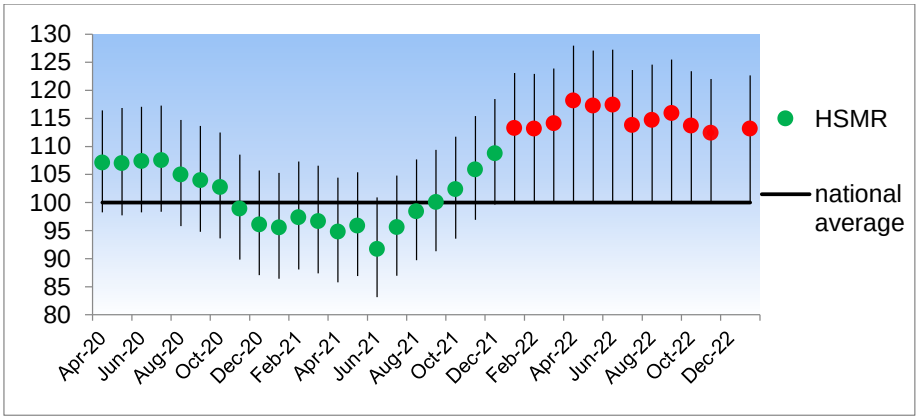


Figure 3: HSMR. Dots show the recorded values with error bars showing possible range of true values.

Figure 3, which is included in the IBR, shows the rolling 12 month HSMR around the national benchmark score of 100. In addition to the overall score, we have generated charts to demonstrate the number of observed deaths and the number expected. This enables a clearer indication of why the indices may be changing over time. Please note that the number of

observed deaths is the number which qualify for use in the mortality indices – HSMR includes fewer deaths than SHMI (determined by the underlying diagnostic category), and both exclude Covid-19 cases which are included in the crude mortality numbers.

Figures 4 to 8 give some more context to the headline figure. Note that the low level of observed and expected deaths in February 2023 is almost certainly a data error and will likely be corrected when coding is completed. Overall it appears that the number of expected deaths is now beginning to rise after the pandemic.

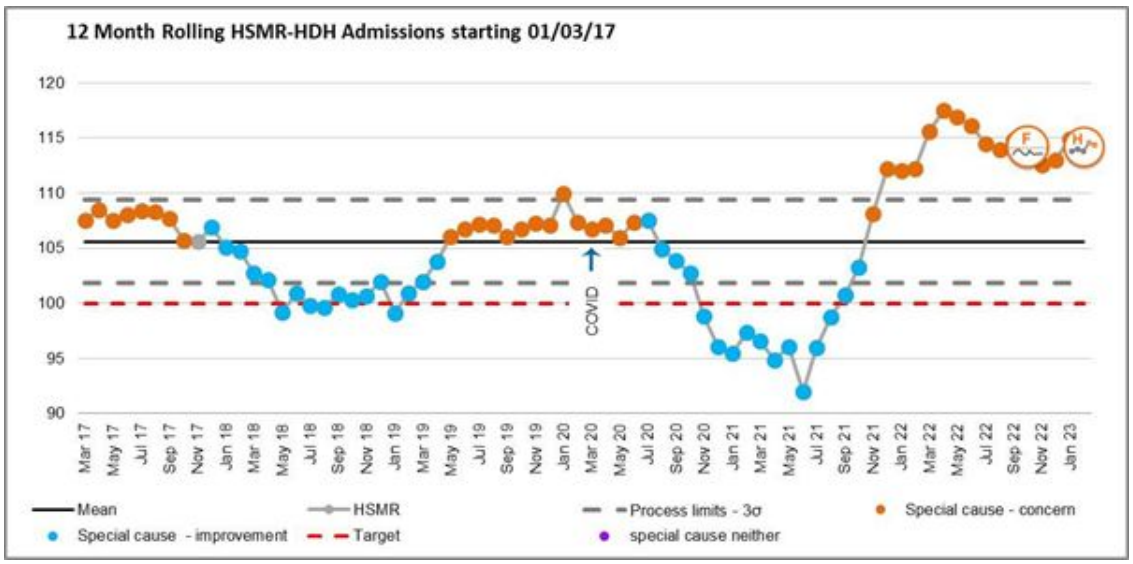


Figure 4: HDFT HSMR since 2017

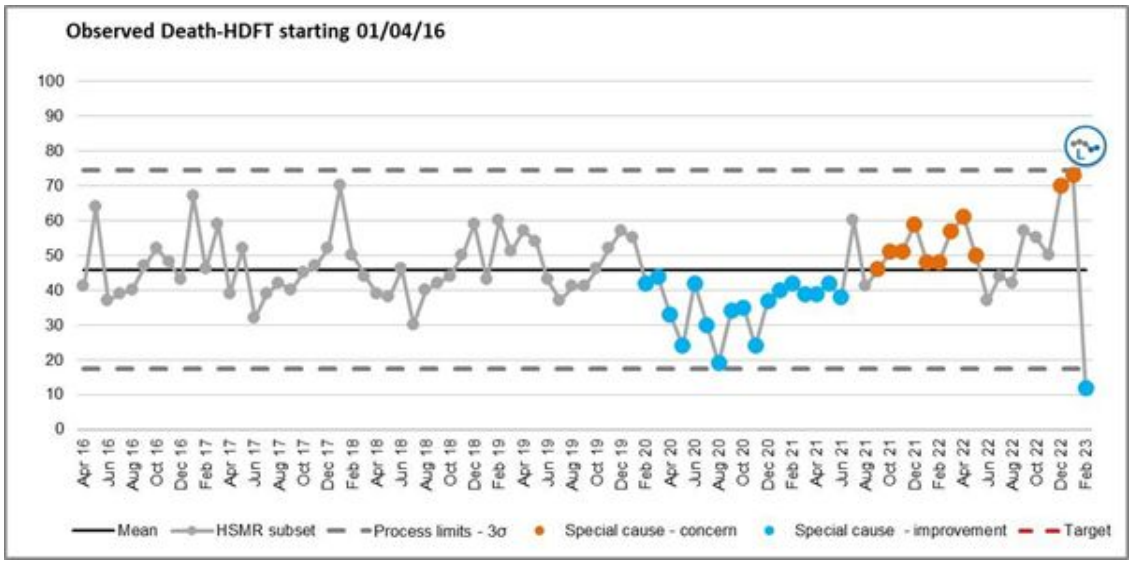


Figure 5: Observed deaths included into HSMR. Note that our observed number of deaths has now returned to pre-Covid levels

Harrogate and District NHS Foundation Trust

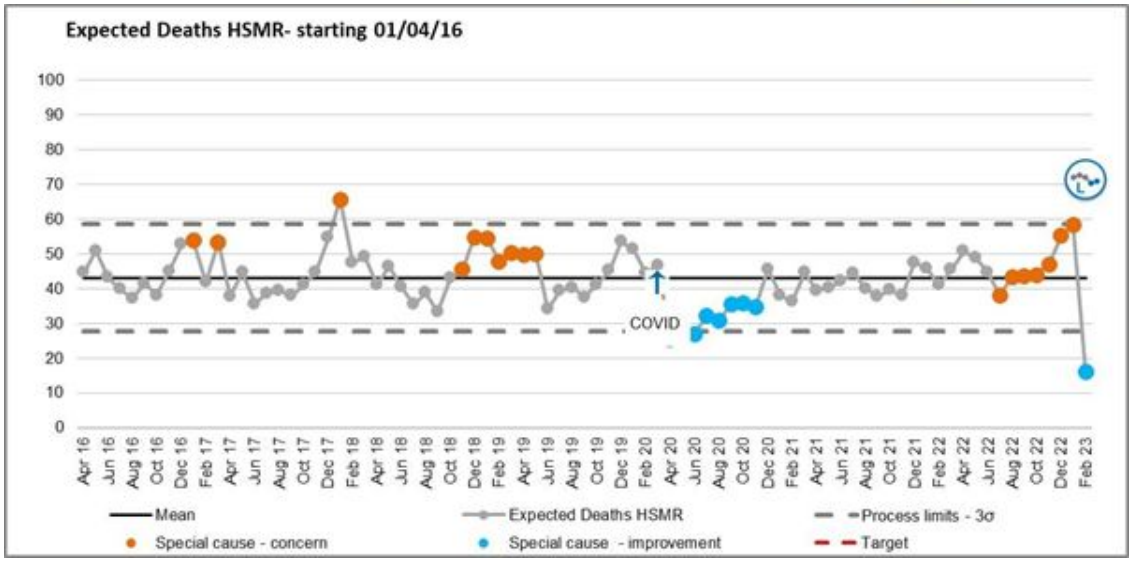


Figure 6: Expected deaths as predicted by HSMR. Note this has still not returned to pre-Covid levels

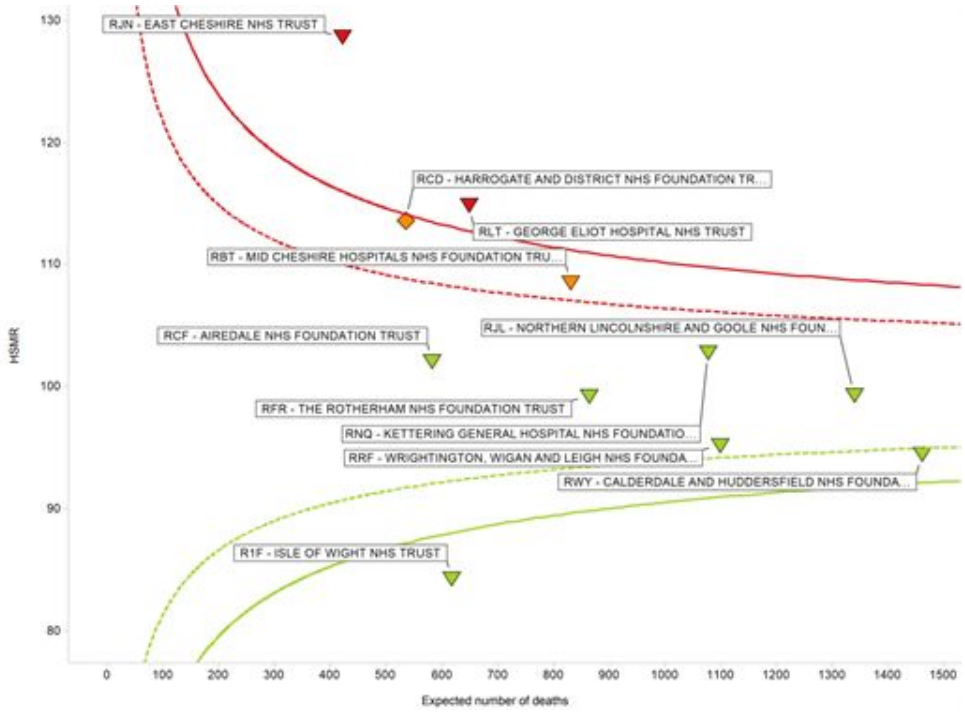


Figure 7: HSMR data for national peer organisations

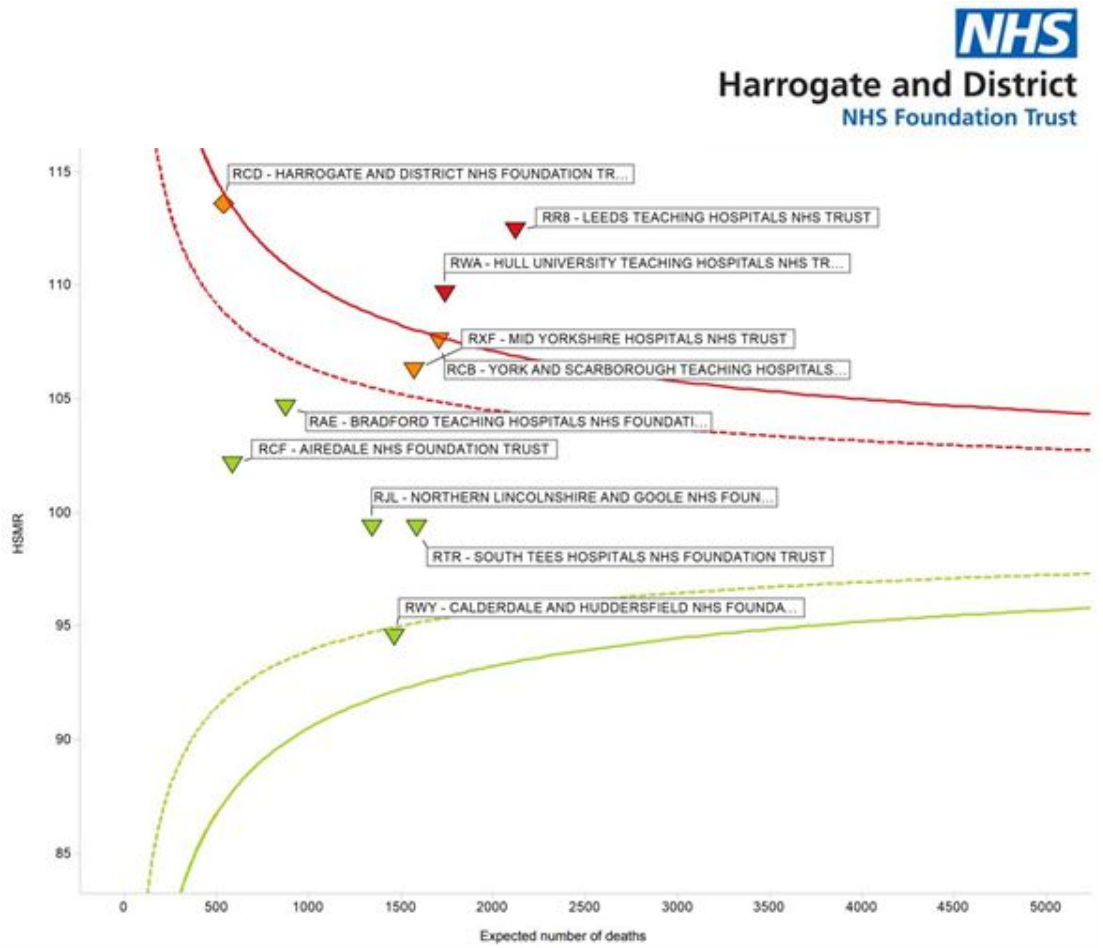


Figure 8: HSMR data for regional organisations

Overall, there appears to be a plateauing in our HSMR. This has come about primarily of a rise in expected deaths back towards pre-pandemic numbers.

3.2.2 SHMI

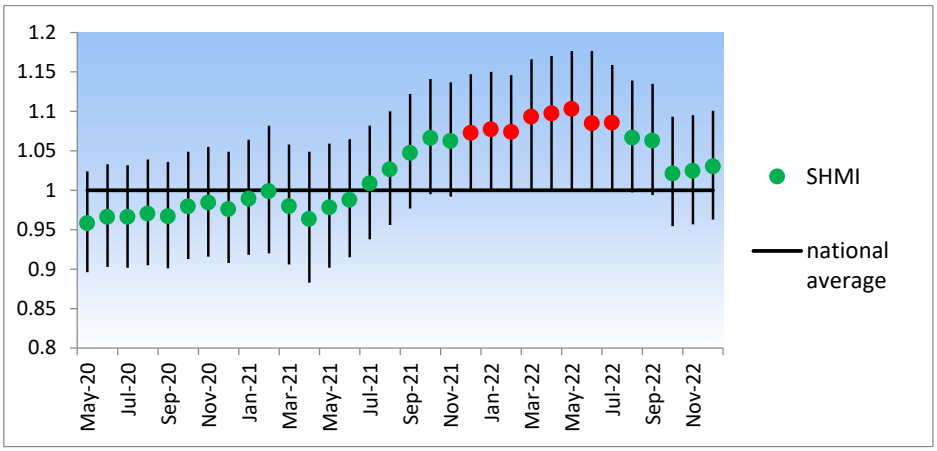


Figure 9: SHMI Dots show the recorded values with error bars showing possible range of true values.

Figure 9 shows a decline in SHMI from a peak in May 2022. SHMI captures a higher number of cases as all diagnoses are included (excluding Covid-19), together with deaths occurring within 30 days of discharge.

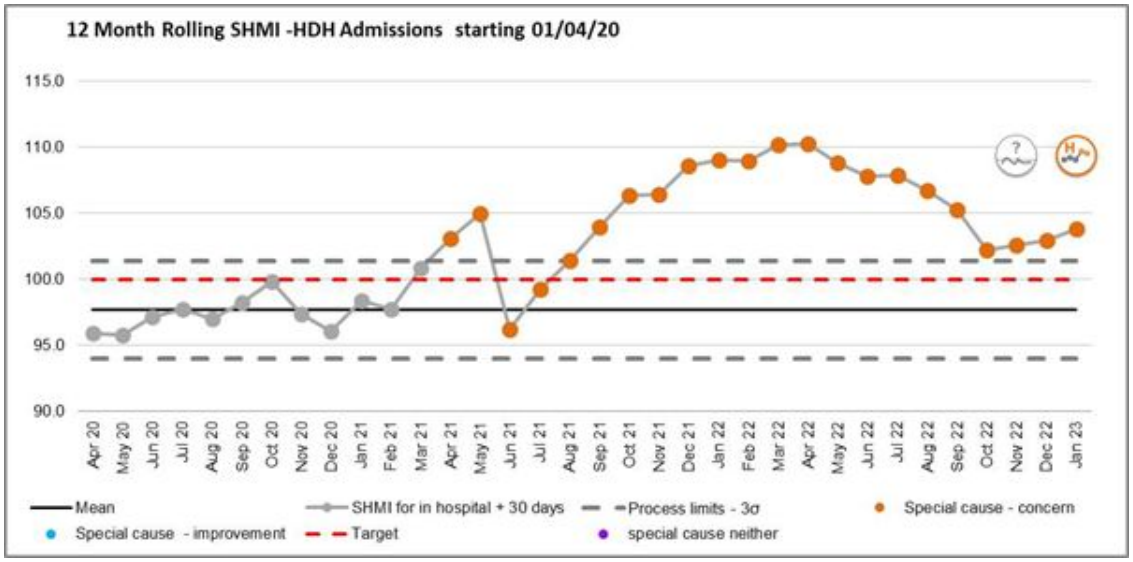


Figure 10: HDFT SHMI since April 2020

NHS
Harrogate and District
NHS Foundation Trust

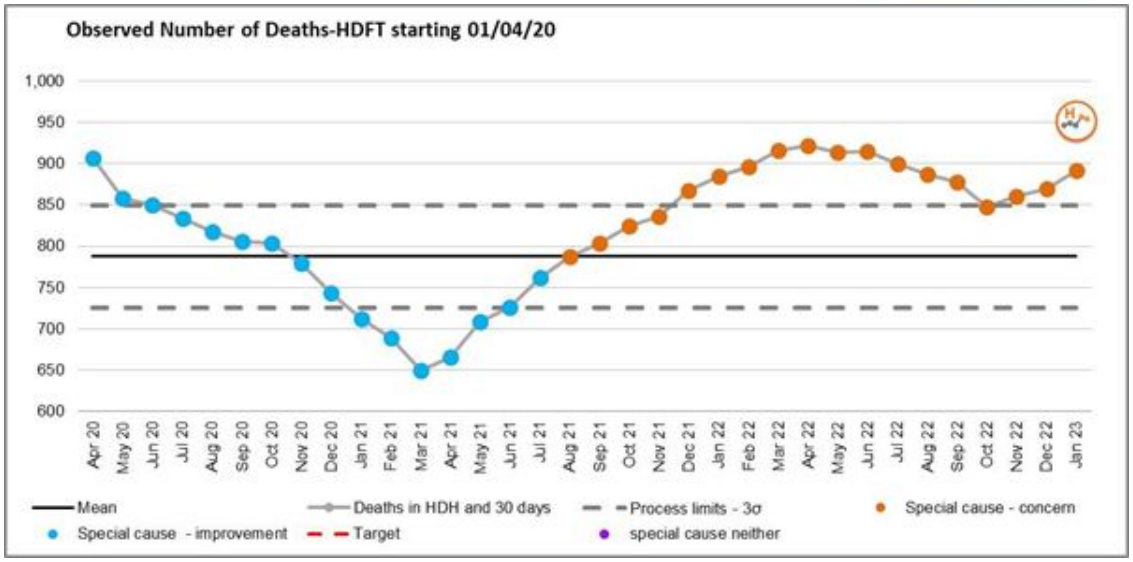


Figure 11: Observed deaths included into SHMI

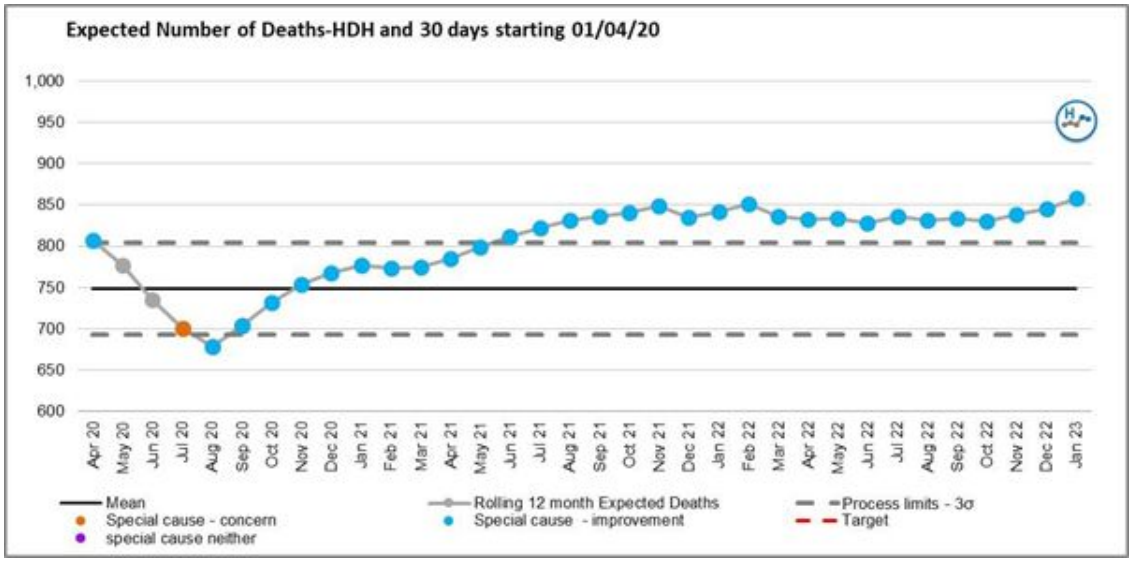


Figure 12: Expected deaths as predicted by SHMI. Note this has still not returned to pre-Covid levels

Harrogate and District NHS Foundation Trust

Figures 13 and 14 demonstrate our SHMI against that of national peer and regional trusts:

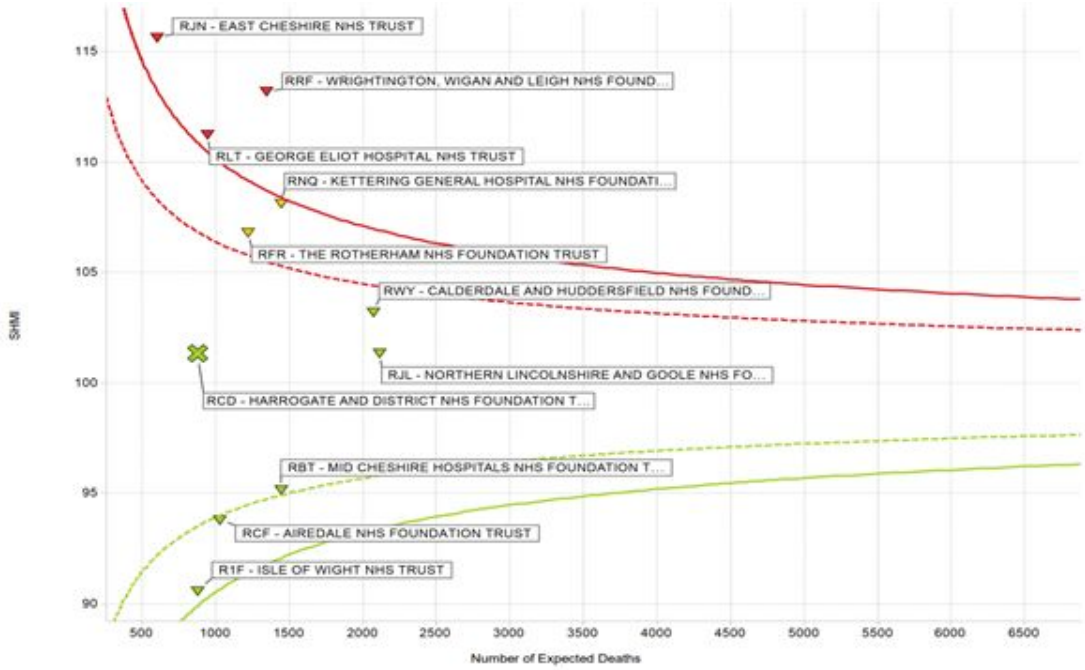


Figure 13: SHMI data for national peer organisations

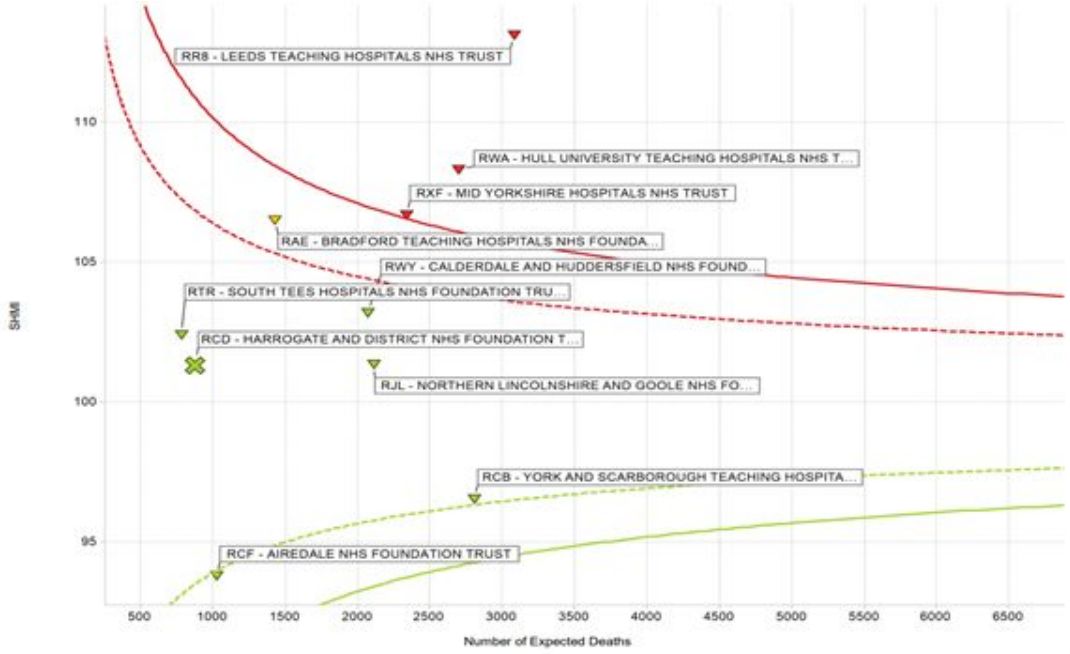


Figure 14: SHMI monthly data for regional peer organisations

The fall in SHMI has primarily due to a rise in the number of expected deaths. Figures 15 and 16 show how the gap between observed and expected has varied over time with both indices. Note how the difference remains larger for HSMR compared to SHMI. The precise cause of this is unclear, but the likeliest hypothesis remains that frail, elderly patients who would previously have been discharged to a care facility are remaining for longer on the acute site. Such patients can unfortunately have short life expectancies, and their deaths are now occurring in hospital and included as an additional death in HSMR. Such deaths, if they occurred within 30 days of discharge, would have always have been included in the SHMI, so the effect on that indicator is lessened. Figure 17 shows the rolling 12-month total of "super-stranded admissions" – ones which last 21 days or more. This appears to have finally reached a plateau, but remains significantly elevated compared to pre-pandemic levels.

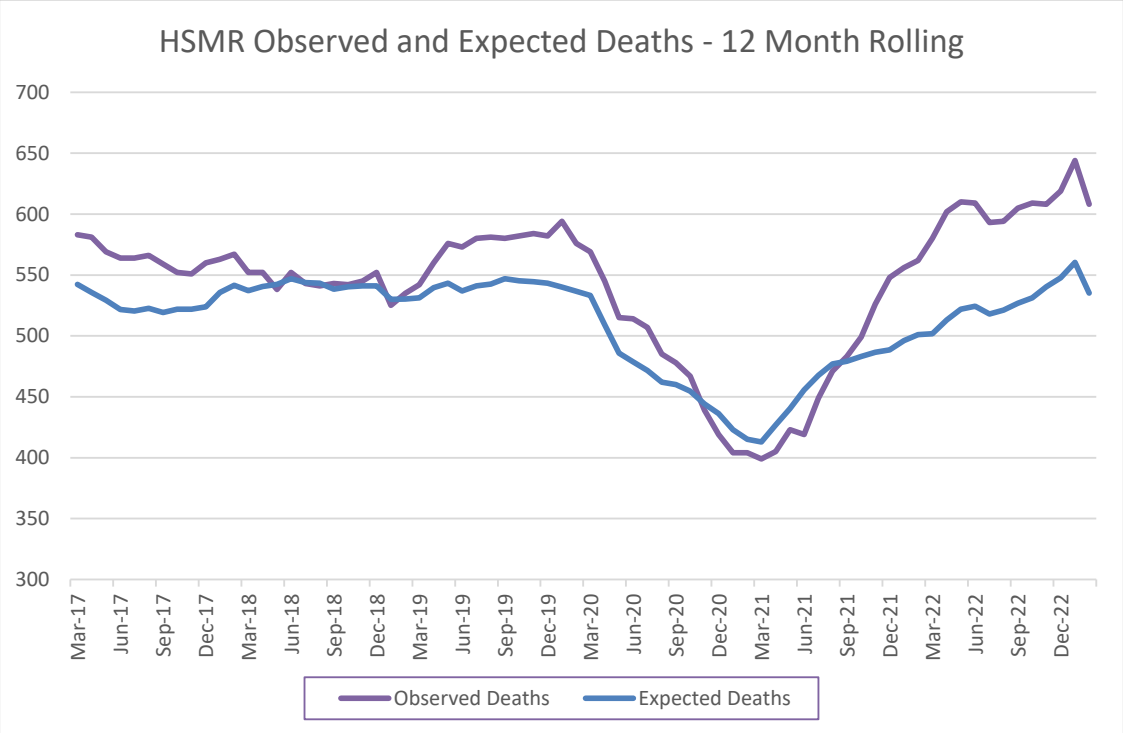


Figure 15: 12 month rolling observed and expected deaths from HMSR. Observed deaths are slightly above pre-pandemic baseline (as seen nationally), but there is a lag in the expected number.

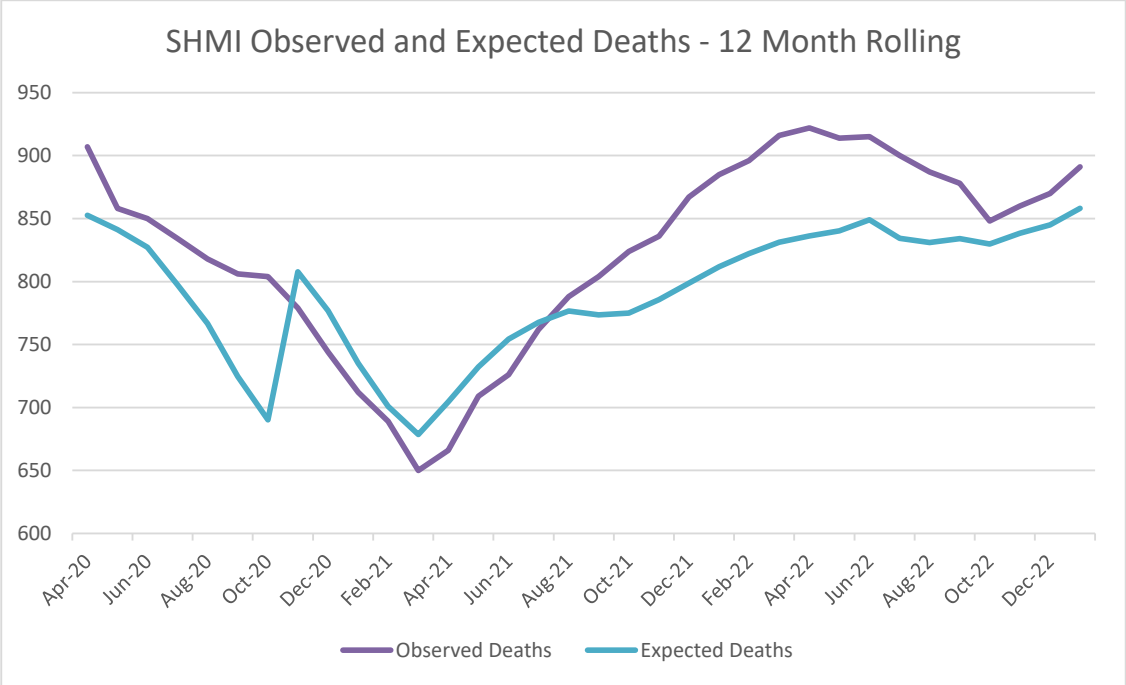


Figure 16: 12 month rolling observed and expected deaths from SHMI. As for HSMR, there has been a lag in expected deaths.

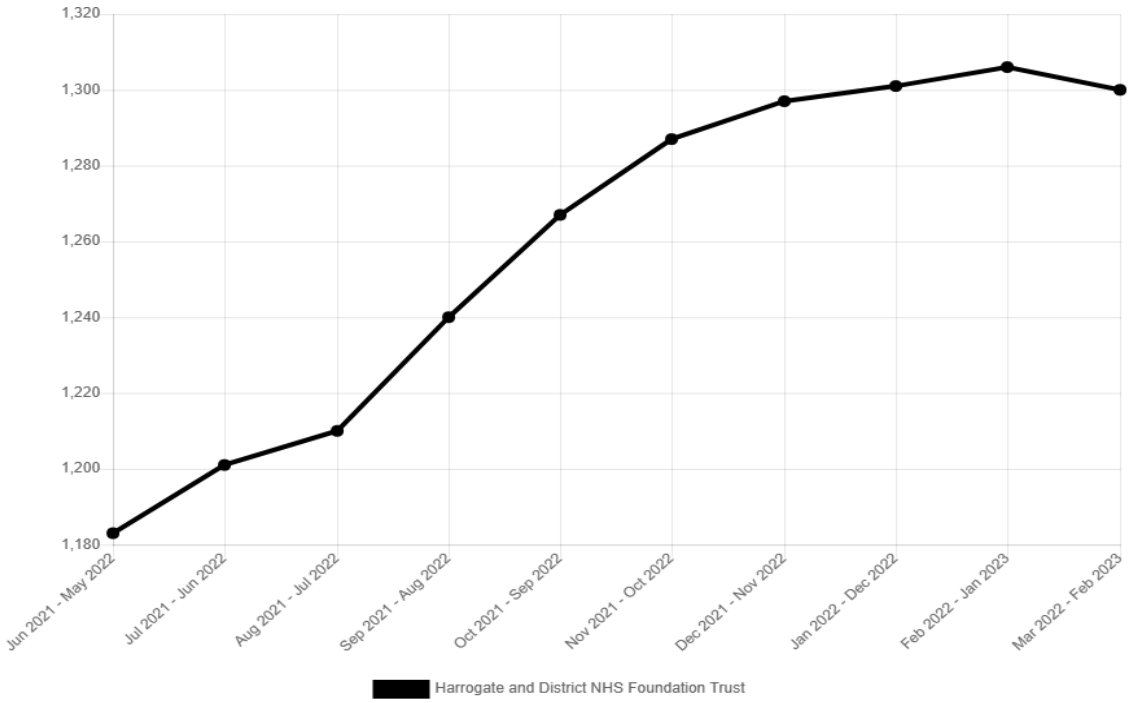


Figure 17: Rolling 12 month numbers of super-stranded patients (length of stay >21 days)

Harrogate and District NHS Foundation Trust

3.3 Structured judgement reviews (SJR)

21 cases have been reviewed in this quarter with 4 relating to deaths in this quarter, 3 from Q1, and the remainder preceding that. Cases are selected following recommendation from a Medical Examiner or randomly for assurance. We also review any case with a known learning disability or autism. The older cases in this review were investigated following mortality alerts in specific diagnostic categories. The overall assessment of standard of care of all cases is shown in Table 1:

Case ID	Admission Date	Learning Disability	Serious Mental Health Issue	Quality of Care in first 24hr (1-5)	Quality of Ongoing Care if applicable (1-5)	Quality of End of Life care (1-5)	Quality of Overall Care (1-5)	Quality of Note-keeping (1-5)
1	Sept 22	No	No	3	3	4	3	3
2	Aug 22	No	No	4	4	3	4	4
3	Mar 23	No	No	2	4	3	2	2
4	Aug 22	No	No	3	3	NA	3	3
5	Apr 22	No	No	4	4	NA	4	3
6	Aug 22	No	No	4	4	NA	4	4
7	Jun 22	No	No	5	4	4	4	4
8	Oct 22	No	No	4	4	4	4	4
9	Feb 22	No	No	4	4	5	4	4
10	Sep 22	No	No	4	4	4	4	4
11	Feb 23	Yes	No	4	4	5	4	4
12	Dec 21	No	No	4	4	4	4	4
13	Sep 22	No	No	4	4	4	4	4
14	Nov 22	No	No	5	4	4	4	4

15	Jun 23	No	No	3	NA	4	3	3
16	Jan 23	Yes	No	3	4	4	4	3
17	Oct 22	No	No	4	4	4	4	4
18	Aug 22	Yes	No	3	3	NA	4	3
19	Sep 22	Yes	No	4	3	4	3	3
20	Feb 22	No	No	4	4	4	4	4
21	Sep 22	No	No	4	3	NA	3	3
Median Score				**4**	**4**	**4**	**4**	**4**

Table 1: Structured Judgemental Reviews (SJR) conducted in Q4 2022-2023

No significant themes have been identified in these reviews, although it was noticeable that many cases had hospital acquired Covid-19 infection which was not thought to have contributed to death.

Case 3 relates to a patient newly admitted to Critical Care. There was a failure of resident staff to promptly escalate to the consultant. The case was reported as a concern before the patient died via the Datix incident reporting system. A 48 hour review was held and it was felt that although there were opportunities to deliver more timely care, the severity of the illness meant that even with optimal management, death was likely. The case will be discussed within the Critical Care team once a further local investigation has been completed.

4 cases were identified as having a Learning Disability. These will be subject to external review as part of the LeDeR process, and feedback from that will be provided when available in a future report. (There has been a recent delay in receiving feedback from the external LeDeR reviewers).

Overall, the quality of care being delivered during this period remained of a good standard, although it should be noted that the deaths cover a broad timescale. The Medical Examiner team have confirmed that they are not seeing any recurrent themes in the recent cases scrutinised. This is despite the previously noted HSMR and SHMI. SJRs are a more reliable method of detecting poor quality clinical care and provide assurance that the mortality indices, although warranting close scrutiny, have not been mirrored by concerns in the subjective case reviews.

The relaunched Mortality Review Group is continuing to meet to discuss individual cases or any identified concerns. We have also formed a new Mortality Group which receives input from areas including the Medical Examiner, Mortality Review Group, Palliative Care, Bereavement and Organ Donation. This group will report to QGMG and the Quality Committee.

The trust is in the process of implementing new “Datix iCloud” software, which has a module specifically for undertaking and interrogating SJRs. It is hoped to implement this in July 2023, and it should enable easier identification of any emerging themes.

Previous mortality alerts had highlighted excess deaths associated with aspiration pneumonia, septicaemia, acute renal failure, stroke, injuries to the scalp or trunk and general gastrointestinal disorders. All groups have had SJRs performed in selected cases and no concerns raised. As of May 20223, the only active “red alert” relates to “pneumonia”, and cases with a low predicted mortality with pneumonia will be scrutinised in the next quarter.

3.4 Medical Examiner Service

The Medical Examiner service has now completed its roll-out, providing scrutiny to all GP practices in the Harrogate & Rural and Richmondshire Primary Care Network areas and St Michael’s Hospice. Harrogate is the first ME Office in the North of England to achieve this target.

Secondary legislation is expected to pass Parliament in the autumn, and there is now a firm commitment for the Medical Examiner process to become statutory in April 2024. This will coincide with the introduction of an electronic medical certificate for the confirmation of death, and possible changes in who can issue the certificate which reflect modern ways of delivering healthcare (Allied Health Professionals, part-time and shift working).

In this quarter, 257 hospital deaths were scrutinised and 266 community deaths. This split is interesting, as in most areas there are approximately twice as many deaths in the community than in hospitals. As the Medical Examiner roll-out continues in other areas, we will continue to see if our area in indeed an outlier.

4.0 Recommendation

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

Board of Directors
31st May 2023

Title:	**Eliminating Mixed Sex Accommodation (EMSA) – Annual Statement**
Responsible Director:	Emma Nunez Executive Director of Nursing, Midwifery and AHPs Deputy Chief Executive
Author:	Emma Nunez Executive Director of Nursing, Midwifery and AHPs Deputy Chief Executive

Purpose of the report and summary of key issues:	This paper provides the Board with the Annual Declaration on Eliminating Mixed Sex Accommodation (EMSA)	
Trust Strategy and Strategic Ambitions	**The Patient and Child First** Improving the health and wellbeing of our patients, children and communities	
	Best Quality, Safest Care	X
	Person Centred, Integrated Care; Strong Partnerships	X
	Great Start in Life	X
	At Our Best: Making HDFT the best place to work	X
	An environment that promotes wellbeing	X
	Digital transformation to integrate care and improve patient, child and staff experience	X
	Healthcare innovation to improve quality	X
Corporate Risks	N/A	
Report History:	The Board receives and approves the annual declaration each May.	
Recommendation:	The Board is asked to approve the EMSA declaration.	

TRUST BOARD (in Public)
Eliminating Mixed Sex Accommodation (EMSA) – Annual Statement
31st May 2023

1.0 INTRODUCTION

The Operating Framework 2011-12 made it clear that NHS organisations are expected to eliminate mixed-sex accommodation, except where it is in the overall best interest of the patient, or reflects their personal choice. During 2022-2023 there have been no reported breaches at the organisation.

2.0 ANNUAL DECLERATION

Harrogate and District NHS Foundation Trust (HDFT) can confirm that the organisation is compliant with the government's requirement "to eliminate mixed sex accommodation except where it is in the overall best interest of the patient, or reflects the patients choice".

HDFT has the necessary facilities, resources and culture to ensure that patients who are admitted to our organisation are treated with respect and dignity and that the EMSA is adhered to.

Evidence of compliance includes reports of any and all breaches via the organisation's incident reporting system and is monitored through the Quality Report submitted to our operational Quality Governance Management Group and to our strategic, sub-committee of the Trust Board the Quality Committee.

3.0 RECOMNMENDATIONS

The Trust Board is requested to note and approve the statement as outlined at Section 2.0 of this report. Following which the statement will be placed on the Trust website.

Emma Nunez
Executive Director of Nursing, Midwifery and AHPs
Deputy Chief Executive

May 2023

Board of Directors (held in Public)
31st May 2023

5

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 Trust Board with key updates and actions since the previous update from the Guardian of Safe Working	
Trust Strategy and Strategic Ambitions	**The Patient and Child First** Improving the health and wellbeing of our patients, children and communities	
	Best Quality, Safest Care	x
	Person Centred, Integrated Care; Strong Partnerships	x
	Great Start in Life	x
	At Our Best: Making HDFT the best place to work	x
	An environment that promotes wellbeing	x
	Digital transformation to integrate care and improve patient, child and staff experience	x
	Healthcare innovation to improve quality	
Corporate Risks	All	
Report History:	Previous updates submitted to Public Board meetings.	
Recommendation:	The Board is asked to note this report and identify any areas in which further assurance is required.	

HARROGATE AND DISTRICT NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

MAY 2023

1.0 Executive Summary

This is the Nineteenth 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 January 2023 – 15th May 2023– Q4 and half of Q1 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.

68 exception reports were submitted in Q3, down from the high of 102 in Q2. 16 have been submitted for Q1 2023/24 so far. There was 1 education exception reports submitted in Q4, bringing the total to 21 for 2022/23 year. This maintains the higher than usual numbers we have been seeing. There have already been 2 submitted for Q1 2023/24

3 further breaches of contract have been reported, bringing the total number of breaches to 21, and fines totalling £3064.67 have been levied. These breaches relate to working beyond the maximum 13hr shift length, either within general surgery on SAU or acute medicine.

There has been one regional meeting for Guardians since the last report. Trainee doctors' fora have been held jointly with the Director of Medical Education. These continue in both a face-to-face and virtual capacity 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. August 2022 saw doctors joining the workforce whose entire 'clinical' training had taken place under COVID-19 safety measures. As a result, they have had significantly reduced clinical exposure to patients and have needed 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 being submitted and their reasons for doing so.

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 remains exceedingly high. Further Guardian fines were levied against the trust in Q4 2023/23. The concerns over workload have yet to be successfully addressed. Locum expenditure data suggests there remain significant staffing gaps/pressures, especially within LTUC'

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 Nineteenth 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.

Clinical Fellow Posts

The trust appointed a total of 6 fellows in general medicine, 2 in emergency medicine and 1 in dermatology who will be working with us until August 2023. 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. Unfortunately recruitment for August 2023 has yet to be completed, meaning there could be increased staffing pressures placed on LTUC if there remain vacant posts.

Changes to Medical Curricula

Changes to several postgraduate medical curricula came 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 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.

May 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 10 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	NHSE or Trust	WTE	Recruitment
LTUC	Acute Medicine	Aug/Aug	CEF	Trust	1	To be re-advertised to start in August (not yet requested).
LTUC	Acute Medicine	Aug/Feb	ST3+	NHSE	1	Post remains unfilled, department filling gap with locums. Fellows will aid this gap once recruited
LTUC	Cardiology	Aug/Feb	ST3+	NHSE	1	Post remains unfilled, however previous LAS doctor in this post is now a substantive SAS doctor in Cardiology. Fellows will aid this gap once recruited
LTUC	Emergency Medicine	Aug/Feb	GPTS 1/2	NHSE	1	Filled with fellow post
LTUC	Elderly Medicine	Aug/Aug	FY2+	Trust	1	Filled with LAS doctor due to start in August for 12 months
LTUC	Orthogeriatrics	Aug/Feb	GPTS 1/2	NHSE	1	Previous LAS resigned, new LAS FY2 recruited and started 09/05/2023.
LTUC	Diabetes & Endocrinology	Aug/Feb	CT1/2	NHSE / Trust	1	The LAS doctor who filled this gap, has now finished their maternity, and left the trust, post remains unfilled until next rotation.
LTUC	Haematology / Oncology	Aug/Dec/ Apr	FY2	NHSE	1	This gap (Apr-Aug) has now been filled with a trainee who was transferred to us.
LTUC	Microbiology	Aug/Feb	ST3+	NHSE	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	NHSE	1	No plans to fill this post.

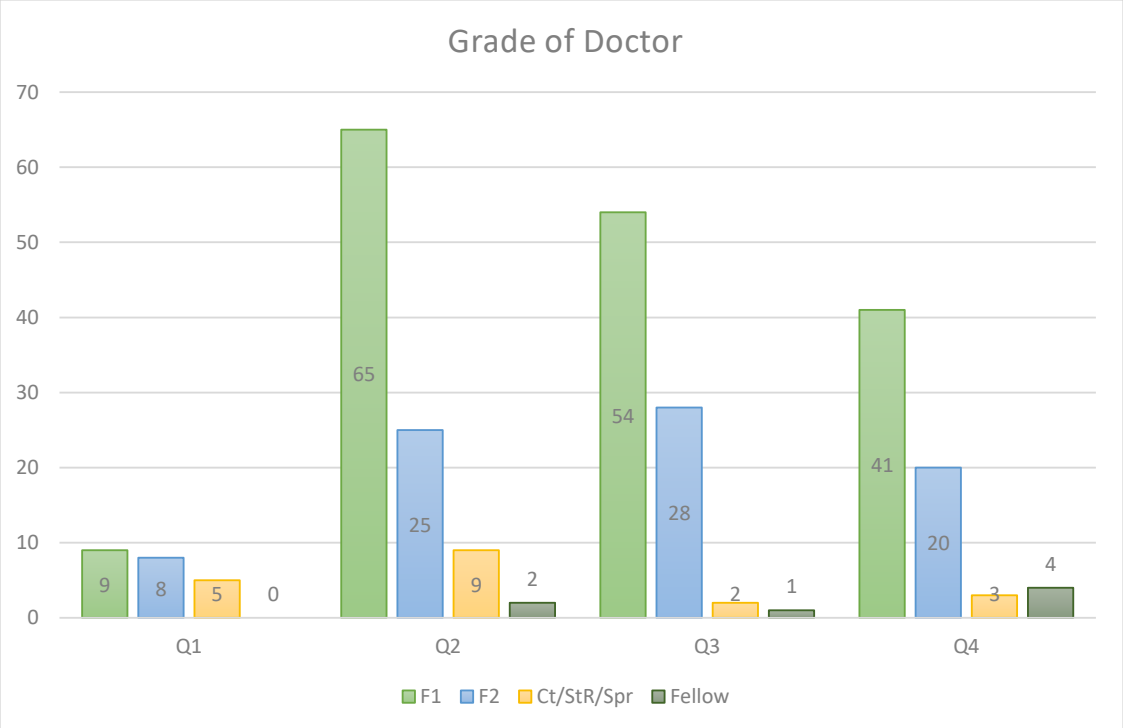
4.0 Exception Reports – Qualitative Analysis

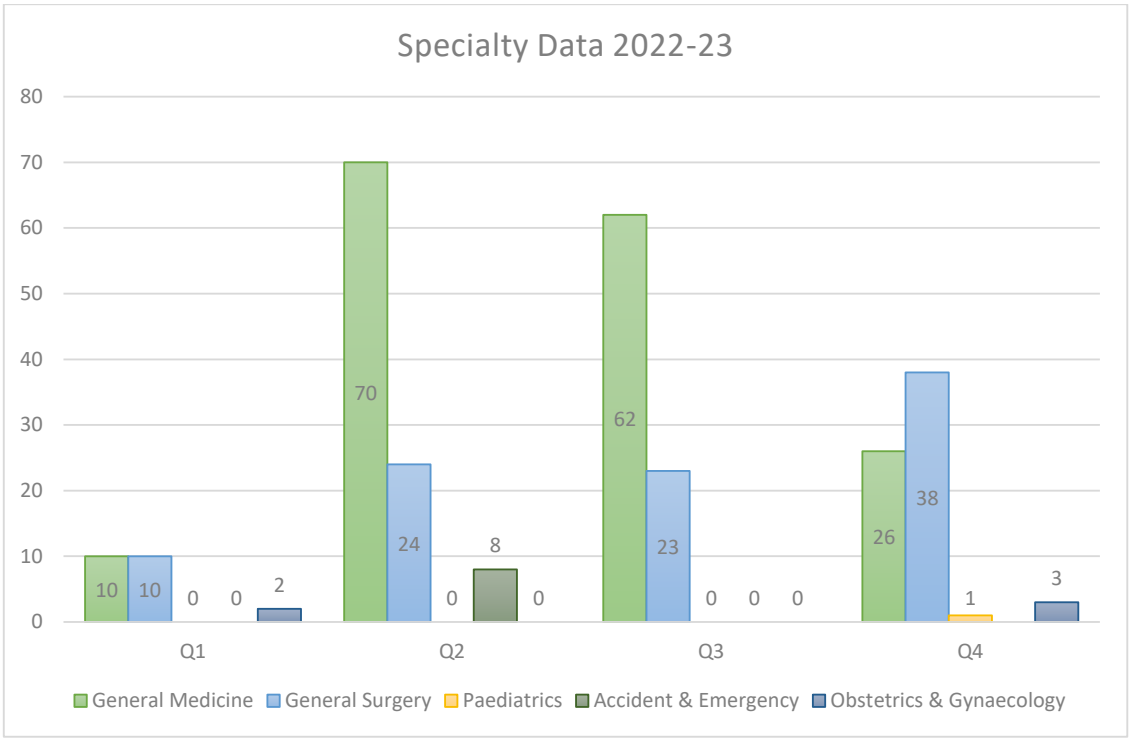
Exception reports are individual notifications to the DRS system by trainee doctors who have experienced an issue causing them to vary their working hours from the contracted work schedule. This may be repeatedly missing breaks during the day, being unable to attend scheduled teaching (either internal 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 2022-23
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70
60
50
40
30
20
10
0
10
10
0
0
2
70
24
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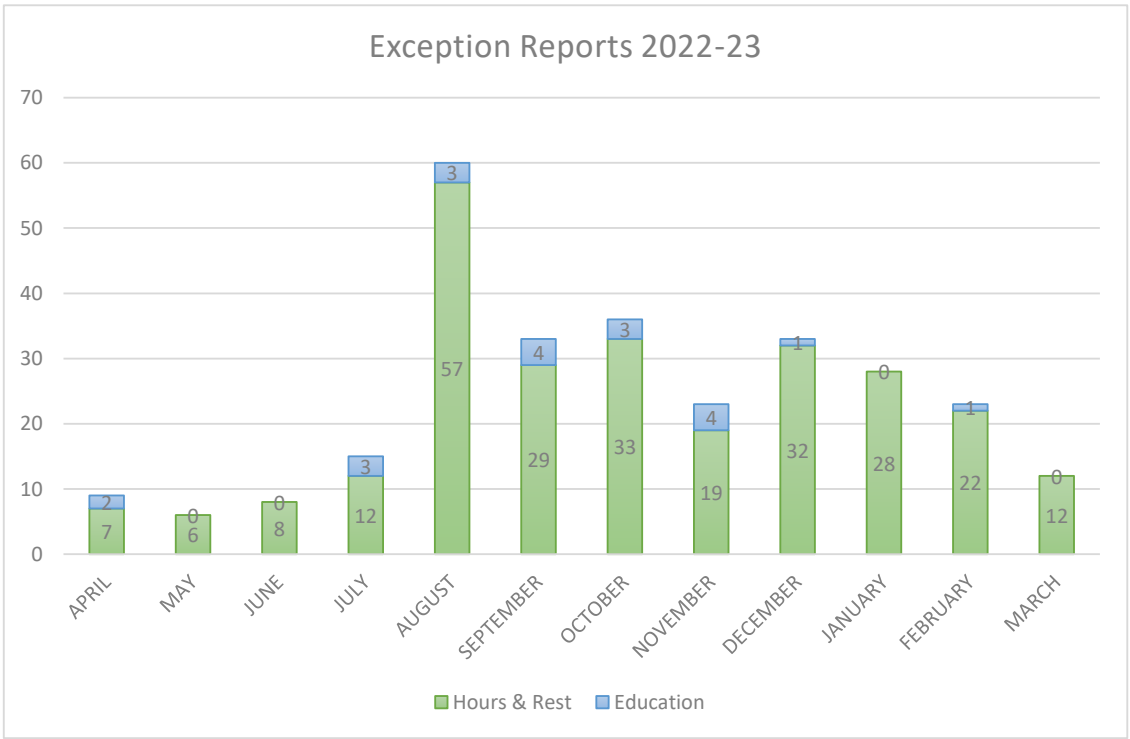
8
0
62
23
0
0
0
26
38
1
3
Q1
Q2
Q3
Q4
General Medicine
General Surgery
Paediatrics
Accident & Emergency
Obstetrics & Gynaecology


Exception Reports 2022-23
70
60
50
40
30
20
10
0
2
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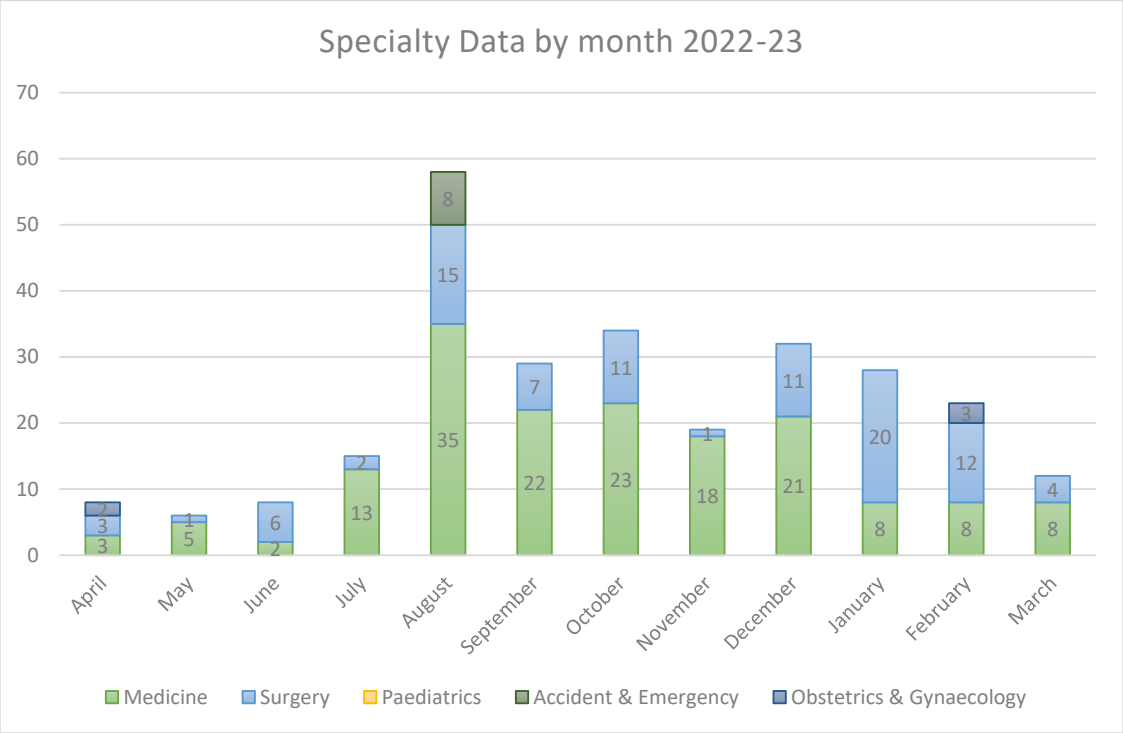
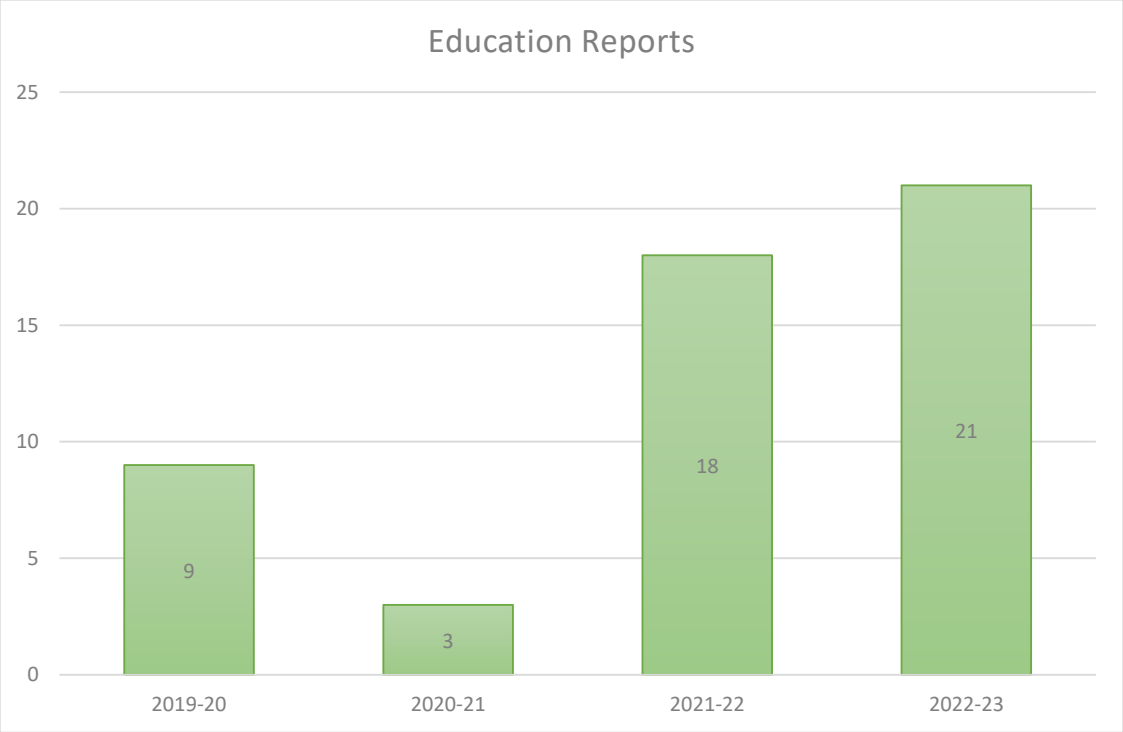
JANUARY
FEBRUARY
MARCH
Hours & Rest
Education





The increased trend in education exception reports has continued with 21 submitted 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).

This year has seen a significant increase in the number of exception reports submitted. 277 in 2022/23 vs 220 in 2021/22, representing a **25% increase**. Although the rate of reports being submitted has tapered out as the year has gone on, the overall trend is concerning when the content of the reports is considered.

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 Q4 2023/23 and Q1 2023/24 exception reports. Due to the publicly available nature of this report any names or other identifiable material have been removed.

Medicine

117807: 01 Jan 2023 Nature: Hours & 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 PP during the day which he asked me to datix the shift which I did.

An auspicious start to 2023.

117970: 07 Jan 2023 Nature: Hours & Rest

06/01 - Operational pressures in the hospital with emphasis on patient discharges. Minimum staffing on ward but 10 patients medically fit for discharge requiring letters, with some discharge decisions made late. Both of the other doctors I worked with stayed until 17:30, I stayed until 17:45 completing the letter for the patient deemed fit later in the day.

Steps taken to resolve

Managers were visiting the ward several times during the day to try and facilitate discharges; they were aware that we all stayed late to help.

118763: 21 Jan 2023 Nature: Hours & Rest

Very busy in the afternoon and minimum staffing simply not sufficient. In the afternoon we received transfers from acute admissions, many of whom were unwell and needed attention/jobs doing immediately. Frailty consultant came to do ward round late afternoon and was still giving us jobs for her patients at 4pm. Just myself and the F3 at that point trying to get everything done as quickly and safely as possible. Had to stay over an hour late to get everything immediate done. Had to hand over the rest to the long day team.

Steps taken to resolve

Handed over as much as was possible to the long day team. Even asked F1 long day ward cover if they're free to help.

120988: 17 Feb 2023 Nature: Hours & Rest

A colleague was moved onto a different ward due to staffing issues on that ward, which resulted in our ward being left with staffing levels below minimum staffing. As a result, the workload was increased, resulting in taking longer for jobs to be completed. Furthermore, that weekend there were several patients expected to be discharged, and so myself and a colleague had to stay longer to complete discharge letters for these patients, and to ensure that TTOs on the discharge letters were sent to pharmacy prior to the weekend, as there is reduced staff available on the weekends, and pharmacy is only available until the early afternoon on weekends. Without these discharge letters being made and submitting, patients expected to be discharged over the weekend would not have been discharged.

Steps taken to resolve

Organised jobs in priority order and completed essential jobs. All other remaining jobs was handed over the Ward cover teams or placed on the weekend handover list. Myself and a colleague stayed behind to ensure these TTOs would be submitted to ensure patients would be able to be discharged over the weekend, and the weekend ward cover team would not be under huge pressures to complete TTOs for patients whose care they had not been involved in, when already having to manage a huge workload whilst on ward cover. Discussed the situation with my clinical supervisor and was advised to exception report such cases.

120458: 24 Feb 2023 Nature: Hours & Rest

Below minimum staffing on ward at the start of shift. One junior brought over to help later on but not sufficient to deal with significant workload required. Afternoon in particular very busy with lots of last-minute discharges.

Steps taken to resolve

Spoken to rota coordinator who helped to get cover from another ward. Worked as fast as safely possible and very little break taken.

120987: 24 Feb 2023 Nature: Hours & Rest

Late finish due to late cardiology referral review of an unwell patient, resulting in additional jobs being created just prior to my shift ending. As a result, I attempted to complete said jobs as quickly and efficiently as possible but resulted in me finishing 2 hours after my shift had ended. As it was a Friday, and I knew there was to be reduced staff over the weekend, I did what was in my power to ensure the best patient care. After completion of these jobs, I handed the patient over to the ward cover doctor, along with Jobs I was unable to complete.

Steps taken to resolve

Attempted to gain help of my colleagues with this patient. However, my colleague also had an unwell patient that required their attention (which also resulted in them finishing at a similar time) and thus was unable to provide me with any assistance. Discussed the situation with my clinical supervisor and was advised to exception report.

120926: 05 Mar 2023 Nature: Hours & Rest

I was working medical SHO nights Friday-Sunday this weekend. On both Saturday and Sunday night I ended up being the only SHO on due to sickness. This meant I covered both medical bleeps and was responsible for all the medical wards, Farndale and clerking new patients. The med reg on (AA) was extremely supportive however the workload was unmanageable for 2 people, and it was not possible to take proper breaks. On Saturday night I only had a 20-minute break in a 12 1/2-hour shift which was interrupted by being bleeped. I received a message around 11am on Saturday morning from the SHO who was ill to let me know and at that point they said they had informed the site manager. I did not see this message until 6:30pm but in that time no messages or emails were sent out from the hospital in an attempt to get cover. The med reg on-call sent out a message on the junior doctor WhatsApp group at evening handover asking if anyone could help to cover (she was not aware of the situation until we started the shift) but by this point it was understandably too late. At Sunday morning handover we informed Dr LL (on call cons) that we were short staffed, and I am told she escalated this straight to the site manager however again no contact was made in any of the junior doctor/locum WhatsApp groups or emails sent out. I can't understand how there was no contact in any of the WhatsApp groups or via email urgently asking for cover for all or part of the shifts. I know that the rota team only work during the week but there should be a way for situations like this occurring OOH to be addressed. We are fortunate that we did not have multiple sick patients at the same time or any crash calls, but the pressure and lack of breaks made for a very stressful weekend.

Steps taken to resolve

Clinical site manager aware. Consultant on call aware. Datix submitted.

Staffing issues/ failure to meet minimum staffing dominate the reasons for exception reports being submitted, particularly from the medical wards. There seems to be very little flex in the system and even minor sickness quickly has a significant and sweeping affect across the wards.

121805: 28 Mar 2023 Nature: Hours & Rest

Stayed over an hour late and didn't have a chance to take any breaks throughout the day. Very busy (particularly in the afternoon) trying to balance all the jobs for sick patients whilst also getting the well one's home. 3 juniors are simply not enough most days on Oakdale. I strongly suggest that the minimum for that ward be raised to 4. It's a stressful shift and you're rushing non-stop from 8am till whatever time you finish. Trying to manage 30 patients with new admissions and discharges - especially when there are sick patients - is too much for 3 juniors. I'm surprised there aren't more errors on the ward and that alone is a credit to the team.

Steps taken to resolve

The registrar came in the morning to help see patients. I called the rota coordinator in the morning to discuss our ward staffing and ask if we could have another junior transferred, given the staffing on other wards seemed good. They said no because we were at minimum staffing and that is sufficient. One of my colleagues, XX was included in this minimum despite the fact that she is supernumerary, and the rota states she is not counted.

Further details from this exception report have been withheld as it would disclose the identity of the doctor, but they highlight a worrying lack of concern for the doctors' welfare and the reasons as to why they should be considered supernumerary within the working roster. This has been investigated and support offered.

Surgery

119030: 19 Jan 2023 Nature: Hours & Rest

Due to the major understaffing issues on the new SAU on Littondale, namely clinical support staff being pulled from covering SAU in order to help on wards and there not being enough nursing staff to do their assigned jobs (comparative to numbers of nursing staff who could do practical jobs on SDEC to support doctors), I had to perform practical jobs like bloods, cannulas, urine dips, and escorting patients to imaging. This caused major delays in patient care and reduced turnover times, with patient care delayed to hours greater than there was in the old SDEC surgical unit. There have been major flaws with the current reassignment of the SAU and poor planning from the managerial staff, and there have been really big issues with lack of communication between those in charge of the move and staff like me who will actually be running it- which is just frankly disrespectful and dangerous for patient care. Aside from this, there have been issues with the closing time/last referral accepted to SAU; SDEC had a clear closing time of 8pm, however every shift there are patients with unclear plans regarding being discharged/admitted etc by the time it hits 8pm because other departments deem it to be ""24-hour"", and these plans aren't decided until after 10pm. No member of staff running SAU has been given clear guidance about what the rules regarding the purpose or limits of SAU are, and if it were to be open past 8pm then it needs to have more staffing to support this- it is dangerous to think it okay that the night team will be able to cover the remaining patients left in SAU after 8pm as they have all the surgical wards and admissions to deal with, along with emergency theatre. These are not simply ""teething problems"" that will go away within a few weeks- major changes and communication needs to happen.

Steps taken to resolve

On multiple occasions we asked SDEC nurses/clinical support staff to come over to help on SAU which took up to an hour for help to arrive and is not practical or safe in the long term.

119018: 26 Jan 2023 Nature: Hours & Rest

No nurse or health care support worker allocated to SAU who can do bloods, cannulas, or male catheters. When escalated concern to SAU sister & Littondale ward sister/manager told 'they're the doctors' jobs' and that there was no one I could escalate this to further and would have to just make do as it is my job. I explained that I did not feel this was safe as yesterday even with the support of an excellent HCA we were very busy, with myself not managing to have lunch until after 3pm and my twilight colleague having to stay on SAU until after 9pm to complete assessments. Multiple juniors have escalated this concern with lack of clinical support when SAU was moved from SDEC, and we were assured it would be dealt with. No one was sent to assist and kindly the general surgery ward doctors provided help with jobs, above and beyond their intended role. Feel very unsupported and like the expectation was that I would just have to cope. The SAU was moved against what we had been told the plan was (were told it would move after our rotation) and expectations have not been clearly set

out e.g. being consistently referred orthopaedic patients when the team believes we only see surgery/urology and insufficient skill sets of staff.

Steps taken to resolve

Escalated concern to ward sister, ward manager, consultant on call, rota coordinator and matron.

119239: 30 Jan 2023 Nature: Hours & Rest

Due to staff sickness we were below minimum staffing on the ward, (1 ward cover and myself on call as the juniors) one of us was needed to assist in theatre which meant I was the only doctor covering the ward round and SAU in the morning, to bridge the gap the twilight junior (created to help sdec/ sau staffing) was brought in to instead cover the ward during the day. But this left SAU understaffed in the afternoon/ evening. The volume of patients in SAU was too much for one person to manage, others were brought in for short periods to help but difficulties declining and stopping referrals lead to overcrowding in the department and being unable to assess patients due to lack of trolleys and treatment rooms. Slow scans and difficulty contacting busy seniors meant it took longer times to clear the back log and so SAU remained open later than it should have, beyond 20:00, waiting for scans and plans to be made. I remained at work for an additional 2 hours to try and clear this backlog and make sure everything was documented, managements set in motion and remaining tasks handed over sufficiently before leaving having worked 14.5hours in all

Steps taken to resolve

Escalation to Rota team early to try and get additional help, nursing staff escalated issues with volume of patients being referred,

120173: 14 Feb 2023 Nature: Hours & Rest

This week the staffing on general surgery has been extremely poor. There have been multiple sicknesses, however, when we constantly run on minimum staffing, this inevitably throws everything into chaos, despite the fact that unexpected absences should be able to be accounted for and still maintain safe minimum staffing levels. We are completely reliant on our locums for staffing at the moment, and when they are sick there are no other options. The day team for wards only had 1 junior doctor (minimum is 2), and subsequently, when I arrived for the twilight shift SAU was significantly behind, as the SAU doctor had had to attend the full ward round, conduct reviews, do jobs, and even attend a crash call on the wards before beginning the SAU work. We then worked constantly without the opportunity for breaks in SAU for the rest of the day however still finished half an hour late.

Steps taken to resolve

I would like to note that AA (who appeared to be in charge of the rota this week) came to visit us in SAU, at which stage I told her that if she did not have 2 people on the day ward cover for the rest of the week, I would like her to contact me so that I could come in at 8am and work the long day as opposed to the twilight, which would have lost us only 2 hours in the evening, but made the day shift and afternoon on wards/SAU significantly more manageable for everyone. She acknowledged this, and I asked her to contact me if this was the case, however, when I arrived the following day, there had again only been 1 person on the day ward shift and therefore SAU was not under control either. I do not understand why I was not taken up on my offer to come in at 8am and assist earlier, or at the very least informed that cover for the day shift had not been found because this could have prevented some of the understaffing and subsequent chaos that occurred in SAU over the following days (see Datix).

120057: 14 Feb 2023 Nature: Hours & Rest

Stayed late to complete required TTOs on SAU and finish the necessary on-call tasks that couldn't be handed over and was unable to achieve allocated break times due to a particularly busy and understaffed shift. General surgery was very busy (approximately 40 patients), so the ward round was long and was below minimum staffing with just one locum doctor for all of general surgery. I therefore helped with the ward round as much as possible before being pulled to SAU for multiple waiting patients. We were below minimum staffing in that the general surgery wards were staffed by one locum (single shift so patients not known to him) due to sickness and then the twilight tier 2 doctor was pulled to cover the tier 1 Night Shift. The previous day general surgery was also below minimum staffing with just one doctor and whilst it was also a busy day the system worked fine, and I enjoyed the shift. The difference between the two days I think was the additional of multiple unwell patients for ward cover that meant jobs and patients accumulated on SAU whilst I was needed elsewhere with no one else to cover me. I was also receiving bleeps for ward jobs throughout the day and at five I received quite a few outstanding tasks handed over as, understandably, the sole doctor couldn't complete the full list of necessary jobs. Furthermore, there was an emergency buzzer pulled on Littondale ward (SAU is on Littondale) and I was the sole doctor on the ward at the time, so I had to leave SAU to assess and manage this patient. 4 patients slept in SAU overnight due to a lack of beds the previous day, so space was very limited, especially in the morning but patients were still being sent/turning up which was causing concern for the nursing staff re. space and responsibility for patient care. Missed the f1 teaching (I didn't select the above box for education as I'm aware whilst on-call attendance isn't compulsory but when we are at least at minimum staffing it facilitates being able to manage time to attend educational experiences).

Steps taken to resolve

The twilight tier 1 doctor provided a lot of support, including writing several of the TTO's for SAU attenders that she was able to do from during the day whilst I assessed unwell patients on the wards. Was able to handover some outstanding tasks to the night doctor. A manager did bleep me at 15:40 (whilst I had managed to grab some food for lunch) to say that she had heard we were very busy and how could she support. We agreed to stop accepting SAU referrals and I suggested support was sent to the single general surgery doctor, but none was able to be sent. Excellent teamwork from the SAU nurses & healthcare support workers & support to complete tasks together and the twilight doctor and I worked together to prioritise appropriately. The registrars were very present to support throughout the day.

120174: 17 Feb 2023 Nature: Hours & Rest

Whilst on a shift covering SAU (Twilight support shift), as of 6pm we had 7 patients awaiting general surgical senior review (one of which had self-discharged by this stage), which had not been able to be done as the general surgical registrar was in theatre undertaking a laparotomy. We then also had a patient arrive in the department at 6pm, who was not able to be reviewed by a registrar until the night shift had begun after 8pm and so stayed in the SAU after it should have closed. A combination of late accepting/admissions to SAU and a busy registrar who had not been able to make admission/discharge decisions for the patients in the department meant that the work accumulated at the end of the day and breaks were not able to be had.

Steps taken to resolve

Surgical Registrar aware

120236: 17 Feb 2023 Nature: Hours & Rest

On Friday I was the SAU FY1. SAU was extremely busy but with a manageable steady patient flow which was well controlled. This was the case until the twilight doctor joined me at 14:00,

when a large volume of patients all arrived within a short time frame. Furthermore, I was pulled by the urology registrar to review three patients on the ward at 15:00, including a patient who had been admitted as an emergency immediately from ED to the ward and required an extensive discussion for breaking bad news. I was unable to take my planned lunch break because of this, as the volume of patient to clerk in SAU was unsafe to leave to one doctor. Both myself and the twilight doctor clerked the majority of patients, however the surgical reg was in theatre so none of our patients were fully completed or discharged. The reg did not return to review patients until 19:00, leaving us a very long jobs list to complete in the hour before handover. This was in addition to updating the handover list for admissions. Consequently, I was required to stay late to help with the workload on SAU and update the handover list for admissions. When I left at 21:00, there were still two patients in SAU which should not be the case.

Steps taken to resolve

Attempted to contact reg but was unavailable as was in theatre. Patients had already been accepted earlier in the day, but all arrived in a short period so stopping accepting referrals would have made little difference.

120890: 18 Feb 2023 Nature: Hours & Rest

Very busy shift on the Saturday. Large number of general surgical, orthopaedic and urology patients. 21 TTOs were requested and needed to be done. This was impossible to achieve as ward round finished at 12 and pharmacy closes at 2pm. There was a lot of pressure from ward staff to complete these ttos despite more important jobs needing doing so it left an uncomfortable atmosphere. The SAU doctor was also swamped with jobs, so it was not possible to ask for their help. Having pharmacy closing so early on a weekend when they are not prescribing pharmacists is so inefficient as ttos cannot be the most important jobs a doctor has to focus on when they are looking after all unwell surgical patients

Steps taken to resolve

Tried to explain to ward sisters that some ttos are not going to happen and tried to prioritise jobs as much as possible.

120790: 02 Mar 2023 Nature: Hours & Rest

Was asked to come in early for my twilight shift (12pm) with the view of finishing at 8pm so I could come in at 8am-5pm to cover the general surgery the following day (instead of my twilight shift 2pm-10pm) due to last minute rota changes. Was not possible to have a break or to leave at 8pm due to a very busy shift. The board of SAU was entirely filled, and we were struggling for space to see patients. Three separate patients self-presented from GP without a referral. Myself and the long day doctor had to stay late to complete all of the letters and we still had a patient waiting to be seen at handover time (which we stayed and sorted as there were a significant volume of tasks also handed over from the day team that the night doctor needed to focus on).

Steps taken to resolve

Worked as a team with the nurses and HCAs and with excellent SpR support (CC & SS) to see patients directly to speed up reviews & utilise maximum space. The urology day doctor also reviewed two patients for us.

122388: 18 Apr 2023 Nature: Hours & Rest

I was working a long day, covering SAU on 18/04. It was a very busy day with a full board of patients, and a team on SAU that were unable to help me with any clinical skills. I had also

been on SAU the day before- the team (VV - RN and CC - CSW) I was working with were diligent, requesting and carrying out bloods if they thought these were necessary, and were able to put catheters in. As SAU got busier on Friday with more patients attending, I tried to delegate any tasks that the nurse/CSW were able to do. She told me neither of them were able to do bloods, cannulas or put in catheters. I am aware this seems to be an ongoing issue in SAU and that more of the team are getting trained, however on a day when SAU is very busy, it just adds further jobs to an already long jobs list. I managed to finish on time however I had to hand over many outstanding jobs to the night F1. I was unable to attend mandatory F1 teaching or take my breaks during this shift due to how busy it was.

Steps taken to resolve

At one point there were 5 general surgical patients waiting for a registrar review (I'm aware this doesn't sound like a lot of patients but when we only had room to examine 6 patients, they were taking up a lot of room and I had to try and move people from day room-bay and then back to day room once I'd seen them as there isn't much space). I had previously bleeped the registrar; however he told me that he was going to theatres and would come to SAU once finished. It was getting so busy in SAU (both the bay and day room were full of patients) that the nurse rang management, I'm unsure what then happened but both the registrar and consultant came to SAU to review patients to see if we could discharge anybody.

122562: 20 Apr 2023 Nature: Hours & Rest

Took longer than it should have to complete jobs due to lack of computers on Littondale and Nidderdale. There were many times in the day when I was unable to do work because I could not access a computer on the wards as there are more staff requiring using them than there are available computers.

Steps taken to resolve

Looked for computers at nurses' station, however these were also in use

In mid-January, surgical SDEC moved to a separate location and is now known as the Surgical Assessment Unit (SAU), housed on Littondale ward. It is fair to say that this move was somewhat rushed in its implementation, more detail is included below.

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.

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 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".

There was one serious failure to cover a medical registrar shift in March, following which a series of steps have had to be taken to ensure it does not happen again. To summarise, there was a vacancy for the medical registrar nightshift which had not been filled. The IMT1 (less than 6 months out of foundation program) was asked to act up as registrar, unsupervised and unsupported by the consultant. This went against all guidance, where it is not possible for anybody to act up without the appropriate competencies (something that they would not be expected to have achieved until the end of IMT2 at the earliest). In this instance the hospital was left with unsafe staffing, with too junior and inexperienced doctor as the most senior medical doctor on site. This occurred due to a series of system errors and a failure to follow the policy correctly. The expectation would be that the consultant on-call act down and cover the shift, if they feel they can't as they have been at work all day (as was the case in this instance) then another consultant should be asked to stand in for them, either that night or the next day if the original consultant is on-call again then (again as was the case in this instance).

5.3 Locum Cost

It is a requirement that once a year the Guardian report includes information on locum expenditure for the financial year. Information has been obtained from TempRe Liason Workforce (utilised by all the Junior Doctors) and I have been able to produce the following calculations. It should be noted that the following figures do not include internal locum expenditure paid directly through Salaries20 Forms (more commonly utilised by SAS or Consultants), as such the actual cost is higher (the figure from the Medical Additional Rates Group (MARG) is circa £6M).

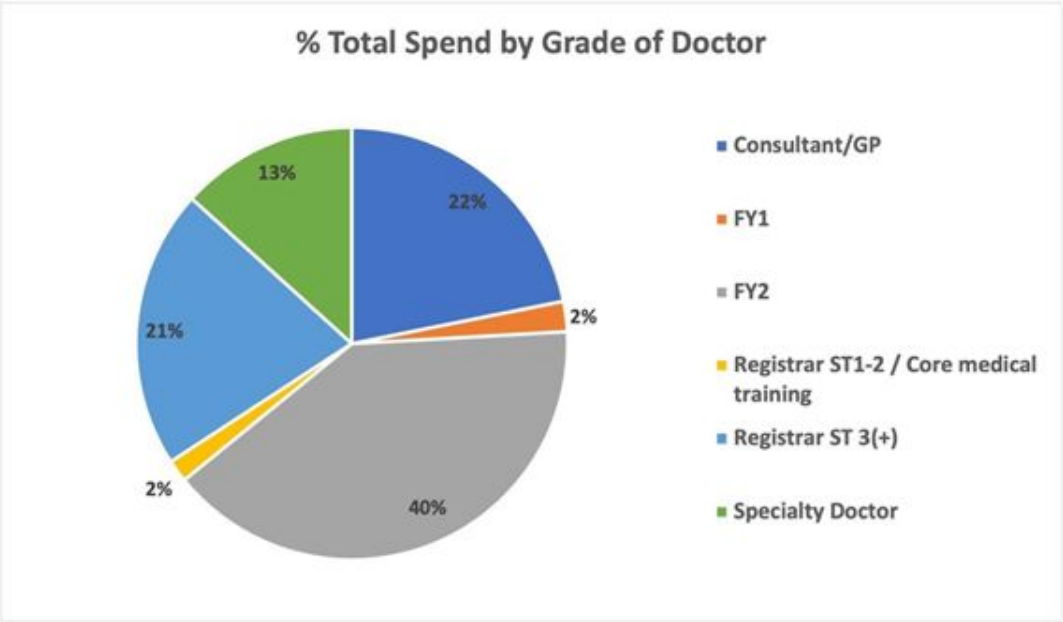
I have analysed the data by both directorate and grade of doctor. The spend for the 2022-2023 financial year as follows:

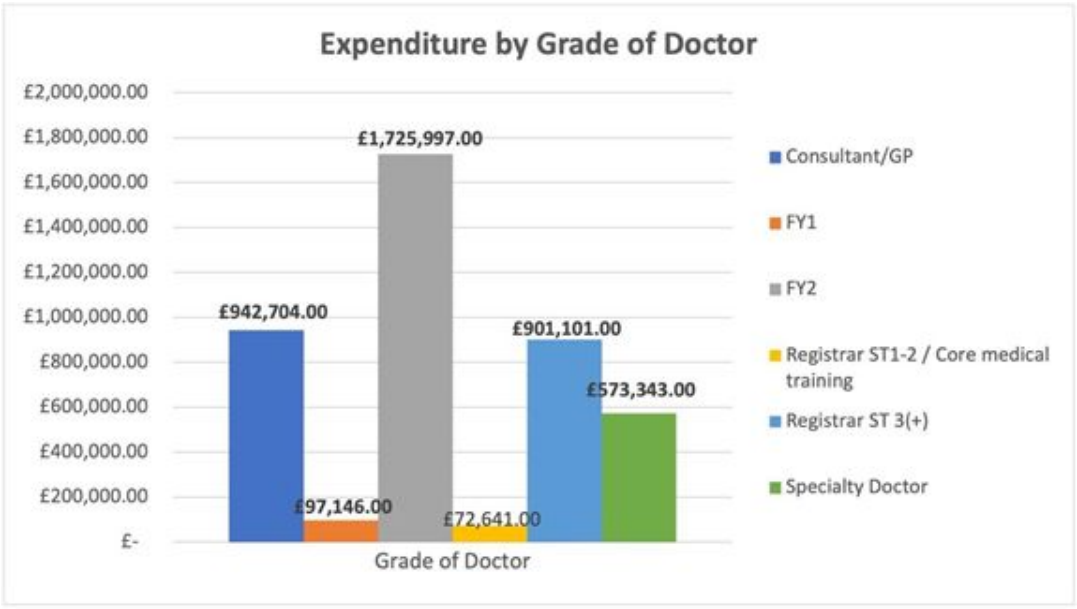
TOTAL COST	**£ 4,312,932.00**
AGENCY COST	**£ 1,098,127.00**
INTERNAL BANK	**£ 3,214,805.00**
LTUC	**£ 2,876,387.00**
PSC	**£ 1,236,033.00**
CCC	**£ 196,758.00**

LTUC	Total Cost	Number of Shifts
Consultant / GP	£880,008	767
FY1	£168,13	61
FY2	£1,259,097	2529
Registrar ST1-2 / Core Medical	£4,706	13
Registrar ST3 (+)	£697,148	909
Specialty Doctor	£18,615	66
TOTAL	**£2,876,387**	**4345**

PSC	Total Cost	Number of Shifts
Consultant / GP	£60,794	107
FY1	£60,691	176
FY2	£404,817	909
Registrar ST1-2 / Core Medical	£51,601	106
Registrar ST3 (+)	£180,934	273
Specialty Doctor	£477,196	505
TOTAL	**£1,236,033**	**2076**

CCC	Total Cost	Number of Shifts
Consultant / GP	£1,831	1
FY1	£19,642	27
FY2	£59,462	98
Registrar ST1-2 / Core Medical	£16,263	24
Registrar ST3 (+)	£22,028	21
Specialty Doctor	£77,532	84
TOTAL	**£196,758**	**255**




Expenditure by Grade of Doctor
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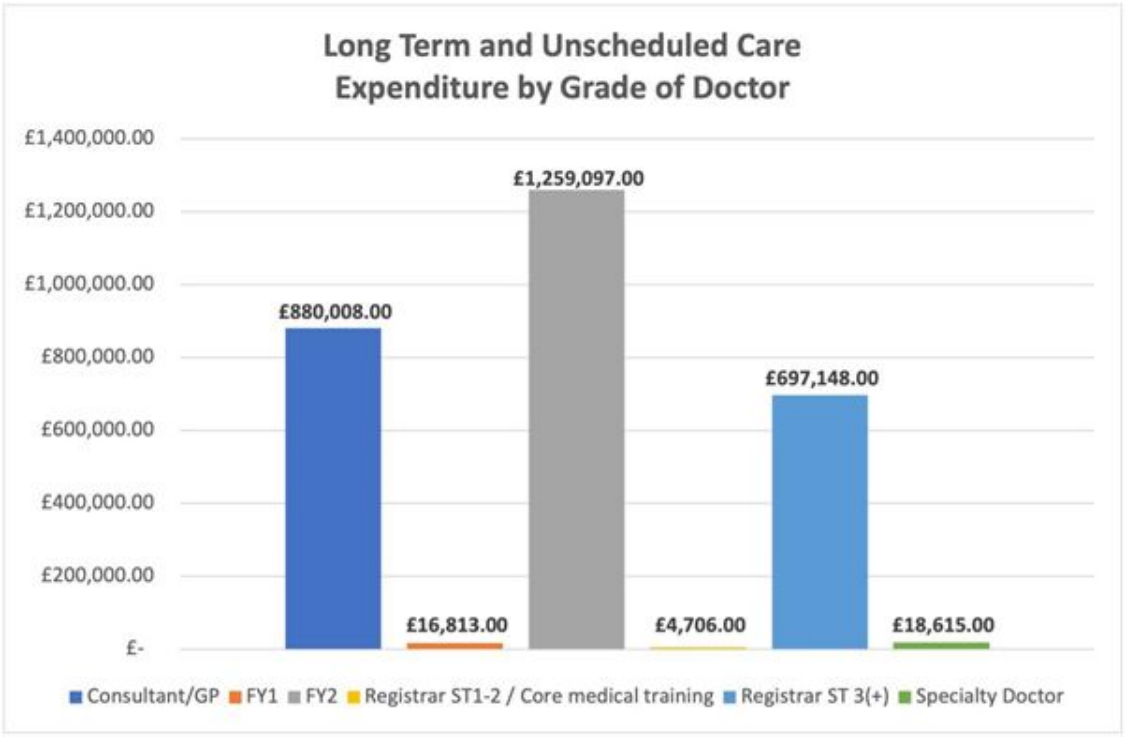
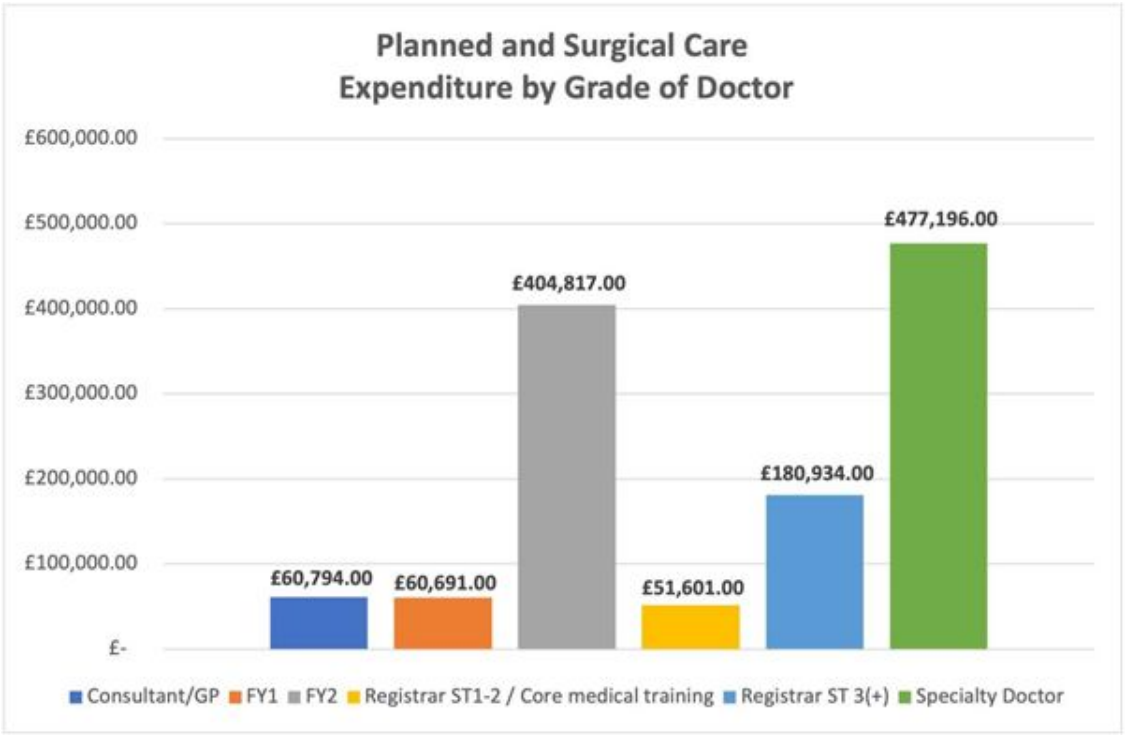
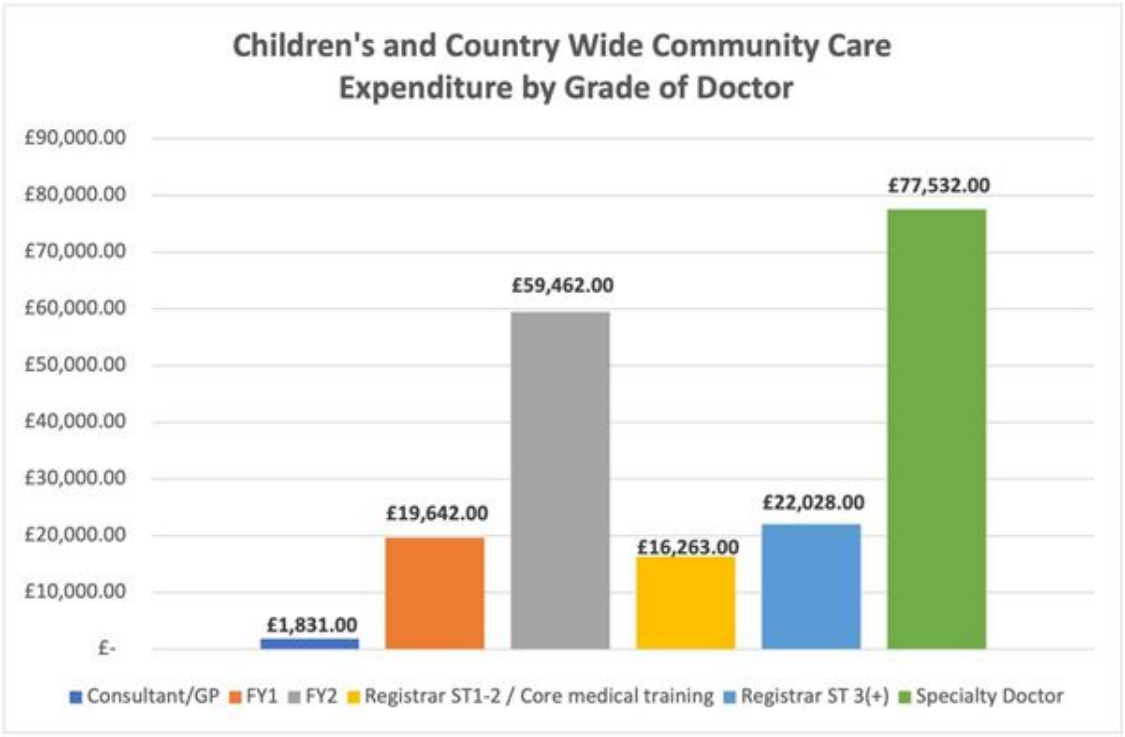
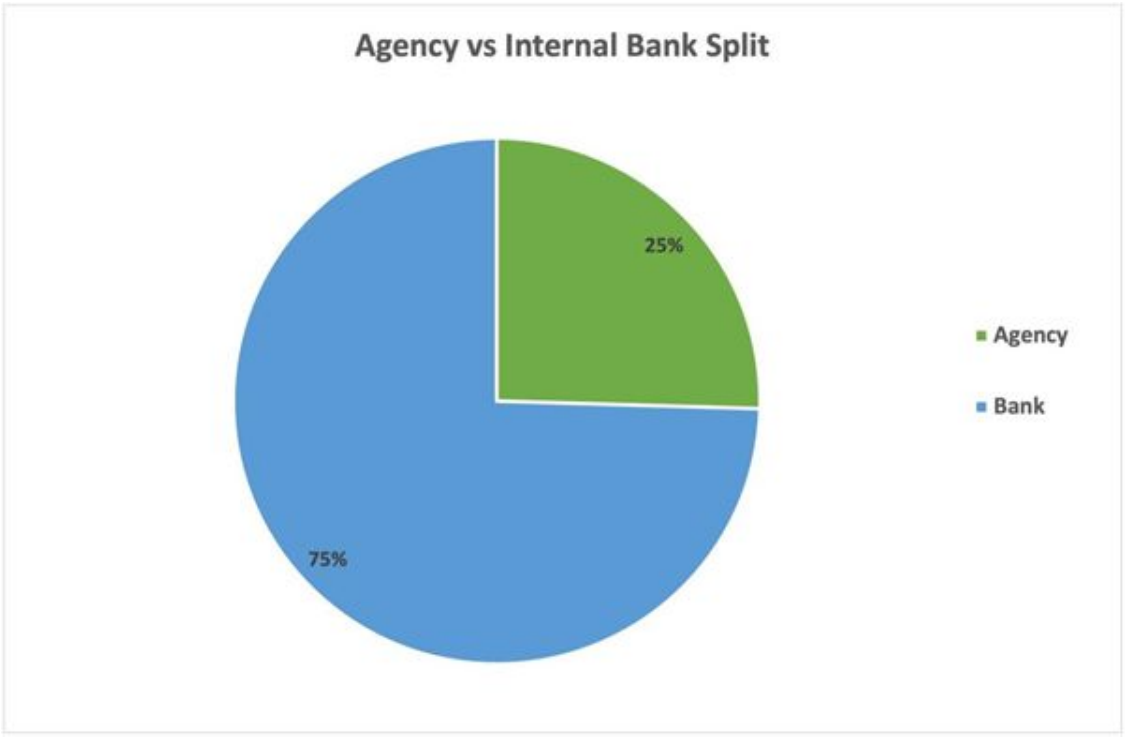
£1,800,000.00
£1,600,000.00
£1,400,000.00
£1,200,000.00
£1,000,000.00
£800,000.00
£600,000.00
£400,000.00
£200,000.00
£-
£942,704.00
£97,146.00
£1,725,997.00
£72,641.00
£901,101.00
£573,343.00
Grade of Doctor
Consultant/GP
FY1
FY2
Registrar ST1-2 / Core medical training
Registrar ST 3(+)
Specialty Doctor


Long Term and Unscheduled Care
Expenditure by Grade of Doctor
£1,400,000.00
£1,200,000.00
£1,000,000.00
£800,000.00
£600,000.00
£400,000.00
£200,000.00
£-
£880,008.00
£16,813.00
£1,259,097.00
£4,706.00
£697,148.00
£18,615.00
Consultant/GP
FY1
FY2
Registrar ST1-2 / Core medical training
Registrar ST 3(+)
Specialty Doctor


Planned and Surgical Care
Expenditure by Grade of Doctor
£600,000.00
£500,000.00
£400,000.00
£300,000.00
£200,000.00
£100,000.00
£-
£60,794.00
£60,691.00
£404,817.00
£51,601.00
£180,934.00
£477,196.00
Consultant/GP
FY1
FY2
Registrar ST1-2 / Core medical training
Registrar ST 3(+)
Specialty Doctor


Children's and Country Wide Community Care
Expenditure by Grade of Doctor
£90,000.00
£80,000.00
£70,000.00
£60,000.00
£50,000.00
£40,000.00
£30,000.00
£20,000.00
£10,000.00
£-
£1,831.00
£19,642.00
£59,462.00
£16,263.00
£22,028.00
£77,532.00
Consultant/GP
FY1
FY2
Registrar ST1-2 / Core medical training
Registrar ST 3(+)
Specialty Doctor



5.4 SDEC / SAU

As mentioned in the January report, there had been concerns from the Junior Doctors over a proposed move away from SDEC and onto a separate SAU, on Littondale. 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 prior to the proposed changes. At the time of submitting my last report the move had not taken place and was scheduled for "the spring".

SDEC became SAU on 16th January. The suddenness of this change led to a flurry of concerning exception reports, including some stating they had immediate patient safety concerns. In response, a meeting was held to discuss things, attended by the 11 FY doctors (including those on nights attending via MS Teams), Directorate management (Service manager and Operational Director), Director of Medical Education, Guardian of Safe Working, Group Clinical Lead for Surgery and both Foundation Training Program Directors.

Summarised feedback from the initial meeting (1st February):

- Very poor communication around SAU opening, first the FY1s knew about the change was an hour after they were supposed to be working on there. Expectation had been much later in Spring after much more organisation.
- Concerns raised over lack of preparation for the move:
    - Not enough trolleys (3 instead of 6).
    - No phone (for 2 weeks).
    - No working computer.
    - No cross skilling of nursing staff (limited experience with very different demands of admission/discharge area vs ward care)
    - No clerical support – SDEC has somebody to meet/admit patients, request notes, write name on board but SAU doesn't.

- Referrals process – no mechanism to keep track of referred patients from multiple streams (GP, ART, ED). No single person who is aware of all the referrals. GPs ringing SDEC and the SDEC nursing staff (medical) were accepting everybody. This resulted in an incident with 16 patients being accepted to SAU, which has a capacity for 7 max.
- There was no single person responsible for accepting referrals, multiple processes accepting patients unaware of what had been accepted by other members of the team. i.e. it was impossible to know why a patient was there, who had referred them, who had accepted them or what the intended outcome was to be.
- ASCOM referrals only had an accept button, no reject button for inappropriate referrals.
- ED streaming patients directly to SAU (Clinical Lead had been assured this would never happen).
- No guidance or limits on when SAU would close for admissions – patients accepted at 5pm might not arrive until 7pm. Suggested last patient is accepted 6pm.
- Pharmacy – shuts at 2pm at weekends, SAU essentially open until 8pm. Need a dispensing service from ward stock.
- No consistent Clinical Support Worker rostered. Whilst manageable when quiet, this quickly becomes an issue when the workload spikes and this becomes a safety concern.

Whilst several months later, a lot of these issues have been addressed some are still on going and exception reports continue to be submitted at a higher-than-expected rate, as detailed above. Concerns still exist as to the proper functioning of the SAU and measures are still required to prevent a re-visit by NHSE-WTE (NHS England – Workforce, Training and Education - formally HEE). A planned Referral and Escalation SOP was recently approved at the Surgical Dept Meeting on May 9th, but as yet I have not had sight of this document (despite requests) so cannot comment on the proposed measures.

The previous feedback that SDEC/ SAU was missing an important component in senior support, readily available to make decisions has been addressed with a long-term locum SAS doctor in post from 28/04/23 until 28/07/23. This should be a very welcome improvement. Hopefully during this time a permanent solution can be decided upon.

To briefly summarise, the less than perfect implementation of the move to SAU was damaging in the way it alienated the junior doctor workforce – who felt aggrieved that their concerns had been ignored again. Significant progress has been made in correcting these issues, and the rotation of new FY1s in April who have not worked through the changeover time are able to look at the workings of SAU with a clear perspective.

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 21 reported breaches of the TCS of the new contract caused by the Trust. A Full breakdown of fines is available upon request.

There are plans for some funds to be spent to improve junior doctor wellbeing with improvements to provision within the Doctor's Mess.

Fine number	Directorate	Total Amount	Amount within GOSW Fund
19	LTUC	£ 87.17	£ 54.49
20	PSC	£ 150.64	£ 94.16
21	PSC	£ 150.64	£ 94.16
TOTAL		**£ 3064.67**	**£ 1,915.66**
TOTAL DISBURSED			**£ -**
REMAINING BUDGET			**£ 1,915.66**

7.0 Meetings

There has been one regional meeting of Guardians in this Quarter. This was the first face-to-face meeting since the start of the Covid19 Pandemic. To date, there has been no plan announced for a national meeting.

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, discussions about the impact on training and progression due to time-out-of-training as a result of industrial action was a concern for most. There is a theoretical point of 20 days, after which satisfactory performance at ARCP (annual review) is not guaranteed. This was discussed at the regional Guardian's meeting and the feedback was that this was likely to be "flexed" to 30 days, as was previously done during the COVID-19 pandemic to prevent the participation in industrial action from impacting training.

There remains concern at high level within NHSE-WTE 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 NHS England – Workforce, Training and Education 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 NHSE-WTE.

NHSE - WTE 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.

Changes to reporting structure – reporting to the people and culture committee rather than the trust board directly – fails to satisfy the requirement of NHS Employers for the Guardian to have direct access to the trust board. I have previously made clear that I do not support the change for these reasons, and this has been confirmed by external NHS auditors. It remains my belief as Guardian, that the report should be presented directly to the board as it was prior

to the changes in January 2023 this would prevent the message being lost in transcription and allow for more meaningful discussion around the points raised.

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. The reasons given as to why the SAS doctors are not being afforded this ability is in part due to the complexity of their working patterns and the requirement to use a system separate to the DRS system utilised by the junior doctors. It is also felt that SAS doctors are "likely to be more comfortable reporting concerns via other mechanisms".

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 and be renumerated accordingly, 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 two quarters.
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.
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 despite ongoing work with supervisor training.
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 clinical 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 Board of Directors

a) The board is asked to receive the report of Q4 2022/23 and part of Q1 2023/24 to consider the assurances provided by the Guardian.
b) The Guardian asks the board to consider again where this report should go for discussion considering the findings from our NHS auditors.
c) The issues around persistent overworking of juniors outlined in this report are now a significant concern and urgent action is still needed by directorate management teams.
d) Significant pressure on staffing is currently being felt across the organisation and remains concerning.
e) 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.
f) 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 6%.

Dr Matthew Milsom

Guardian of Safe Working Hours

17th May 2023

Integrated Board Report - April 2023

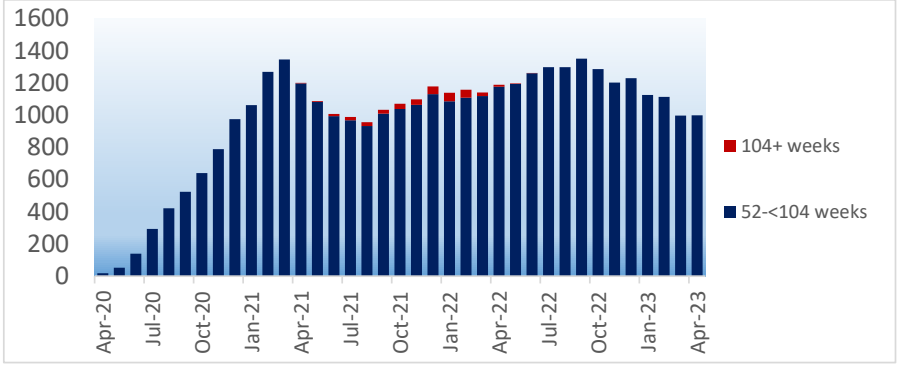
Domain 5 - Responsive

Indicator	**5.1 - RTT Incomplete pathways - 52+ weeks**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Apr-23
Value / RAG rating	998

Indicator description

The number of incomplete pathways waiting over 52 weeks.

Trend chart



Narrative

The overall RTT waiting list increased in April to 25,951 (25,504 last month). The industrial action by junior doctors had an impact on our delivery of both outpatients, elective day cases and endoscopy which impacted on pathway closures in April.

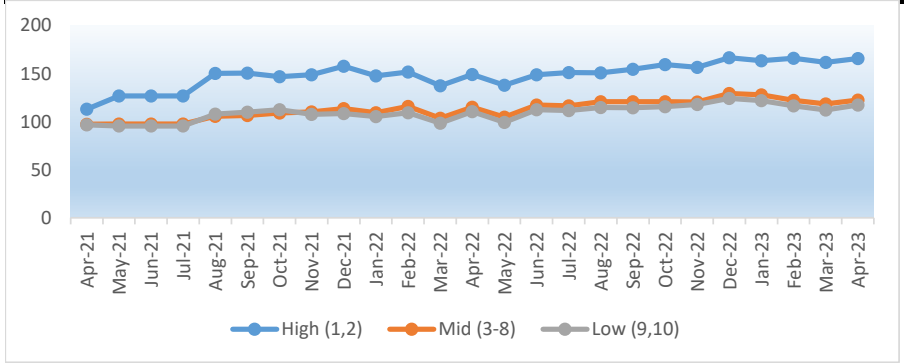
The focus on clearing the longest waiters continues and we currently report zero over 78 weeks. At the end of April, there are 5 patients delayed beyond 78 weeks due to patient choice. The number of patients waiting over 65 weeks was 202, significantly below the plan of 470. The Trust continues to report zero 104+ week waits.

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

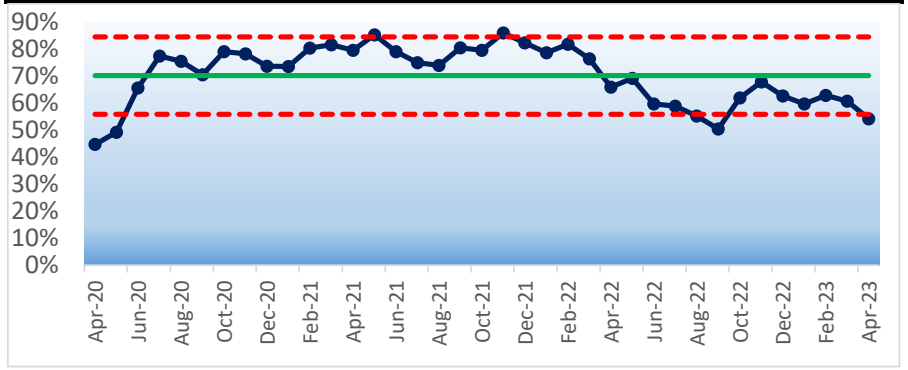
Work also continues in improving the recording of ethnicity and use of the learning disabilities flag across our clinical systems (this will improve further with the reinstatement of patient kiosks).

Indicator	**5.3 - Diagnostic waiting times - 6-week standard**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Apr-23
Value / RAG rating	54.2%

Indicator description

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

SPC chart



Narrative

Performance aganist the 6-week standard slightly deteriorated this month. The main areas of concern continue to be DEXA scans (large numbers compared to weekly activity) and CT(issues with scanner resilience). Whilst the number of patients waiting longer than 6 weeks has grown the total numbers waiting by modality have generally reduced (see below - last month's position in brackets):

- 1,039 DEXA (1,058) - Total waiting reduced by 19
- 396 CT (423) - Total waiting reduced by 74
- 226 audiology (190) - Total waiting increased by 10
- 199 MRI (179) - Total waiting reduced by 41
- 185 colonoscopy (123) - Total waiting reduced by 181
- 170 gastroscopy (113) - Total waiting reduced by 86

Indicator	**5.5 - Data quality on ethnic group - inpatients**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Apr-23
Value / RAG rating	90.5%

Indicator description

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

SPC chart

Narrative

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

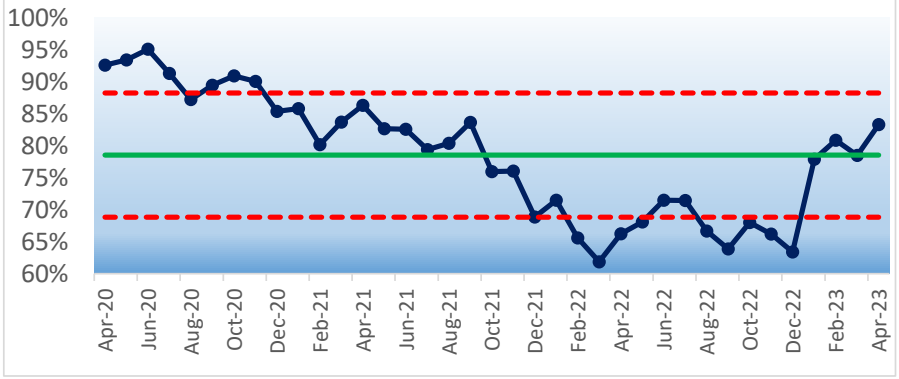
- Made contact with the lead at Central London Community NHS Trust (CLCH) who have improved their ethnicity recording rates on their patient records – they are organising a webinar to talk through their actions
- Reminded staff of the process regarding the collection of this data including reception staff aware that they should be collecting ethnic category, if not already there, as part of the demographic check.
- Progress of new Kiosks – previously electronic check in kiosks included a step to complete / update ethnic category. Removed as a result of COVID, awaiting new kiosks to re-introduce process. New kiosks are now ordered and expect to be implemented end of Q2 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	Apr-23
Value / RAG rating	83.3%

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). From April 2023, the operational standard is now 76%.

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:

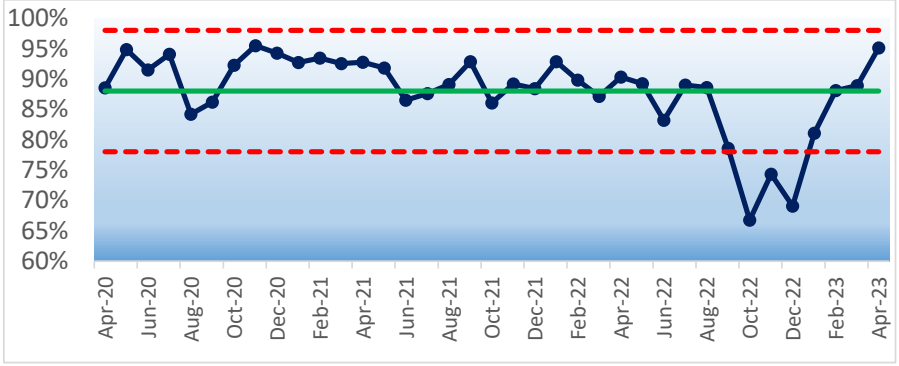
- delivering 7 day SDEC service and a direct to SDEC pathway with YAS;
- streaming of minors at the front door (now in place);
- utilising Criteria to Reside flow software to identify patients no longer requiring hospital care;
- developing a 2 hour crisis response service, expanding ARCH in-reach to 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;(project commenced)
- criteria led discharge implementation;
-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	Apr-23
Value / RAG rating	95.1%

Indicator description

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

SPC chart



Narrative

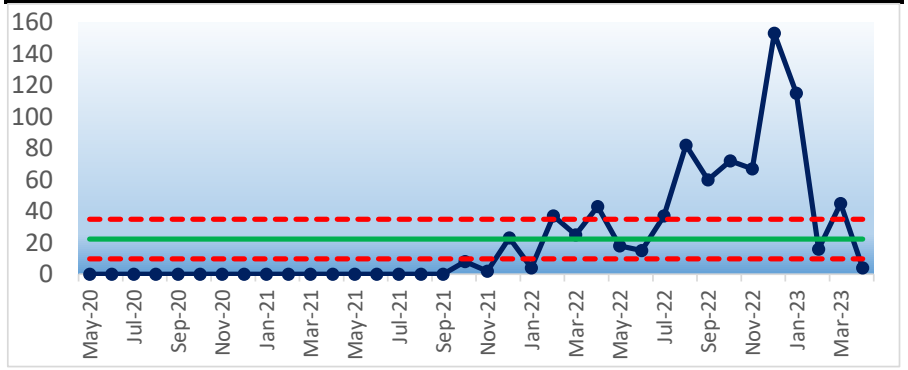
95% of ambulance handovers took place within 15 minutes in April, a continued improvement on recent months. There were no over 30-minute handover breaches in April, a significant improvement. Prevention of ambulance handover delays continues to be a focus with the Trust operational processes being shared 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	Apr-23
Value / RAG rating	4

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

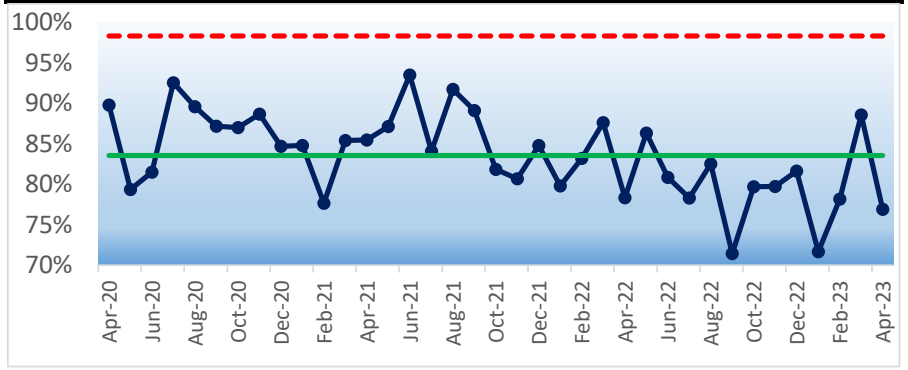
4 over 12 hour trolley waits were reported in April, a significant improvement on recent months. RCAs have commenced and will be reviewed at internal quality and performance meetings.

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	Apr-23
Value / RAG rating	76.9%

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 April (76.9%). There were 71.5 accountable treatments (76 patients) in April with 55.0 accountable treated within 62 days. Of the 10 accountable tumour sites treated in April, performance was below 85% for all apart from Skin (97.2%).

Provisional data indicates that 10% (1/10) of patients treated at Tertiary centres in April were transferred for treatment by day 38, compared to 45% (9/20) last month.

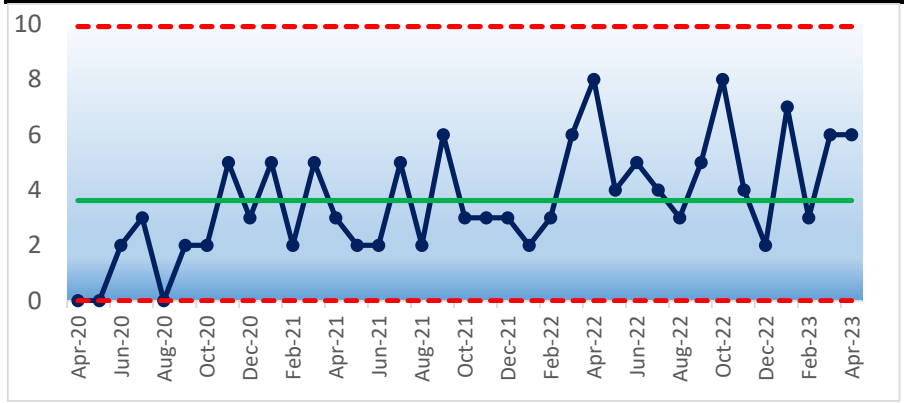
The latest published provisional data reports that national performance for the 62 day standard for all providers was at 63.5% in March. Of 141 providers, HDFT was the 10th best performing Trust. 118 of these providers had 50 or more accountable treatments, and of these, HDFT was the 3rd best peforming 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	Apr-23
Value / RAG rating	6

Indicator description

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

SPC chart



Narrative

6 patients waited 104+ days for treatment in April, all treated at Leeds (2 x York Head and Neck; 1 x Leeds Upper GI; 1 x HDFT Colorectal; 1 x HDFT Prostate; 1 x HDFT renal). The delay reasons were as follows:

- Head and Neck: Complex pathways
- Upper GI: Complex pathway
- Colorectal: Complex and radiology capacity for stent
- Prostate: Outpatient capacity for first apppointment and complexity
- Renal: Complex pathway

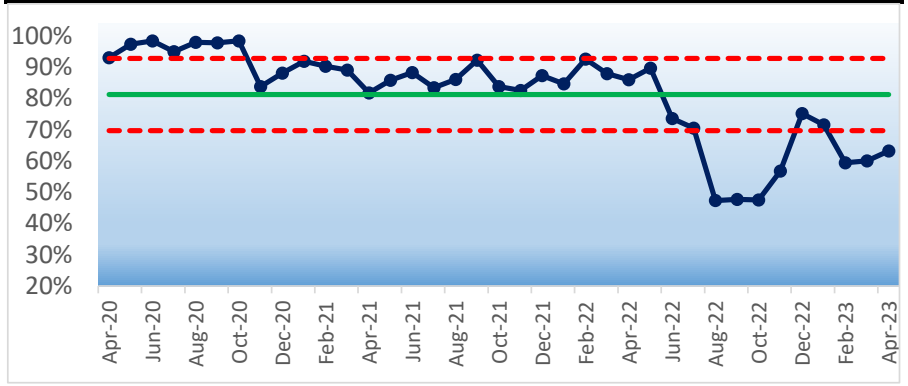
All patients have now received treatment. Following the implementation of a new cancer system in October (Somerset Cancer Registry) and the time constraints on the tracking team, it has been agreed to stand down breach panel meetings until further notice.

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	Apr-23
Value / RAG rating	63.1%

Indicator description

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

SPC chart



Narrative

928 patients attended their first appointment for suspected cancer in April which is a 24.6% decrease on last month (1,230). Of the 928 patients seen in April, 342 were seen outside 14 days (63.1%). 14 day capacity continues to be challenging in April with 9 suspected cancer sites below the 93% standard, and 2 sites less than 60% (Breast - 5.6%; Colorectal - 55.8%). Non-cancer breast symptomatic performance was at 6.8%. Dermatology performance further improved in April compared to last month (47.4% vs 84.4%) but is still below the 93% standard.

The latest published provisional data reports that national performance for the 2WW suspected cancer standard for all providers was at 83.9% in March. Of 141 providers, HDFT was the 7th worst performing Trust. 124 of these providers had 500 or more first attendances, and of these, HDFT was the 7th worst performing Trust.

The cancer away day took place in April with 4 key tumour site teams in attendance - significant progress was made of action plans to improve performance and patient experienc in the pathways. Improvement is expected over the next 3 months.

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	Apr-23
Value / RAG rating	66.9%

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

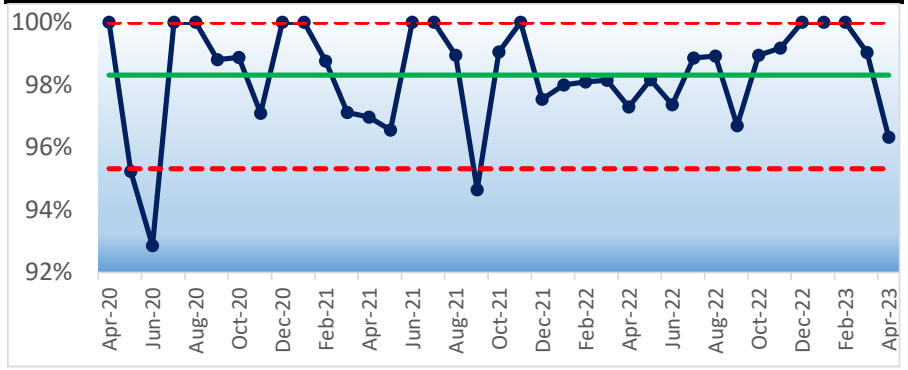
Provisional data indicates that in April combined performance for the three 28 days standards (2WW suspected cancer, 2WW non-cancer breast symptoms, Screening) continued to be below the proposed operational standard of 75% at 66.9% (2WW cancer – 70.6%; 2WW Breast Symptoms – 95.7%; Screening – 12.6%). This is a slight deterioration on last month (67.3%) although it should be noted that at this stage in the month data collection for April will not be complete.

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	Apr-23
Value / RAG rating	96.3%

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 109 patients received First Definitive Treatment for cancer at HDFT in April, with 4 patients treated outside 31 days (2 x Colorectal; 2 x Skin). The delay reasons were as follows:

- Colorectal: 1 x Elective capacity; 1 x radiology capacity for stent
- Skin: 1 x patient with 2 cancers - outpatient capacity

Overall performance was above the expected standard of 96%.

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

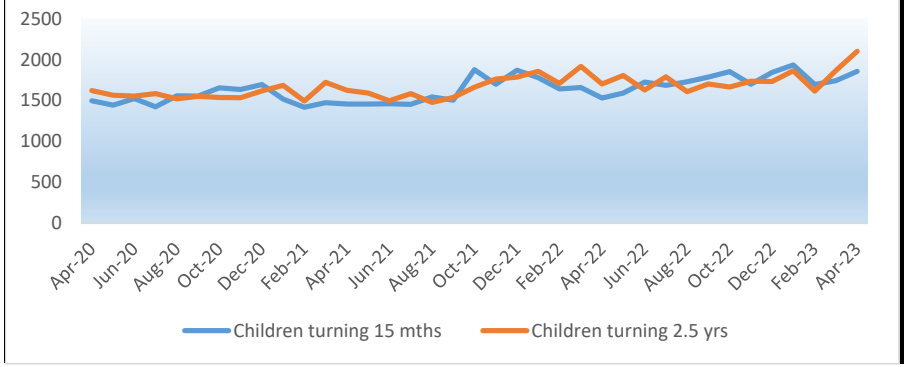
Indicator description

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 increased in April. Data for Wakefield 0-19 Services is included for the first time this month.

SPC chart



Indicator	**5.14 - Children's Services - Safeguarding caseload**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Apr-23
Value / RAG rating	1148

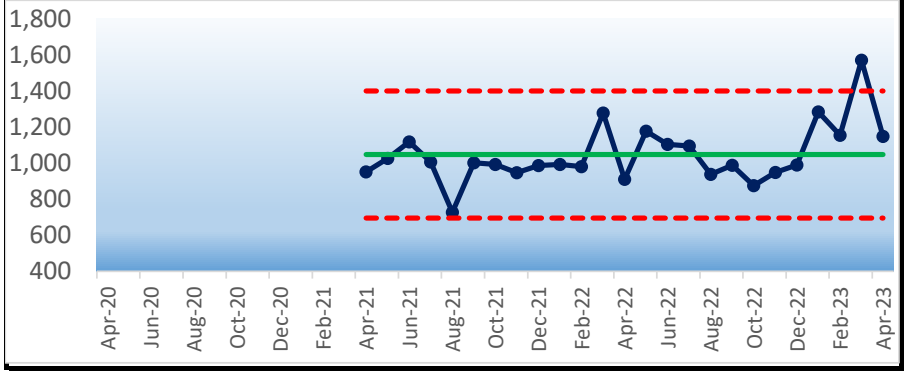
Indicator description

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

Narrative

The chart shows the number of Child Protection strategies as an estimate for Safeguarding caseload. Data for Wakefield 0-19 Services is included for the first time this month.

SPC chart



Indicator	**5.15 - Children's Services - Ante-natal visits**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Apr-23
Value / RAG rating	91.5%

Indicator description

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

Narrative

92% of eligible pregnant women received an initial antenatal visit in April. Data for Wakefield 0-19 Services is included for the first time this month.

SPC chart

Indicator	**5.16 - Children's Services - 10-14 day new birth visit**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Apr-23
Value / RAG rating	95.5%

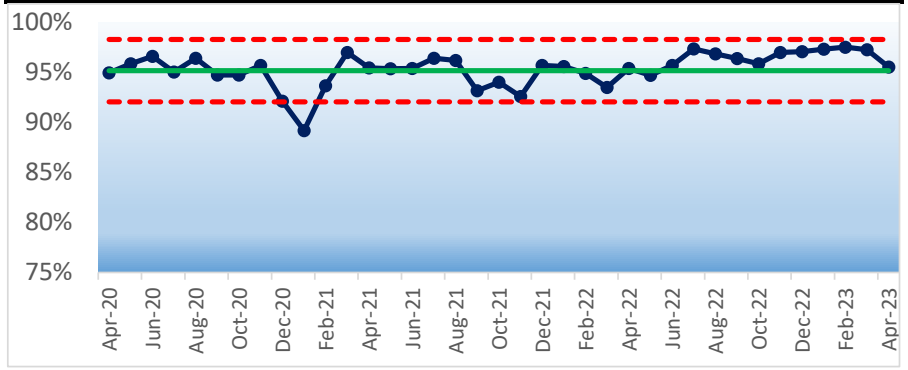
Indicator description

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

Narrative

96% of infants received a new birth visit within 10-14 days of birth during April. Data for Wakefield 0-19 Services is included for the first time this month.

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	Apr-23
Value / RAG rating	93.7%

Indicator description

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

Narrative

94% of infants received a 6-8 week visit by 8 weeks of age during April. Data for Wakefield 0-19 Services is included for the first time this month.

SPC chart

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

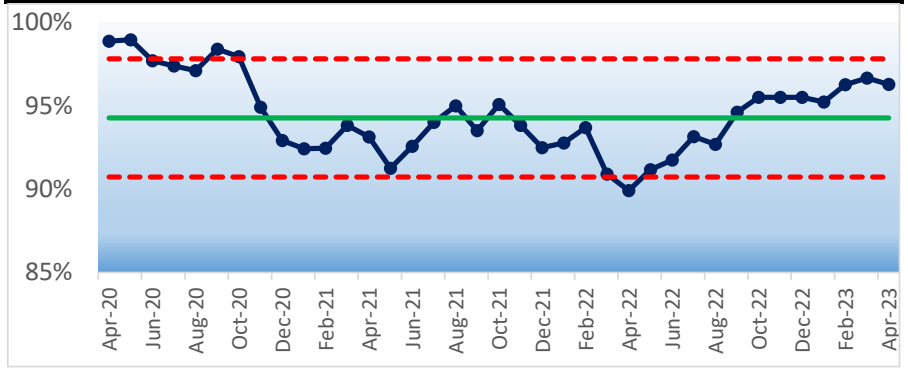
Indicator description

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 April.
Data for Wakefield 0-19 Services is included for the first time this month.

SPC chart

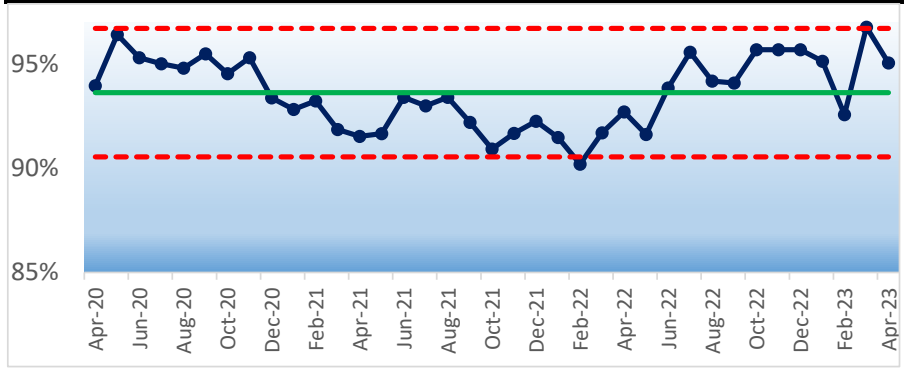


Indicator	**5.19 - Children's Services - 2.5 year review**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Apr-23
Value / RAG rating	95.0%

Indicator description

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

SPC chart



Narrative

95% of eligible children received a 2 - 2.5 year review by 2.5 years of age during April. Data for Wakefield 0-19 Services is included for the first time this month.

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	**5.22 - 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 April was:
Acute Paediatrics - Level 1
Darlington - Level 2
Durham - Level 3
Gateshead - Level 1
Immunisation DDT - Level 2
Immunisation NY - Level 2
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 2022, 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 April 2023.

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	3

Indicator description

This indicator is under development.

SPC chart

Narrative

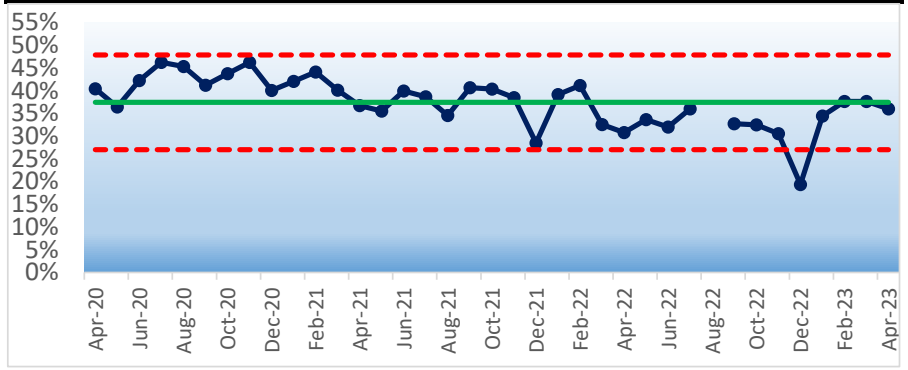
CC Directorate have started to discuss and record OPEL levels for Adult Community Services at their Safety and Governance huddles. The overall position for April remained at level 3.

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	Apr-23
Value / RAG rating	36.0%

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.

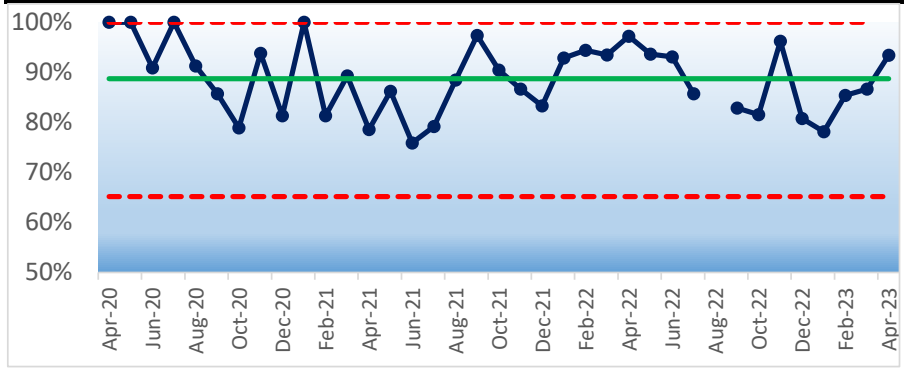
In April, 36% of urgent cases received a telephone clinical assesment within 20 minutes of call prioritisation, a reduction on last month.

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	Apr-23
Value / RAG rating	93.4%

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 April, 93% of urgent cases received a home visit within 2 hours, an increase on the previous month.

Integrated Board Report - April 2023

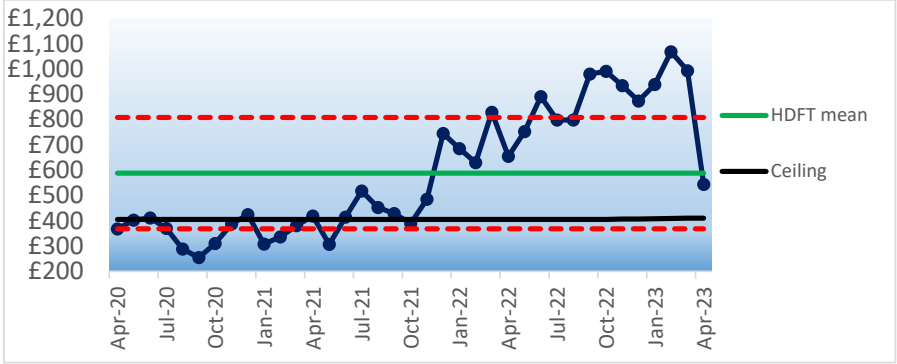
Domain 6 - Efficiency and Finance

Indicator	**6.1 - Agency spend**
Executive lead	Jordan McKie, Finance Director
Board Committee	Resources Committee
Reporting month	Apr-23
Value / RAG rating	£544

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

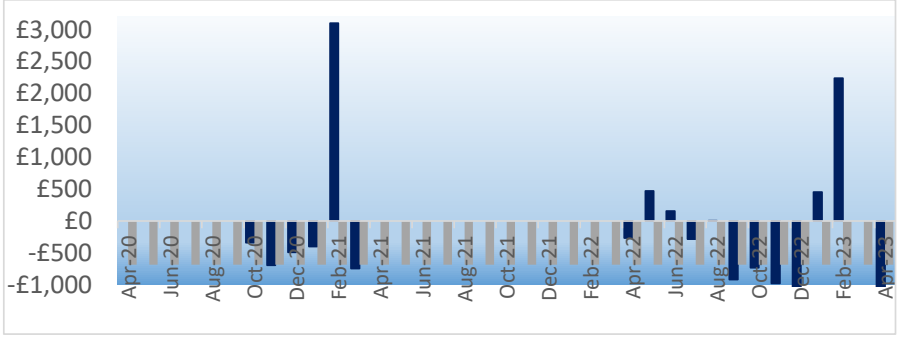
Month 1 expenditure on agency is £544k. This is £200k below plan mainly due to an adjustment relating to last year which has since reversed in month. Agency spend is being monitored via the directorate performance review meetings.

Indicator	**6.2 - Surplus / deficit and variance to plan**
Executive lead	Jordan McKie, Finance Director
Board Committee	Resources Committee
Reporting month	Apr-23
Value / RAG rating	-£1,650

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

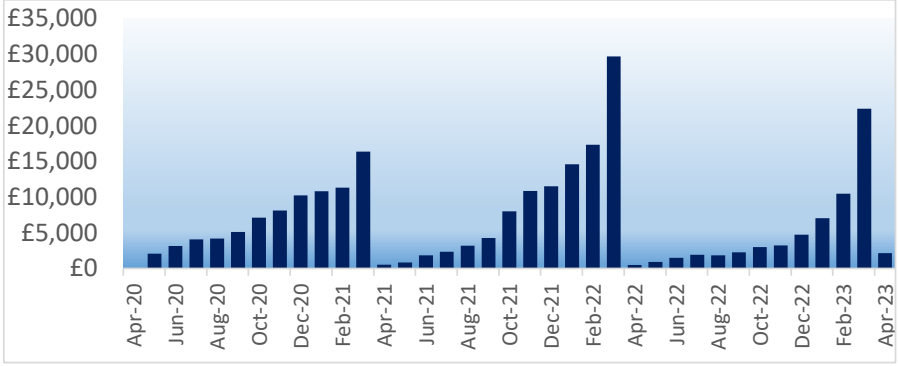
The reported position of £1.65k deficit in-month actual variance. This mainly reflects unachieved CIP including stretch targets set to support the system. There has also been one off pressures relating to back dated pay for waiting list initiatives and industrial action costs.

Indicator	**6.3 - Capital spend**
Executive lead	Jordan McKie, Finance Director
Board Committee	Resources Committee
Reporting month	Apr-23
Value / RAG rating	£2,158

Indicator description

Cumulative Capital Expenditure by month (£'000s)

Trend chart



Narrative

Capital spend is £350k in month 1. Plan currently profiled in 12ths and work is ongoing to understand expected commencement and completion of planned projects. Plan will be re-profiled following this exercise. It is anticipated that most of the spend will be in the latter half of the year.

Indicator	**6.4 Cash balance**
Executive lead	Jordan McKie, Finance Director
Board Committee	Resources Committee
Reporting month	Apr-23
Value / RAG rating	£35,645

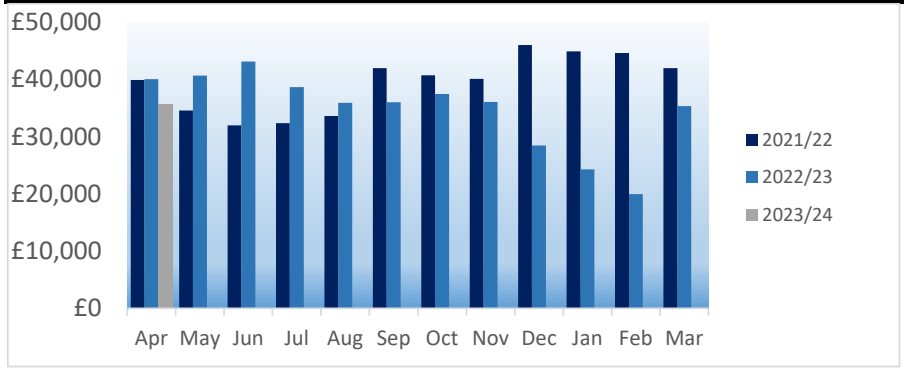
Indicator description

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

Narrative

Trust continues to maintain a positive cash balance.

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	Apr-23
Value / RAG rating	118

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

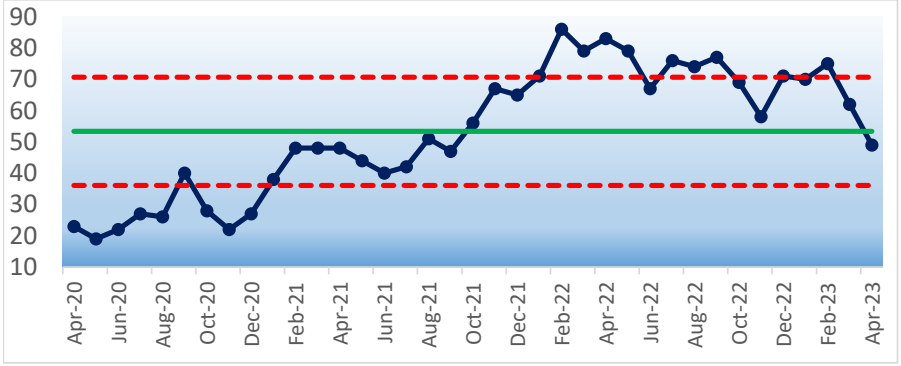
The number of long stay patients (> 7 days) was 118 in April, a continued reduction on recent months.

Indicator	**6.5.2 - Long stay patients - superstranded (>21 days LOS)**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Apr-23
Value / RAG rating	49

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

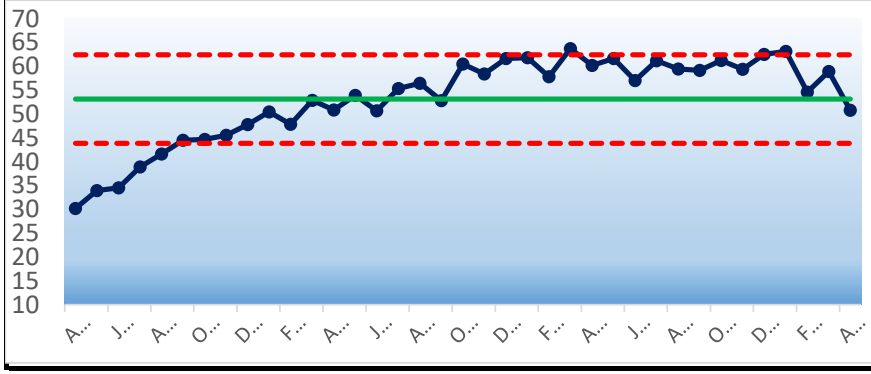
The number of long stay patients (> 21 days) was 49 in April, a continued reduction on recent months.

Indicator	**6.6 - Occupied bed days per 1,000 population**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Apr-23
Value / RAG rating	50.8

Indicator description

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

SPC chart



Narrative

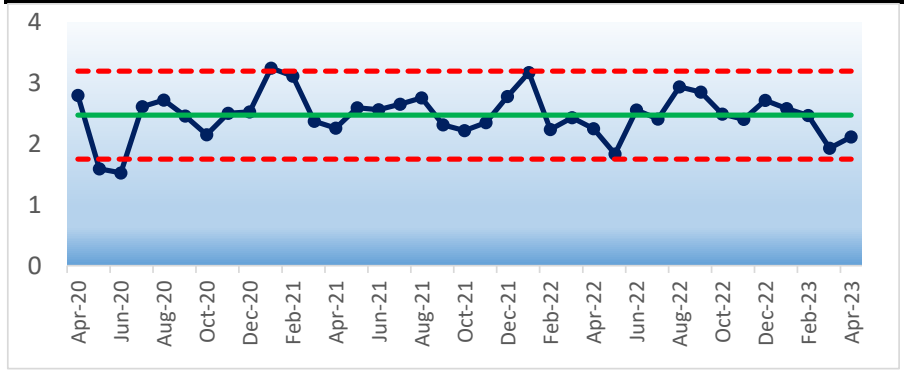
Occupied bed days per 1,000 population were at 50.8 in April, a reduction on recent months. In the 2 years prior to the pandemic, occupied bed days per 1,000 population averaged 57.8, above the current level.

Indicator	**6.7.1 Length of stay - elective**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Apr-23
Value / RAG rating	2.12

Indicator description

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

SPC chart



Narrative

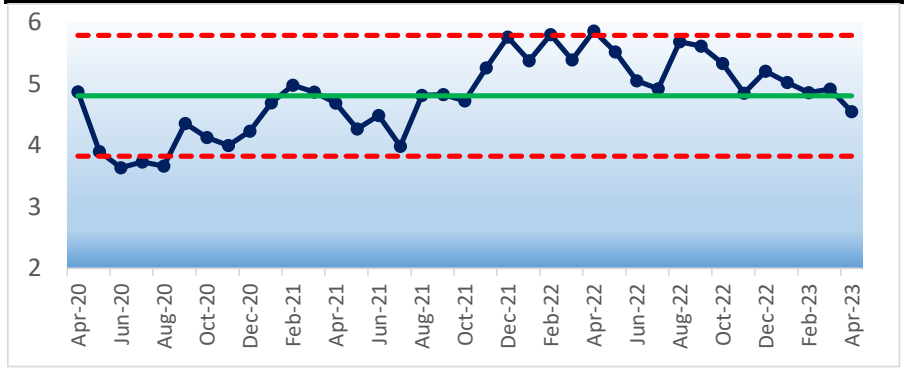
Elective length of stay increased in April but remains below our local stretch target of 2.5 days.

Indicator	**6.7.2 Length of stay - non-elective**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Apr-23
Value / RAG rating	4.55

Indicator description

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

SPC chart



Narrative

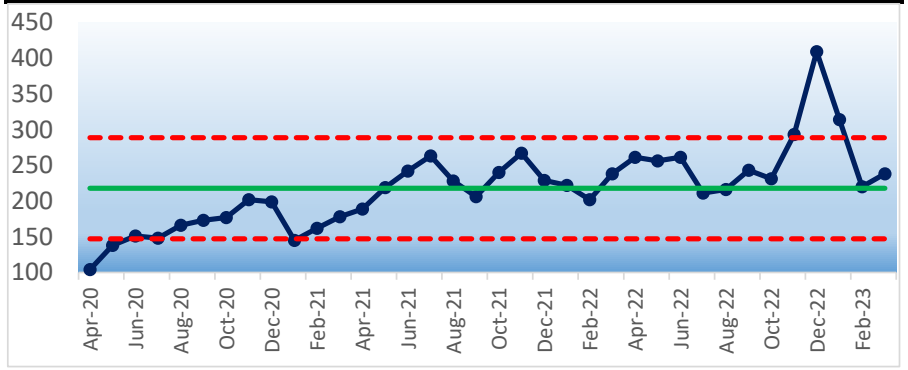
Non-Elective length of stay was 4.6 days in April, a reduction but remaining above our local stretch target. There is a combination of factors affecting patient flow as described in indicators 6.5.1 - 6.7.1. Primarily driven by high numbers of patients remaining with no criteria to reside and patient 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	Mar-23
Value / RAG rating	238

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 238 avoidable admissions in March, within expected levels and a reduction on the winter months. The most common diagnoses were unrinary tract infections and pneumonia. Excluding children and admissions to SDEC, the February figure was 158.

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

Indicator	**6.9 - Theatre utilisation (elective sessions)**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Apr-23
Value / RAG rating	81.2%

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

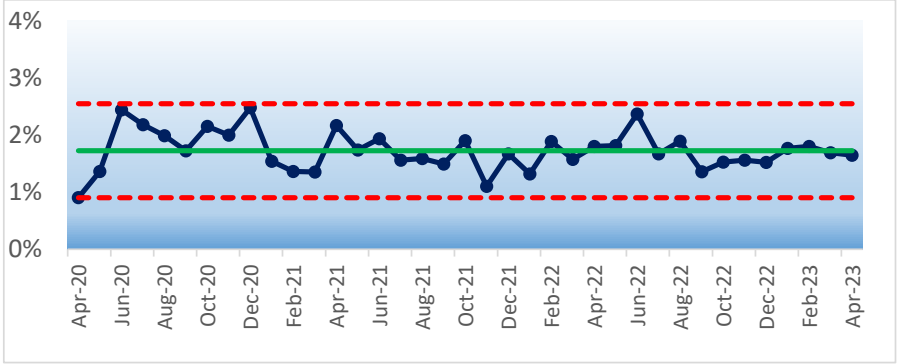
Theatre utilisation was at 81.2% in April, remaining below the local intermediate target of 90%. There is ongoing work across the board but focussed initial work with ophthalmology colleagues to understand how we achieve GIRFT productivity within HDFT. There remains an impact from Covid-19 causing late cancellations, as well as industrial action which impact upon utilisation.

Indicator	**6.10 - Day case conversion rate**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Apr-23
Value / RAG rating	1.6%

Indicator description

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

SPC chart



Narrative

1.6% (36 patients) of intended day cases stayed overnight or longer in April, remaining within the control limits.

Integrated Board Report - April 2023

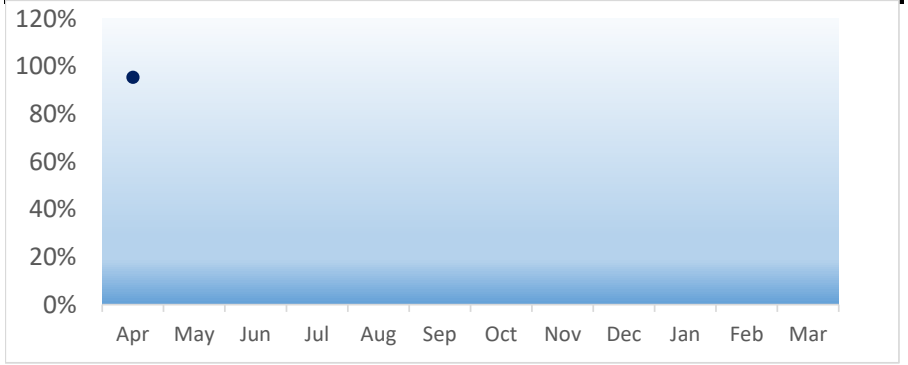
Domain 7 - Activity

Indicator	**7.1 - GP referrals against 2019/20 baseline**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Apr-23
Value / RAG rating	95.4%

Indicator description

GP referrals against 2019/20 baseline.

SPC chart



Narrative

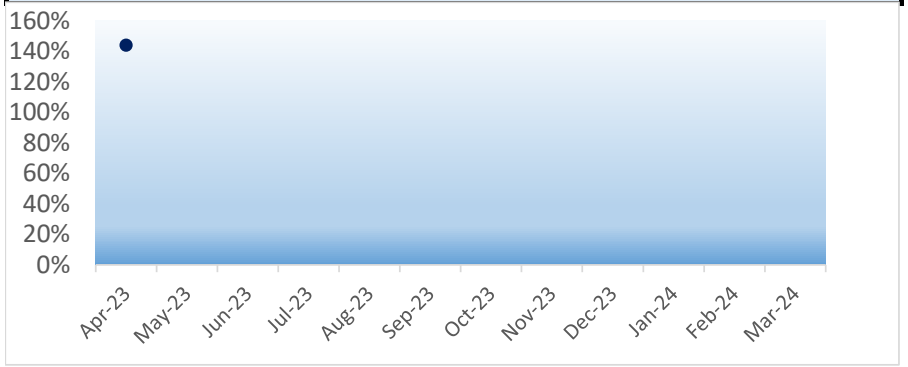
In March, GP referrals were 71% above level of the equivalent month in 2019/20 - the significant difference is due to the comparison with March 2020 which was at the start of the first wave of the pandemic. On a year to date basis, GP referrals are 11% above 2019/20.

Indicator	**7.2 - Outpatient activity (consultant led) against plan**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Apr-23
Value / RAG rating	144.0%

Indicator description

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

Trend chart



Narrative

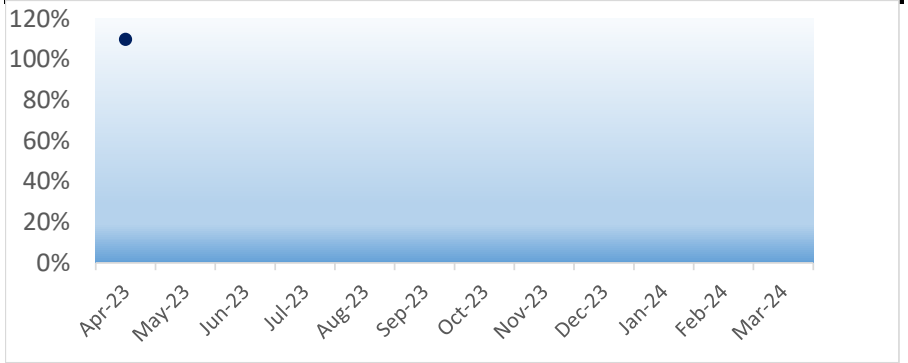
Outpatient activity was 17% above plan in March. New outpatient attendances were 11% above plan and follow up attendances were 20% above plan.

Indicator	**7.3 - Elective activity against plan**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Mar-23
Value / RAG rating	109.9%

Indicator description

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

Trend chart



Narrative

Elective admissions were 10% above plan in March. Elective day cases were 11% above plan and elective inpatients were 1% above plan.

Indicator	**7.4 - Non-elective activity against plan**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Mar-23
Value / RAG rating	106.9%

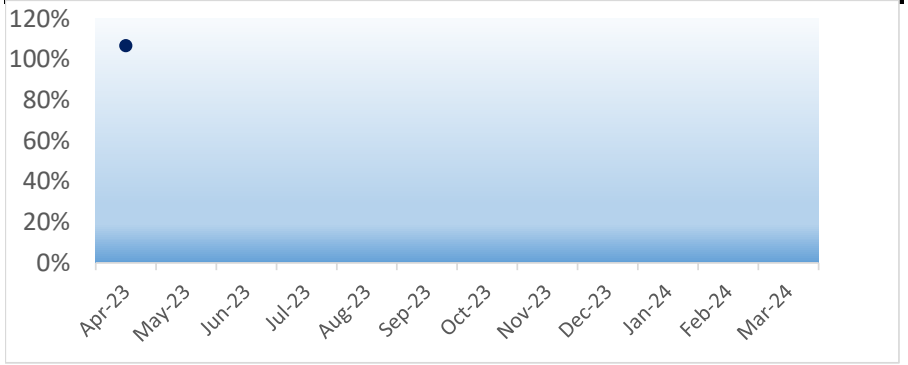
Indicator description

Non-elective activity against plan.

Narrative

Non-elective activity was 14% above plan in March.

Trend chart



Indicator	**7.5 - Emergency Department attendances against plan**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Mar-23
Value / RAG rating	103.1%

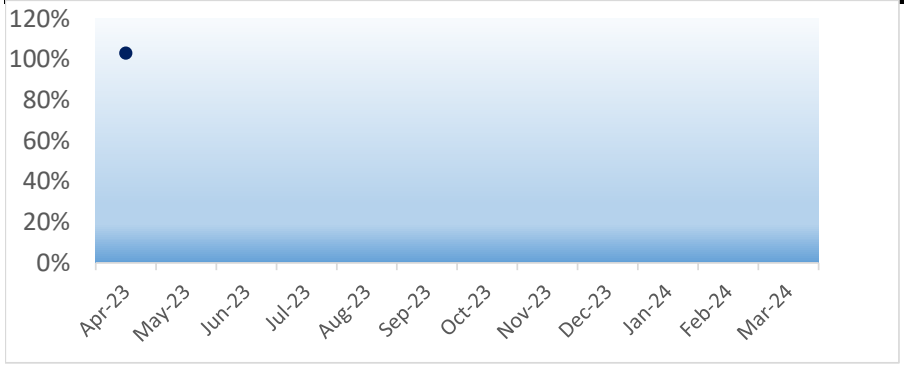
Indicator description

Emergency Department attendances against plan.

Narrative

Emergency Department attendances were 1% above plan in March.

Trend chart



Integrated Board Report - April 2023

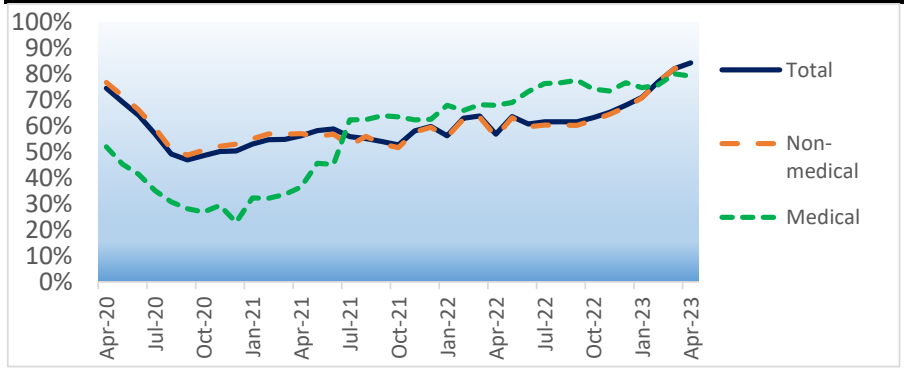
Domain 4 - Workforce

Indicator	**4.1 - Appraisal Rate - Non Medical and Medical Staff**
Executive lead	Angela Wilkinson
Board Committee	People and Culture Committee
Reporting month	Apr-23
Value / RAG rating	84.4%

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 combined overall appraisal rate in April has increased from 82.0% to 84.4%

- Non-Medical appraisal % = 84.8% (previous month 82.1%)
- Medical appraisal % = 79.3% (previous month 80.2%)

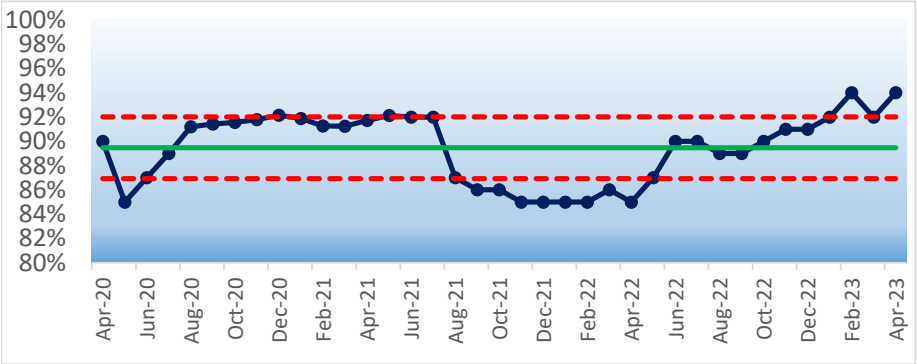
All clinical Directorates have appraisal rates above 84% in April, with LTUC seeing the greatest compliance of 87.1% this month. Corporate Services has the lowest compliance, with a rate of 74.8% in April, however the Directorate did see the greatest increase compared to the previous month, which was an increase of 5.5%.

Indicator	**4.2 - Mandatory and Essential Skills Training rate**
Executive lead	Angela Wilkinson
Board Committee	People and Culture Committee
Reporting month	Apr-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 Mandatory Core elements of training. The overall compliance rate for substantive Trust staff is 94% and has increased 2% since the previous month.

The Mandatory Core overall compliance for bank staff is now 81% and has remained the same since the previous month.

The overall compliance for Mandatory Core and Role Based Training for Trust substantive staff is currently 90%.

Indicator	**4.3 - Staff sickness rate**
Executive lead	Angela Wilkinson
Board Committee	People and Culture Committee
Reporting month	Apr-23
Value / RAG rating	4.6%

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 remained at a similar level in April. “Anxiety/stress/depression/other psychiatric illnesses” remains the top reason for sickness and contributes to 28.6% of the overall sickness. We continue to promote Occupational Health, EAP and Wellbeing Services to support staff.

With the exception of LTUC, sickness has decreased across all Directorates. CC Directorate remains at the highest sickness levels and has a rate of 5.4% in April. The services which have the greatest levels of sickness in April are ‘Children's Safeguarding’ and ‘Children's Services - North Yorkshire’, with sickness rates of 7.4% and 7.1% respectively.

Short term sickness has decreased in April from 2.2% to 2.0%, however long term sickness has increased from 2.4% to 2.5%.

Indicator	**4.4 Staff turnover rate**
Executive lead	Angela Wilkinson
Board Committee	People and Culture Committee
Reporting month	Apr-23
Value / RAG rating	15.1%

Indicator description

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

SPC chart

Narrative

Turnover has decreased in April to 15.1% from 15.4%. (This incorporates voluntary and involuntary turnover). Voluntary turnover has decreased from 12.1% last month to 11.9% in April.

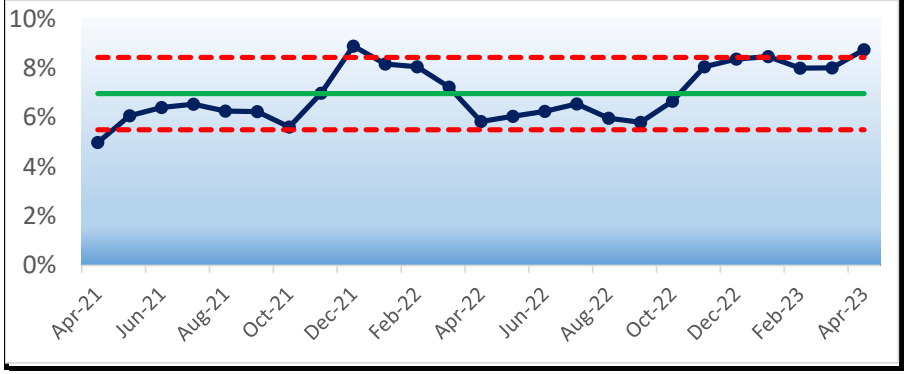
LTUC and PSC Directorates saw a decrease in turnover rates this month, with LTUC decreasing from 13.5% to 12.5% and PSC from 17.3% to 16.3%. Health Visitor turnover has seen a general increasing trend over the last year, with turnover increasing from 16.0% in May 2022 to 19.7% in April 2023. This staff group has a high proportion of staff in the upper age bands and 23.5% of this workforce is aged over 56 years, compared to 17.2% of the overall Trust workforce. Retirements are a significant factor within the Health Visitor turnover and contributes to 28% of the reasons for leaving in the last 12 months. This includes retire and returns. The 'Additional Clinical Services' staff group remains the staff group with the highest turnover rate, which is 18.0% in April, however this is a decrease from 18.6% in March.

Indicator	**4.5 - Vacancies**
Executive lead	Angela Wilkinson
Board Committee	People and Culture Committee
Reporting month	Apr-23
Value / RAG rating	8.7%

Indicator description

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

SPC chart



Narrative

The Trust's vacancy rate in April is 8.7%. This equates to 393.30wte vacancies.

LTUC Directorate has the highest vacancy rate, with a rate of 15.6% (209.45wte vacancies). The areas with the greatest vacancy rates are Bolton Ward (42.0%) and Byland Ward (35.4%).

Board of Directors (Public)
31 May 2023

Title:	Modern Slavery and Human Trafficking Annual Statement
Responsible Director:	Director of People and Culture
Author:	Director of People and Culture Deputy Director of People and Culture

Purpose of the report and summary of key issues:	The aim of this statement is to demonstrate that the Trust follows best practice and that all reasonable steps are taken to prevent slavery and human trafficking.	
Trust Strategy and Strategic Ambitions	**The Patient and Child First** Improving the health and wellbeing of our patients, children and communities	
	Best Quality, Safest Care	
	Person Centred, Integrated Care; Strong Partnerships	
	Great Start in Life	
	At Our Best: Making HDFT the best place to work	√
	An environment that promotes wellbeing	√
	Digital transformation to integrate care and improve patient, child and staff experience	
	Healthcare innovation to improve quality	
Corporate Risks		
Report History:	None	
Recommendation:	The Board is asked to note this report.	

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Modern Slavery and Human Trafficking Annual Statement

Harrogate and District NHS Foundation Trust is committed to ensuring that there is no modern slavery or human trafficking in any part of our business, including our supply chains.

The aim of this statement is to demonstrate that the Trust follows best practice and that all reasonable steps are taken to prevent slavery and human trafficking.

Policies relating to Modern Slavery

All members of staff have a personal responsibility for the successful prevention of slavery and human trafficking with the procurement department taking responsibility for overall compliance.

The Trust has internal policies and procedures in place that assess supplier risk in relation to the potential for modern slavery or human trafficking. The Trust's internal Safeguarding Adults Policy and Procedures supports our staff to identify and report concerns about slavery and human trafficking.

Our Speaking Up policy and procedures also provide supportive guidance for our employees to raise concerns about poor working practices.

Our People

We confirm the identities of all new employees and their right to work in the United Kingdom and pay all our employees above the National Living Wage.

Our Supply Chain

Our procurement senior team are all Chartered of Institute of Purchasing and Supply (CIPs) qualified and abides by the CIPs code of professional conduct. The procurement team follows the Crown Commercial Service standard and includes a mandatory exclusion question regarding the Modern Slavery Act 2015.

When procuring goods and services, we additionally apply NHS Terms and Conditions (for nonclinical procurement) and the NHS Standard Contract (for clinical procurement). Both require suppliers to comply with relevant legislation.

Our Performance

We know the effectiveness of the steps that we are taking to ensure that slavery and/or human trafficking is not taking place within our business or supply chain if:

No reports are received from our staff, the public, or law enforcement agencies to indicate that modern slavery practices have been identified.

Risks associated with this Act are managed in accordance with the Trust's Risk Management Policy.

Approval for this statement

This statement is made pursuant to section 54(1) of the Modern Slavery Act 2015 and constitutes the Harrogate and District NHS Foundation Trust slavery and human trafficking statement for the financial year ending 31 March 2023.

The Board of Directors has considered and approved this statement and will continue to support the requirements of the legislation.

Jonathan Coulter
Chief Executive

Board of Directors (Public)
31 May 2023

Title:	2022 National Staff Survey Results
Responsible Director:	Director of People and Culture
Author:	Deputy Director of People and Culture Senior Organisational Development (OD) Practitioner

Purpose of the report and summary of key issues:	This report provides a summary of the 2022 National Staff Survey results at an organisational level, outlines how the results have been disseminated across the organisation and identifies the key areas of focus for the organisation. The key areas of focus are: • Managing work-related stress • Line manager training • Health and wellbeing • Career progression • Appraisal – quality and impact The report also identifies some of the key actions that are underway against each of the key areas of focus.	
Trust Strategy and Strategic Ambitions	**The Patient and Child First** Improving the health and wellbeing of our patients, children and communities	
	Best Quality, Safest Care	
	Person Centred, Integrated Care; Strong Partnerships	
	Great Start in Life	
	At Our Best: Making HDFT the best place to work	x
	An environment that promotes wellbeing	x
	Digital transformation to integrate care and improve patient, child and staff experience	
	Healthcare innovation to improve quality	
Corporate Risks		
Report History:		
Recommendation:	The Board is asked to: • Note the 2022 National Staff Survey results; • Note the next steps being planned in response.	

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2022 National Staff Survey Results

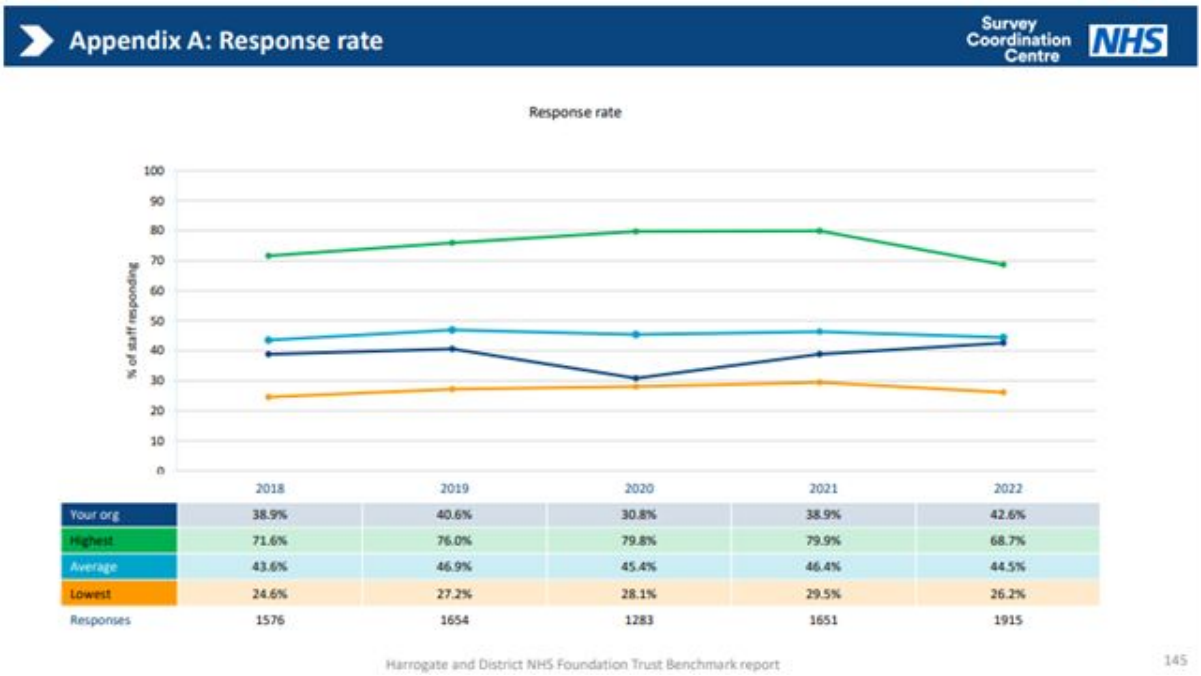
Table of Contents

The 2022 National Staff Survey results were released on 9 March 2023. A summary of our results is provided below. These have been benchmarked nationally against other combined Acute and Acute & Community Trusts and have been weighted by the Department of Health (DoH), for fair comparisons between organisations.

There were 124 organisations in our benchmarking group in 2022. With this group there were 431,292 completed questionnaires, with a median response rate of 44%.

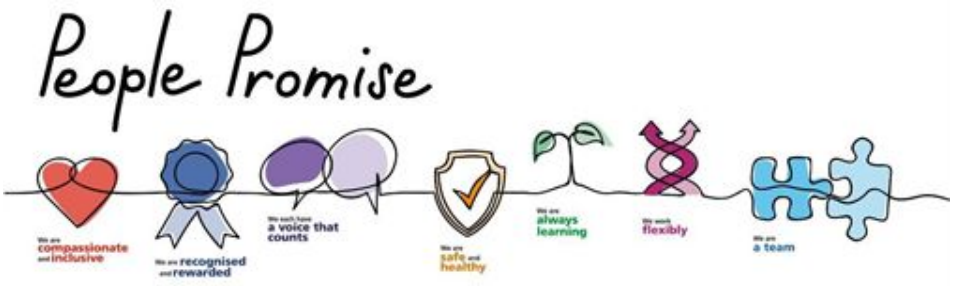
The full benchmarking report for HDFT can be found here: [Local results for every organisation | NHS Staff Survey (nhsstaffsurveys.com)]

Between 3 October and 25 November 2022 we surveyed a full census of our staff, employed as at 1 September 2022. 4,495 surveys were distributed to members of HDFT staff and 1,915 were completed, which represents a 43% response rate. This is our highest response rate in recent years and represents a significant increase since the start of the pandemic.



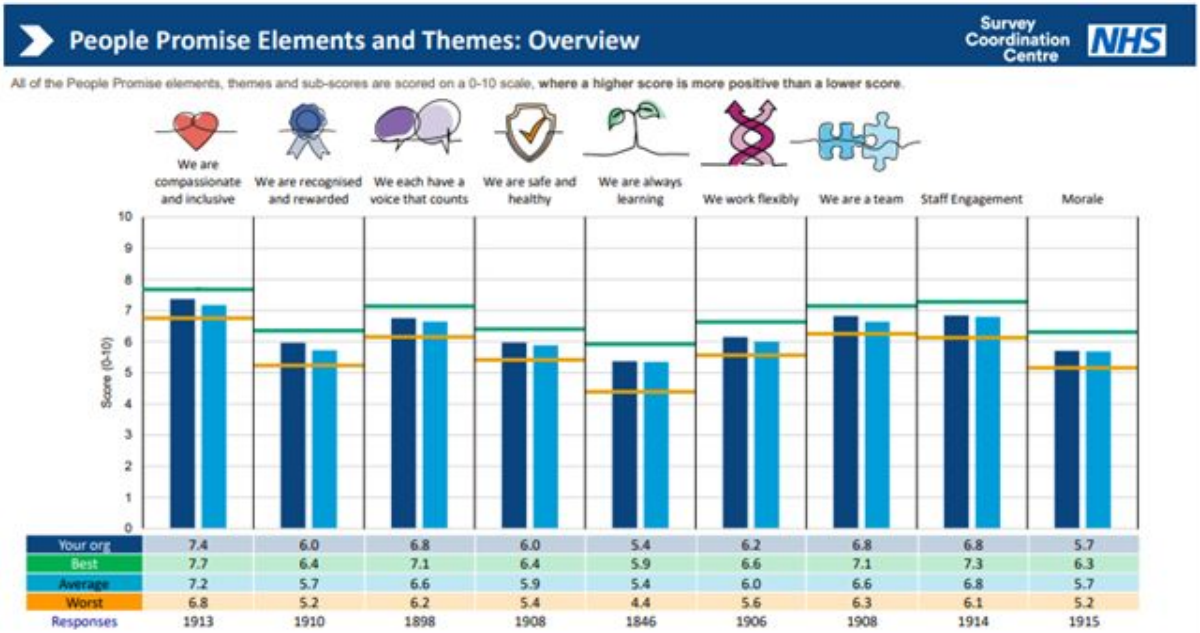
Themes

For the 2021 survey onwards the questions in the NHS Staff Survey are aligned to the People Promise. This sets out, in the words of NHS staff, the things that would most improve their working experience, and is made up of seven elements:



In support of this, the results of the NHS Staff Survey are measured against the seven People Promise elements and against two of the themes reported in previous years (Staff Engagement and Morale). The reporting also includes sub-scores, which feed into the People Promise elements and themes.

HDFT is above average, for our benchmarking group, in six of the nine themes, and meets the average in the other three themes (We are always learning, Staff Engagement, and Morale).

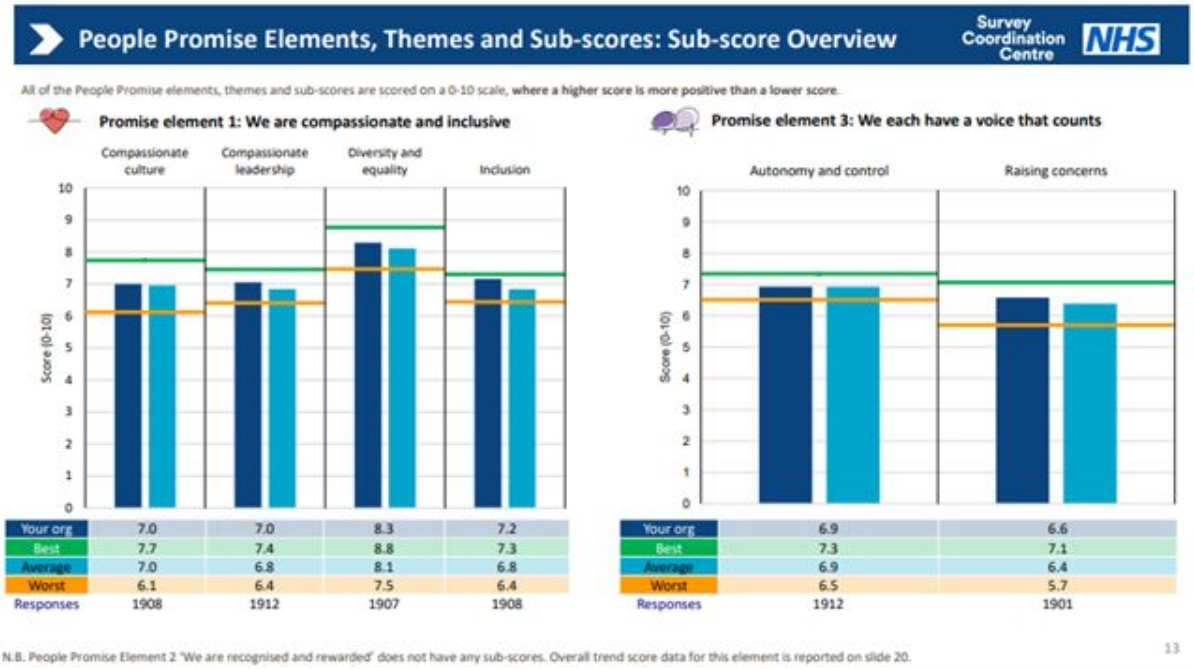


Additional Questions

Additional questions were included in the survey covering:

- The Covid-19 pandemic
- Questions not linked to the People Promise
- Workforce Equality Standards
- Demographic and other classification questions

People Promise Elements, Themes and Sub-scores: Sub-score Overview



Promise element 1: We are compassionate and inclusive

- ✓ 2022 shows increases in 3 of the 4 subcategories over 2021; compassionate culture remained the same
- ✓ Inclusion increasing the most from 6.9 in 2021, to 7.2 in 2022

Promise element 2: We are recognized and rewarded

- ✓ Increase from 5.8 in 2021, to 6.0 in 2022
- ✓ The group average, best and worst scores all declined by 0.1 during this period

Promise element 3: We each have a voice that counts

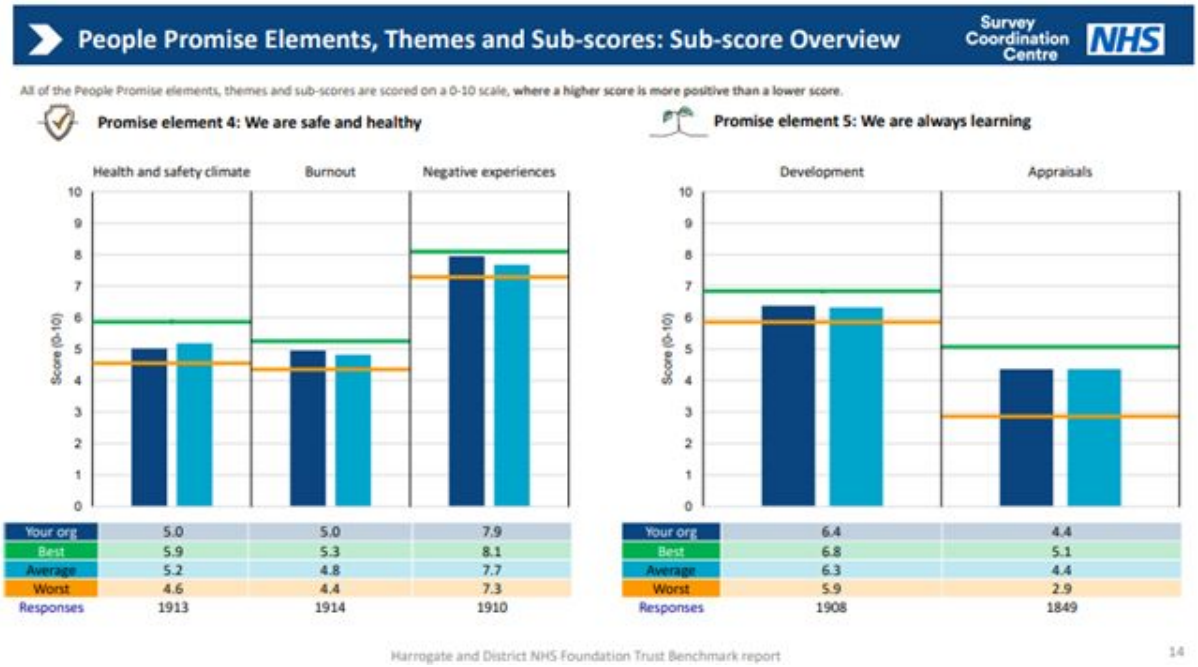
- ✓ Small increase in both sub-categories for 2022

Promise element 4: We are safe and healthy

- ✓ Improvements across all three sub-categories which is marked against the general trend of static to declining across the benchmarking group

Promise element 5: We are always learning

- ✓ Significant increase in the sub-category of Development, from 6.1 in 2021 to 6.4 in 2022 moving us slightly above average
- ✓ Appraisals brings our largest increase in a sub-category, year on year, from 3.6 to 4.4 in 2022, bringing us in line with the average score for 2022

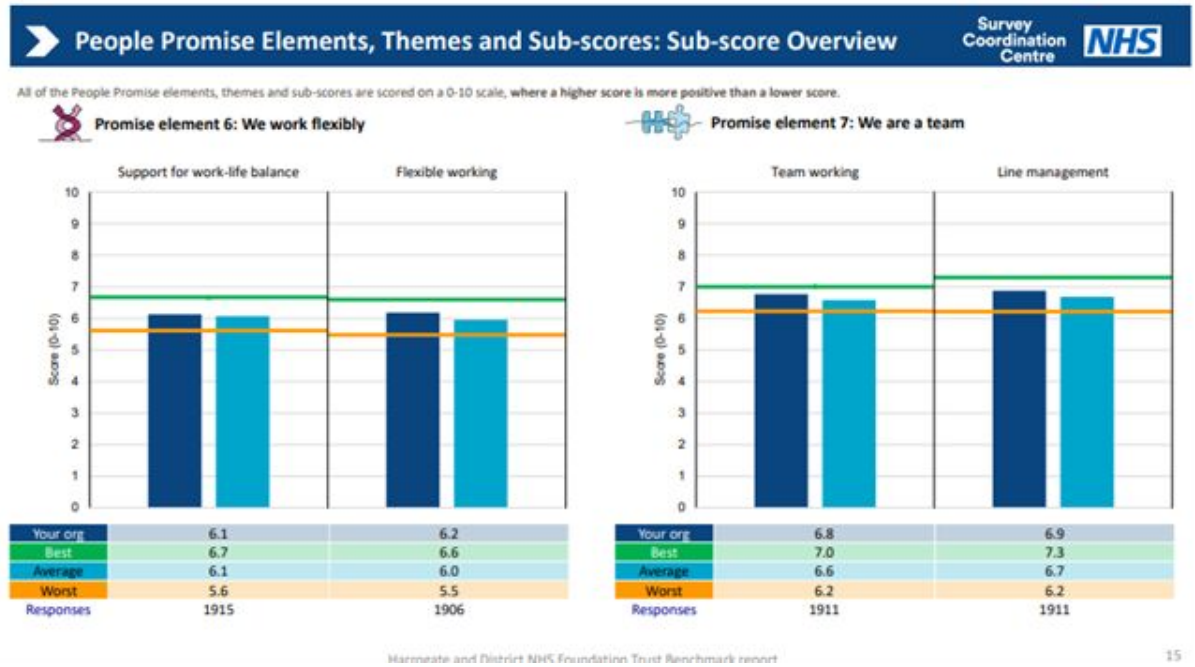


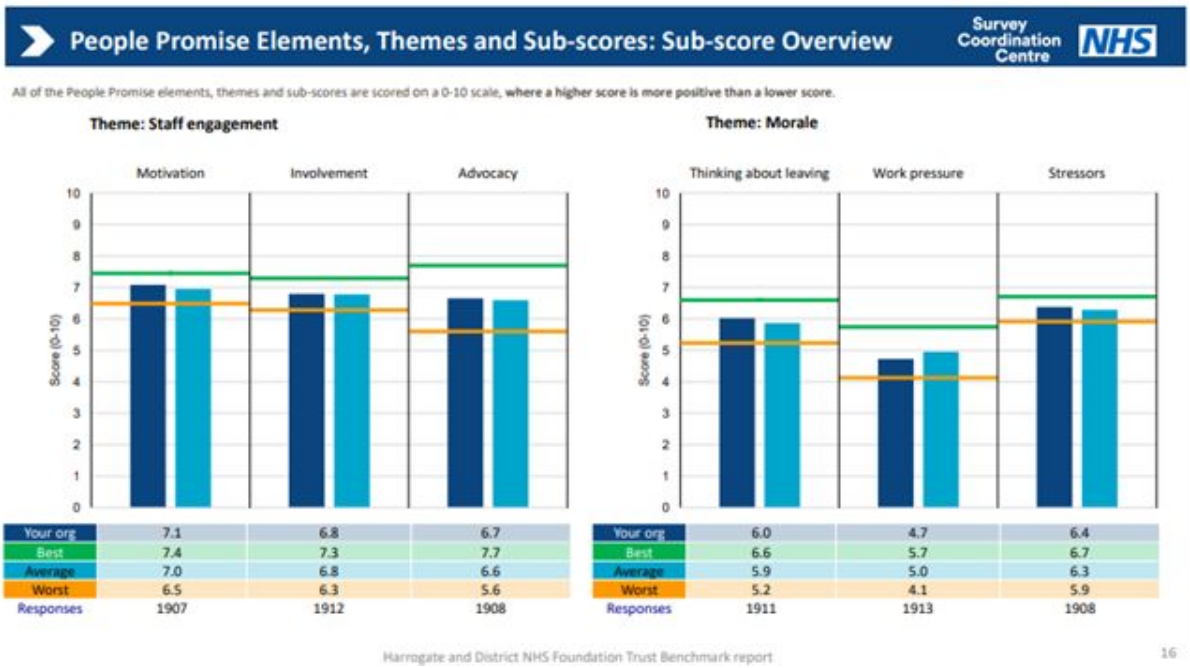
Promise element 6: We work flexibly

✓ Both sub-categories showed a small increase year on year bringing us slightly above average

Promise element 7: We are a team

✓ Both sub-categories increased by 0.2 in 2022 moving us slightly above average



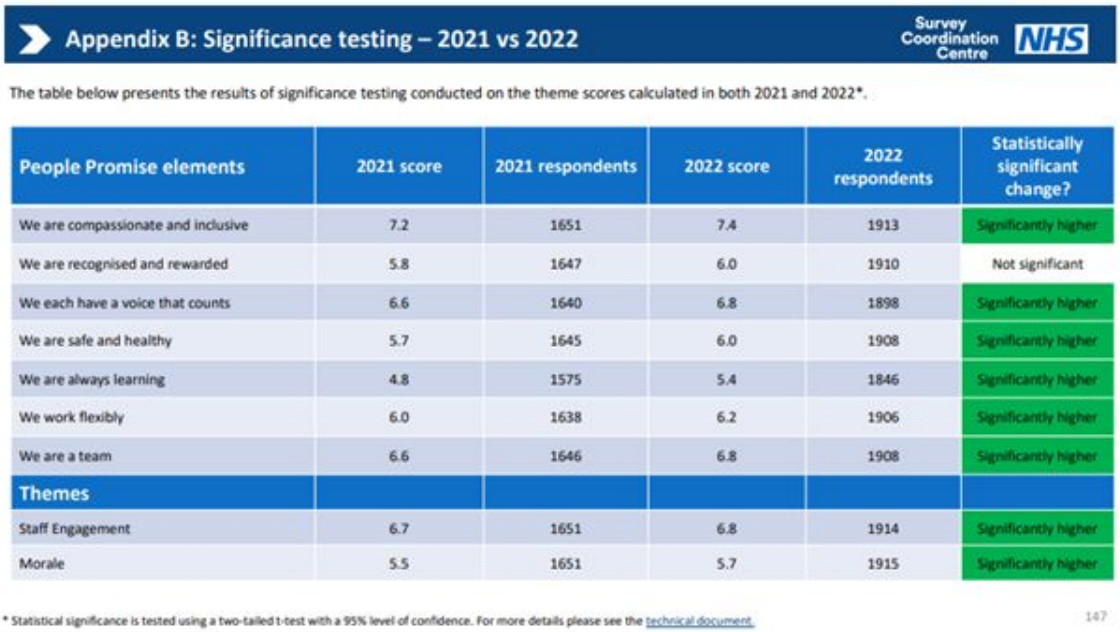


Theme: Staff Engagement

- ✓ In all three sub-categories we are average or slightly above average with an upward trend from 2021
- ✘ Whilst the trend is moving upwards we are still below the high in 2018

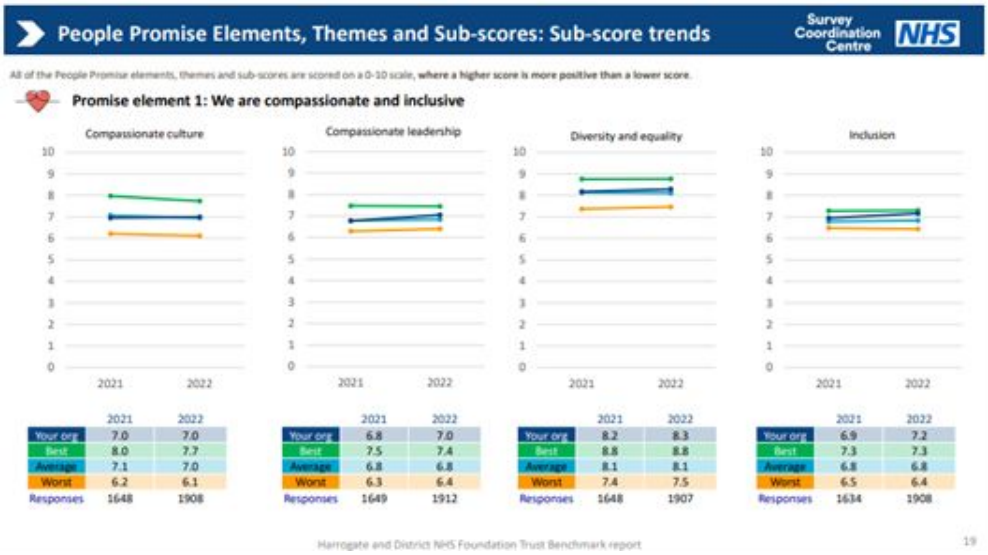
Theme: Morale

- ✓ All three sub-categories have improved by a minimum of 0.2 in 2022 compared to 2021
- ✘ Work pressure is the one area where we are below the average for our benchmarking group



7

People Promise Elements, Themes and Sub-scores: Highlights and Details

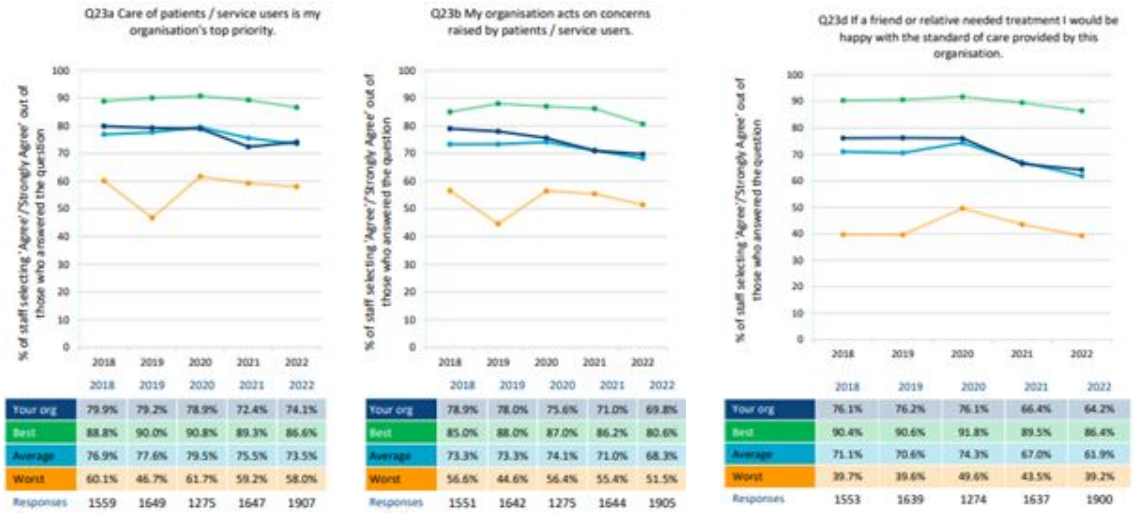


PROMISE ELEMENT 1: WE ARE COMPASSIONATE AND INCLUSIVE

Compassionate culture

The questions in this category indicate an area to focus on:

- Declining scores for being happy with the standard of care provided by HDFT, which follows the general trend in the NHS. Our scores are above the benchmarking group average, at 64%.
- 70% of respondents said that HDFT acts on concerns raised by patients / service users, which is marginally above average but almost 10% lower than our score in 2018 and the highest score in our benchmaking group.
- Care of patients / service users as a top priority scored 74% this year showing a small increase on 2021, but is still an area for concern.
- ✓ 2% more colleagues would recommend HDFT as a place to work than in 2021. Whilst this average for our group it is 7.5% lower than our previous high and almost 20% below the highest in our group.

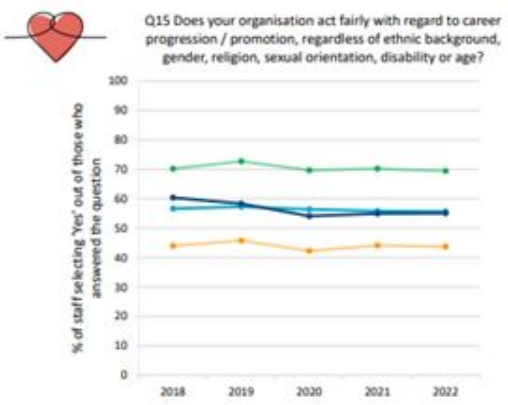


Compassionate leadership

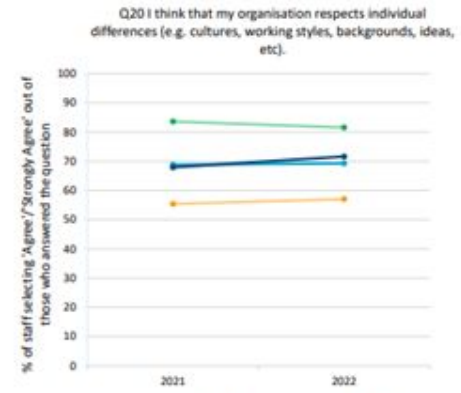
- ✓ Improvements in scores for all questions relating to line manager support. Focus is to keep the momentum and keep listening and supporting using our At Our Best leadership tools incorporated in to all management training.

Diversity and equality

- ✓ Small improvements seen since 2021, and mostly favourable in terms of the average scores.
- ➢ Fairness in career progression remains an area of concern being 15% lower than the best in our group. An average of 55% of colleagues believing we act fairly is not where we would like to be.



	2018	2019	2020	2021	2022
Your org	60.3%	58.3%	54.1%	54.9%	55.0%
Best	70.2%	72.7%	69.7%	70.2%	69.4%
Average	56.6%	57.3%	56.4%	55.8%	55.6%
Worst	44.0%	45.8%	42.2%	44.1%	43.7%
Responses	1568	1618	1246	1634	1907

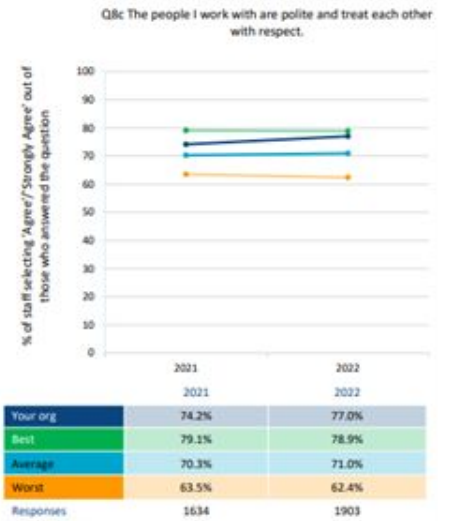


	2021	2022
Your org	67.9%	71.6%
Best	83.6%	81.6%
Average	68.8%	69.3%
Worst	55.4%	57.1%
Responses	1646	1912

Inclusion

- ✓ All areas in this category scored well and close to the highest in our benchmarking group, with 70+% saying the people they work with are living our KITE values, of respect, kindness, feeling valued and good teamwork.

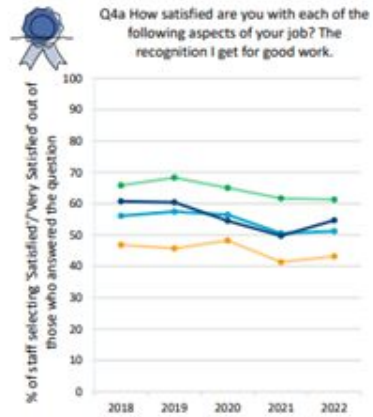
	2021	2022
Your org	73.8%	76.2%
Best	78.4%	78.3%
Average	69.0%	69.6%
Worst	62.5%	61.6%
Responses	1636	1909



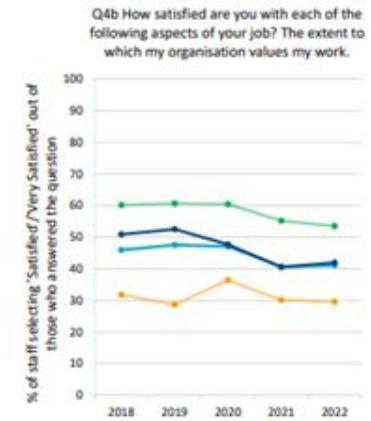
	2021	2022
Your org	74.2%	77.0%
Best	79.1%	78.9%
Average	70.3%	71.0%
Worst	63.5%	62.4%
Responses	1634	1903

PROMISE ELEMENT 2: WE ARE RECOGNIZED AND REWARDED

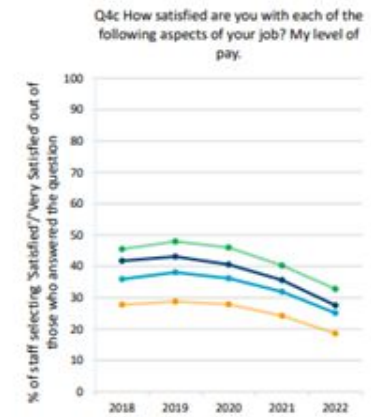
- ✓ More HDFT colleagues reported feeling valued and receiving recognition for their work in 2022 than 2021, especially from colleagues and line managers.
- ➤ In line with general NHS feelings, pay is a major concern for colleagues, with only a quarter of staff saying they were satisfied with their level of pay.
- ✓ For most questions we are significantly better than the average for our group.



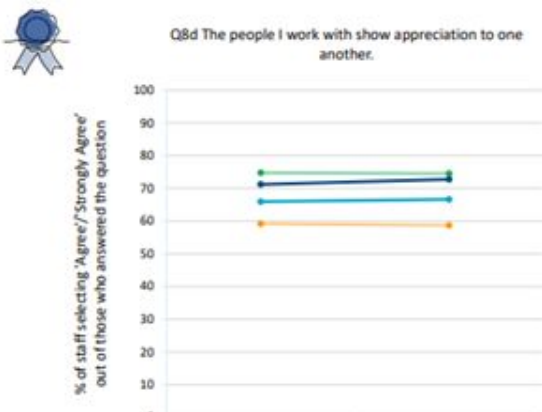
	2018	2019	2020	2021	2022
Your org	60.8%	60.4%	54.5%	49.7%	54.7%
Best	65.8%	68.3%	65.0%	61.7%	61.3%
Average	56.1%	57.5%	56.4%	50.5%	51.2%
Worst	46.8%	45.7%	48.2%	41.4%	43.2%
Responses	1564	1646	1278	1647	1909



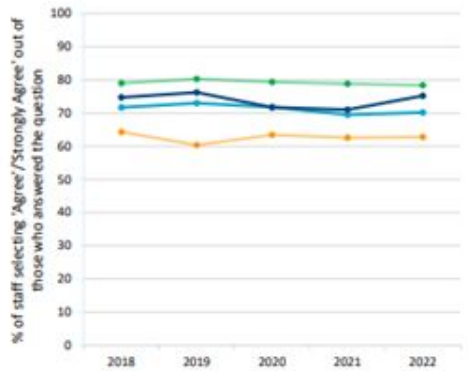
	2018	2019	2020	2021	2022
Your org	50.9%	52.5%	47.7%	40.5%	42.0%
Best	60.1%	60.7%	60.4%	55.2%	53.5%
Average	45.9%	47.5%	47.1%	40.7%	41.1%
Worst	31.8%	28.7%	36.4%	30.1%	29.5%
Responses	1558	1643	1276	1644	1907



	2018	2019	2020	2021	2022
Your org	41.7%	43.1%	40.6%	35.6%	27.5%
Best	45.5%	47.9%	46.0%	40.3%	32.8%
Average	35.9%	38.1%	36.2%	31.9%	25.1%
Worst	27.7%	28.7%	27.9%	24.2%	18.5%
Responses	1563	1645	1275	1642	1909



	2021	2022
Your org	71.2%	72.8%
Best	74.8%	74.5%
Average	66.0%	66.6%
Worst	59.2%	58.7%
Responses	1634	1905

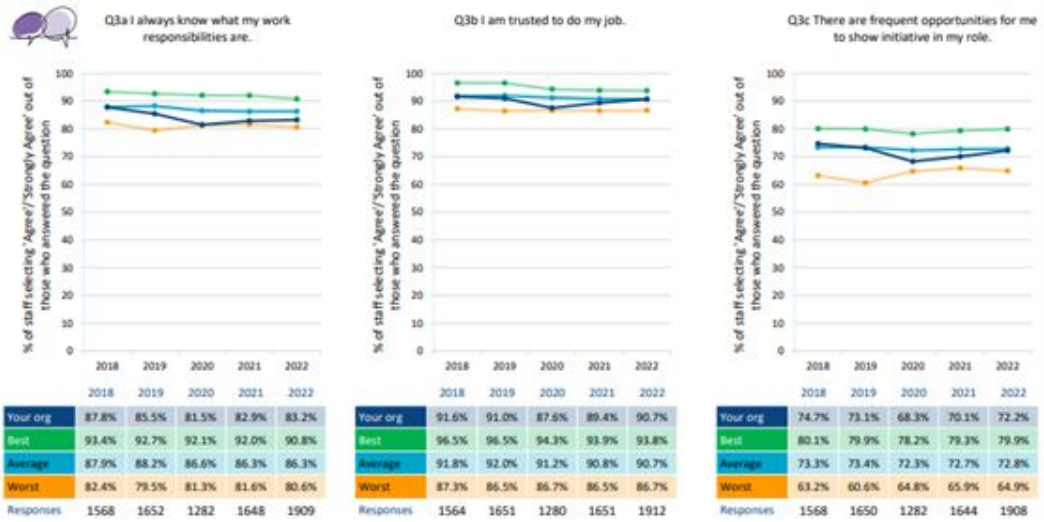


	2018	2019	2020	2021	2022
Your org	74.7%	76.2%	71.7%	71.0%	75.2%
Best	79.0%	80.3%	79.4%	78.8%	78.4%
Average	71.7%	73.0%	71.8%	69.5%	70.2%
Worst	64.3%	60.4%	63.4%	62.6%	62.8%
Responses	1557	1642	1278	1646	1907

PROMISE ELEMENT 3: WE EACH HAVE A VOICE THAT COUNTS

Autonomy and control

- ✓ The way we work, and our ability to make improvements or be involved in change, showed an improvement since 2021. There is still more room for improvement to reach our previous best scores in this area but we are trending closer to the best in our group.
- ➢ The one area which is significantly worse than the group average is knowing what my work responsibilities are, with 83% colleagues saying they agreed or strongly agreed with this.



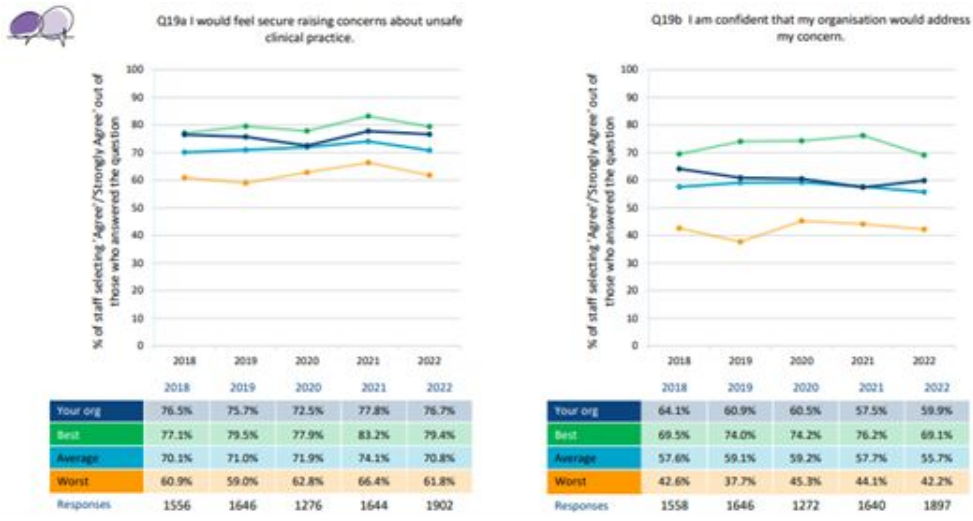
	2018	2019	2020	2021	2022
Your org	87.8%	85.5%	81.5%	82.9%	83.2%
Best	93.4%	92.7%	92.1%	92.0%	90.8%
Average	87.9%	88.2%	86.6%	86.3%	86.3%
Worst	82.4%	79.5%	81.3%	81.6%	80.6%
Responses	1568	1652	1282	1648	1909

	2018	2019	2020	2021	2022
Your org	91.6%	91.0%	87.6%	89.4%	90.7%
Best	96.5%	96.5%	94.3%	93.9%	93.8%
Average	91.8%	92.0%	91.2%	90.8%	90.7%
Worst	87.3%	86.5%	86.7%	86.5%	86.7%
Responses	1564	1651	1280	1651	1912

	2018	2019	2020	2021	2022
Your org	74.7%	73.1%	68.3%	70.1%	72.2%
Best	80.1%	79.9%	78.2%	79.3%	79.9%
Average	73.3%	73.4%	72.3%	72.7%	72.8%
Worst	63.2%	60.6%	64.8%	65.9%	64.9%
Responses	1568	1650	1282	1644	1908

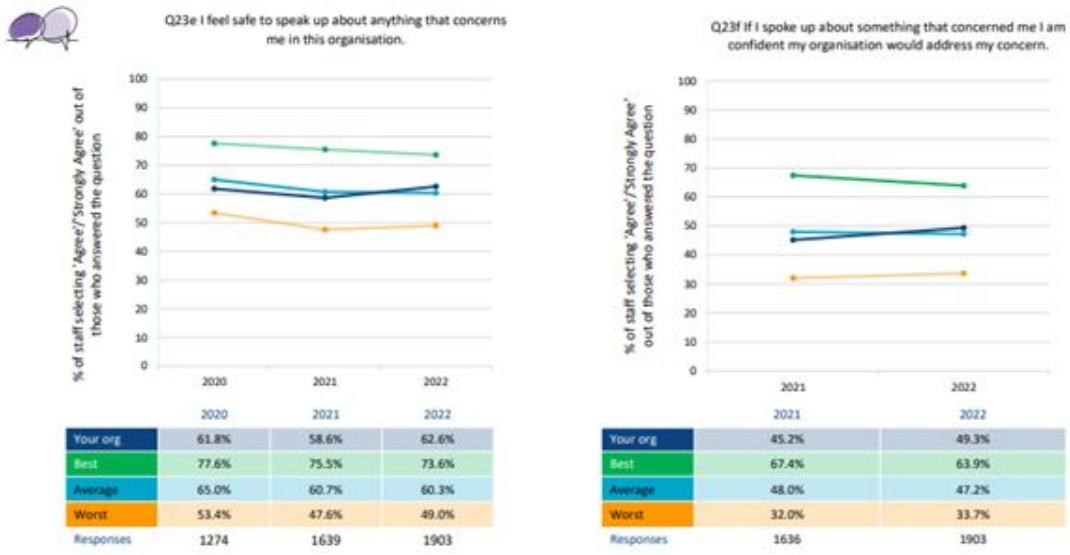
Raising concerns

- ✓ The work done by our Quality and Safety teams is reflected in the upward trends for HDFT across this area which is contrary to the trends in our benchmarking group.
- ✓ More than 75% of colleagues would feel secure raising concerns about unsafe clinical practice. Ideally this would be 100% and we will continue to work on this.
- ➢ More work is required to help colleagues feel safe about speaking up about anything of concern, and then feeling reassured that the concern would be addressed by HDFT.



	2018	2019	2020	2021	2022
Your org	76.5%	75.7%	72.5%	77.8%	76.7%
Best	77.1%	79.5%	77.9%	83.2%	79.4%
Average	70.1%	71.0%	71.9%	74.1%	70.8%
Worst	60.9%	59.0%	62.8%	66.4%	61.8%
Responses	1556	1646	1276	1644	1902

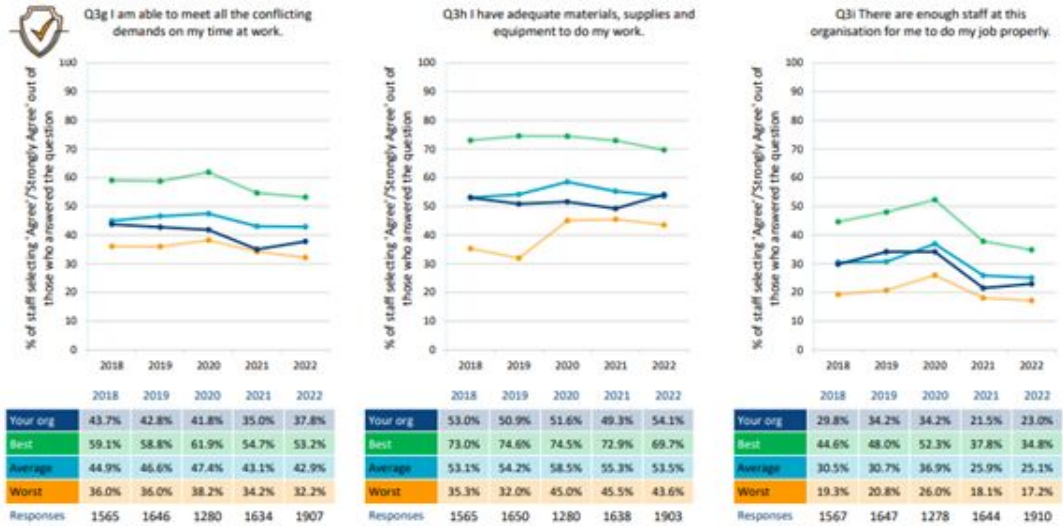
	2018	2019	2020	2021	2022
Your org	64.1%	60.9%	60.5%	57.5%	59.9%
Best	69.5%	74.0%	74.2%	76.2%	69.1%
Average	57.6%	59.1%	59.2%	57.7%	55.7%
Worst	42.6%	37.7%	45.3%	44.1%	42.2%
Responses	1558	1646	1272	1640	1897



PROMISE ELEMENT 4: WE ARE SAFE AND HEALTHY

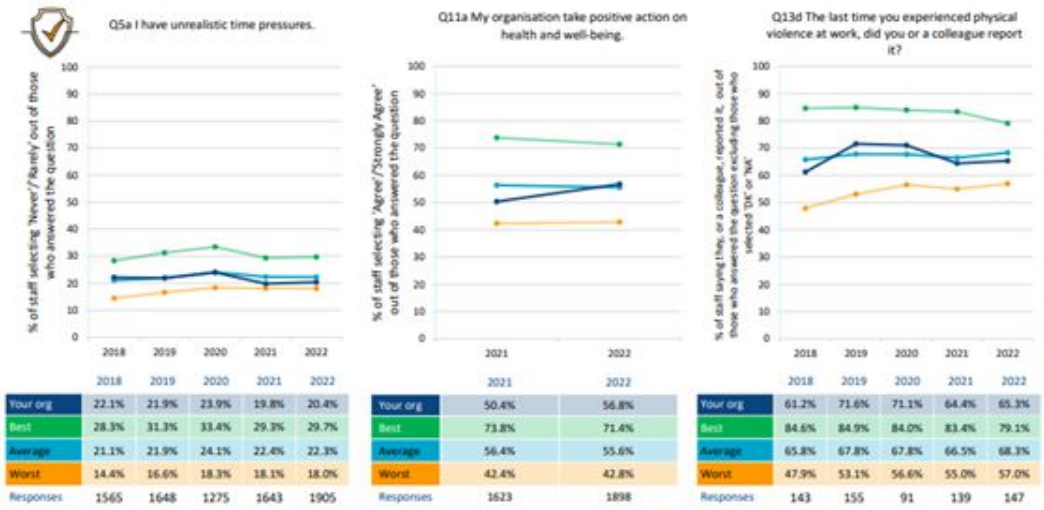
Health and safety climate

- ✓ Improvements since 2021 with plenty more work required. The work pressures which are a key focus for organization are clearly reflected in these questions.
- ➢ Less than 40% of colleagues feel that they have enough time to meet all their conflicting demands
- ➢ Only 23% of colleagues believe there are enough staff for them to do their role properly. Recruitment has been a key focus for HDFT over the last year and continues to be so.
- ➢ 54% of colleagues feel they have adequate materials, supplies and equipment to do their work. This has increased by 6% since 2021 and is a small positive for HDFT against the general downward trends in our benchmarking group.



- ➢ Support for health and wellbeing has improved by 6% year on year. At 57% of colleagues agreeing that HDFT takes positive action to provide support, this is 15% off the group best.

- For colleagues who have experienced physical violence at work, only 65% reported it. Less than 50% reported harassment, bullying or abuse at work. Why are we not feeling the value in reporting incidents?

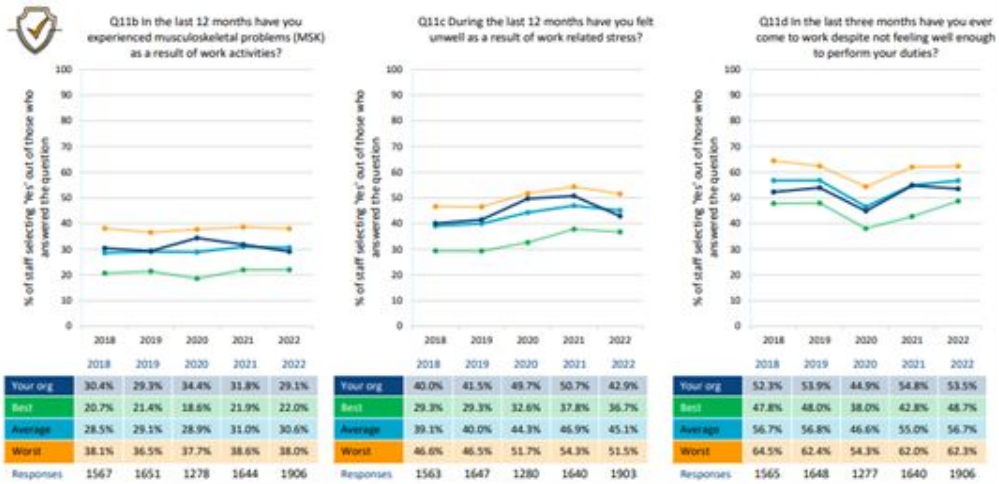


Burnout

- ✓ All questions relating to burnout showed significant improvement on the previous year. There is acknowledgement of how hard colleagues are working with the majority indicating things are improving. There has been a strong focus on getting the right resources and people in the right places to do all jobs effectively. This continues to be a priority.

Negative experiences

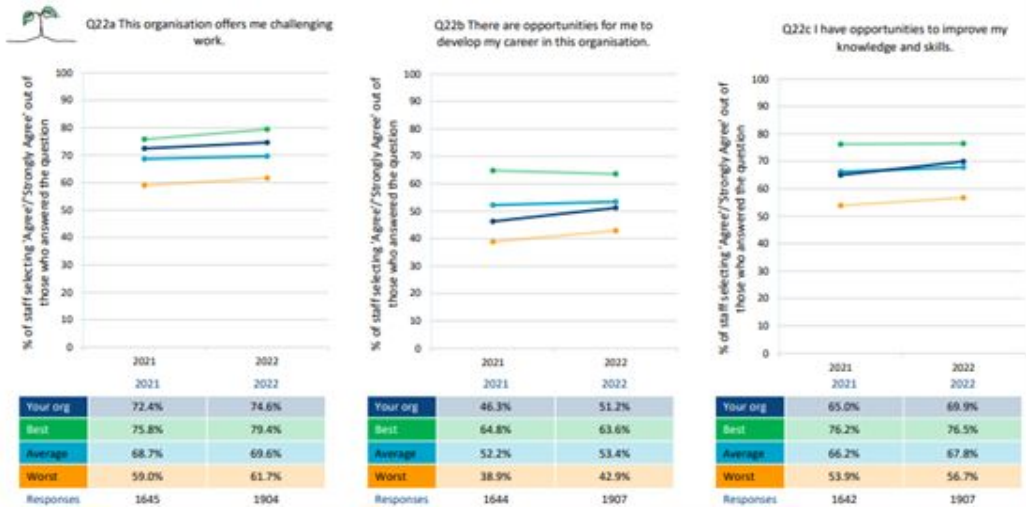
- ✓ Experiences of violence, bullying and harassment have fallen to our lowest levels in recent years. This is from colleagues, members of the public and patients. Our campaign to focus on zero tolerance, along with the focus on security support, appears to be having the desired impact on colleagues feeling safer at work.
- ✓ Work related stress and MSK problems, as a result of work, have also shown marked improvement.



PROMISE ELEMENT 5: WE ARE ALWAYS LEARNING

Development

- ✓ All questions in this sub-category saw a positive improvement since 2021.
- ✓ 75% of colleagues in HDFT reported that HDFT offers challenging work with 70% saying that there are opportunities to improve their knowledge and skills.
- ➤ Whilst the career development opportunities, access and support to the right learning and development opportunities have improved within HDFT there is still a significant gap of more than 10% to reach the levels of the best in our benchmarking group.

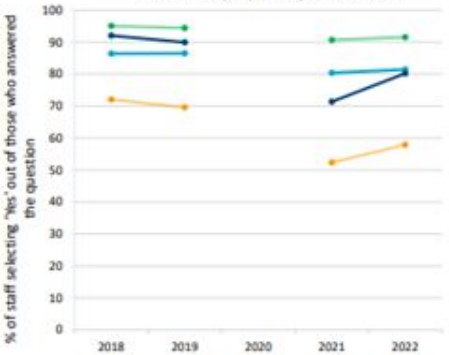


Appraisals

- ✓ Our rate of appraisals has improved significantly since 2021 bringing us in line with the current average rate of appraisals at 80%.
- ✓ 33% of colleagues reported feeling valued through the appraisal process, with an increase 4.5% since 2021, bringing us close to our previous levels. The sector best is 8.5% higher at 40.5%.

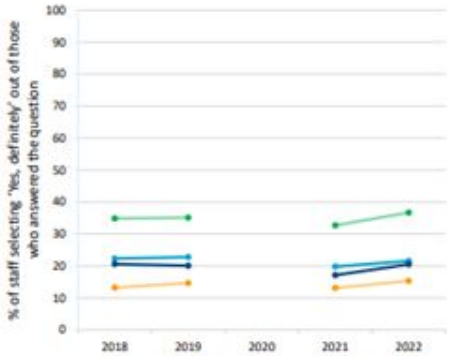
- The highest level of appraisals in our group is comparable with our previous 'normal' above 90%. More work is required on ensuring all colleagues have regular appraisals.
  - The value of the appraisal, in terms of helping to improve how I do my job, has almost improved and is currently average for our benchmarking group, but 15% lower than the best in our group.
  - More work is required to ensure that our appraisal process help set clear objectives. There has been a year on year improvement and we are currently on par with the average, but more than 10% below the best in our benchmarking group.

Q21a In the last 12 months, have you had an appraisal, annual review, development review, or Knowledge and Skills Framework (KSF) development review?



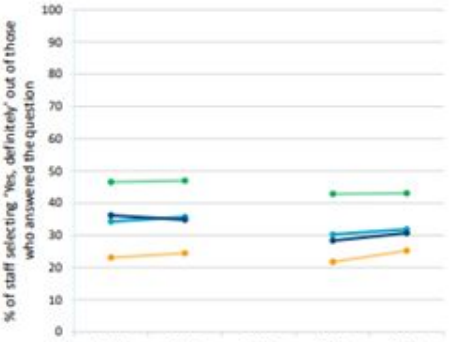
	2018	2019	2020	2021	2022
Your org	92.0%	90.0%	-	71.4%	80.2%
Best	95.1%	94.4%	-	90.7%	91.5%
Average	86.4%	86.5%	-	80.4%	81.4%
Worst	72.1%	69.6%	-	52.4%	57.9%
Responses	1561	1643	-	1635	1896

Q21b It helped me to improve how I do my job.



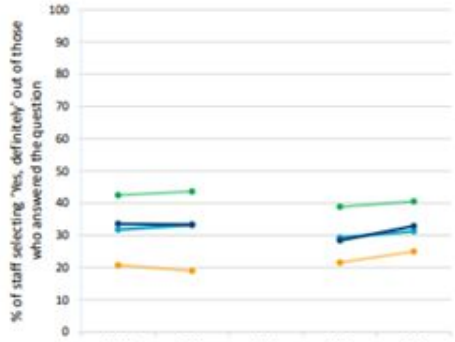
	2018	2019	2020	2021	2022
Your org	20.6%	20.1%	-	17.1%	20.5%
Best	34.8%	35.1%	-	32.7%	36.7%
Average	22.3%	22.8%	-	19.8%	21.5%
Worst	13.2%	14.7%	-	13.1%	15.3%
Responses	1433	1469	-	1162	1526

Q21c It helped me agree clear objectives for my work.



	2018	2019	2020	2021	2022
Your org	36.2%	34.8%	-	28.3%	30.7%
Best	46.5%	46.9%	-	42.8%	43.0%
Average	34.3%	35.7%	-	30.2%	31.9%
Worst	23.1%	24.4%	-	21.8%	25.2%
Responses	1429	1469	-	1159	1527

Q21d It left me feeling that my work is valued by my organisation.



	2018	2019	2020	2021	2022
Your org	33.6%	33.3%	-	28.4%	32.9%
Best	42.4%	43.6%	-	38.9%	40.5%
Average	31.8%	33.2%	-	29.3%	31.3%
Worst	20.7%	19.0%	-	21.5%	25.0%
Responses	1423	1466	-	1159	1522

PROMISE ELEMENT 6: WE WORK FLEXIBLY

Work-life balance

- ✓ The three questions related to this sub-category all showed a significant increase since 2021, moving HDFT above the group average.
- ✓ Being able to approach my line manager and talk opening about flexible working is 3% better than the group average with the best in group being a further 6% above our score.

	2021	2022
Your org	41.0%	46.1%
Best	54.0%	53.5%
Average	42.7%	44.2%
Worst	33.6%	33.9%
Responses	1648	1911

	2021	2022
Your org	48.7%	52.5%
Best	61.5%	61.1%
Average	51.1%	51.7%
Worst	44.9%	44.8%
Responses	1643	1909

	2021	2022
Your org	67.0%	70.5%
Best	75.0%	76.8%
Average	65.2%	66.9%
Worst	58.4%	59.6%
Responses	1647	1914

Flexible working

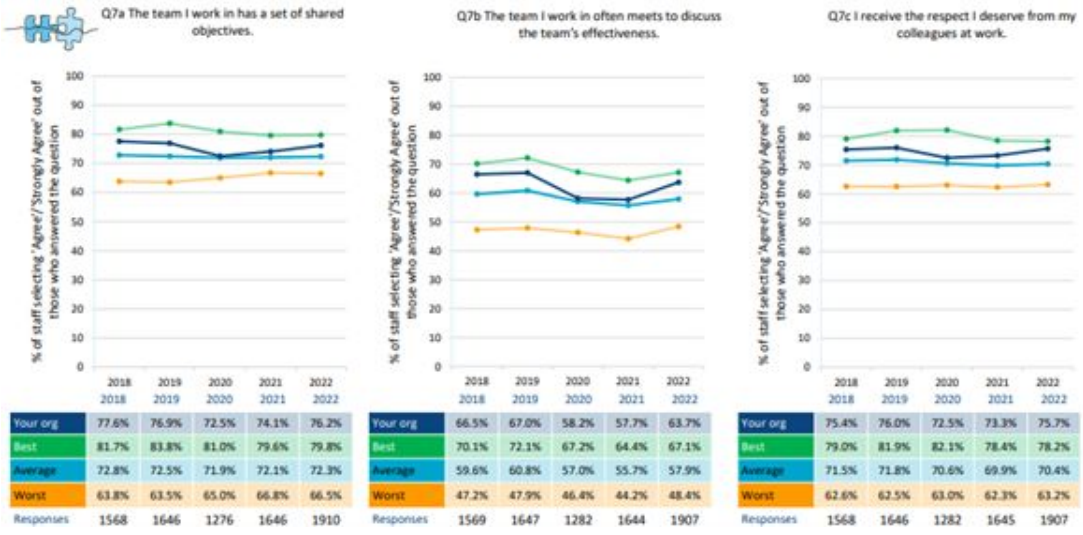
- ✓ Satisfaction with, and opportunities for, flexible working patterns, is above the group average at 55% (vs 53% average) but still lower than our pre-pandemic highs, and the group best, just above 60%.

	2018	2019	2020	2021	2022
Your org	59.2%	61.4%	58.1%	54.4%	55.1%
Best	60.4%	62.4%	65.2%	62.6%	61.9%
Average	52.3%	53.4%	55.7%	52.0%	52.8%
Worst	42.5%	42.0%	47.3%	44.2%	44.6%
Responses	1561	1644	1278	1639	1906

PROMISE ELEMENT 7: WE ARE A TEAM

Teamworking

- ✓ The upward trend in positive responses around shared team objectives, regular meetings to discuss team effectiveness, and respectful colleagues is very pleasing.
- ✓ Our upward trends in understanding roles, enjoying working together, working well to achieve objectives and dealing with disagreements constructively, is different to the group views, which have remained static or declined.



➢ Team freedom to do their work shows an increase but is now average, 8% lower than best.

	2021	2022
Your org	54.1%	56.8%
Best	68.0%	64.9%
Average	56.6%	57.2%
Worst	48.3%	49.0%
Responses	1636	1907

➢ 55% of colleagues felt our teams work well together to achieve objectives, which is above the average of 52%, and an increase of 5% for HDFT since 2021. The best score declined from 70% in 2021, to 65% in 2022, which is still 10% above our very encouraging score.

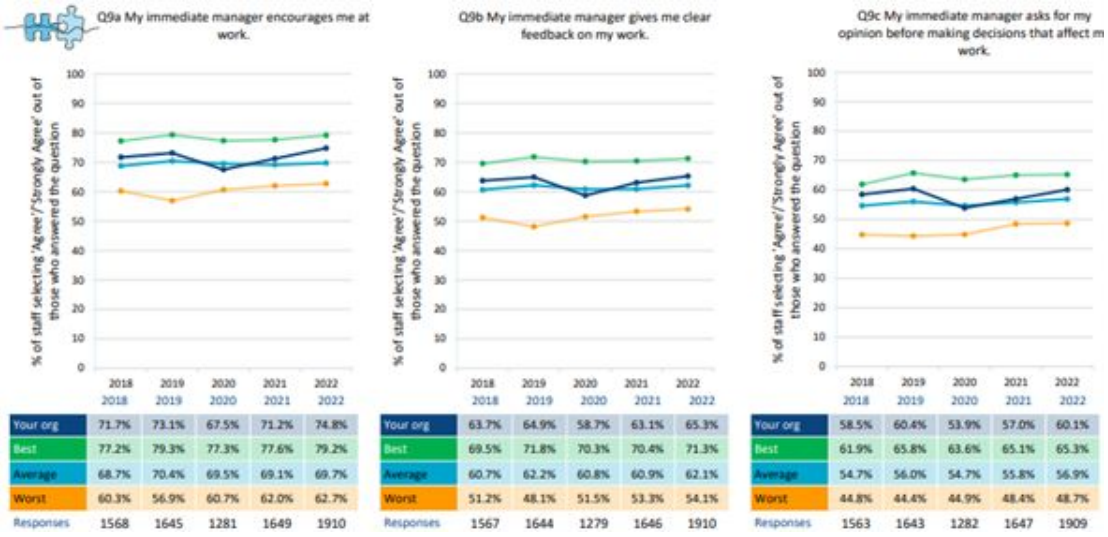
	2021	2022
Your org	49.8%	54.8%
Best	70.6%	65.1%
Average	52.2%	51.6%
Worst	39.1%	39.5%
Responses	1634	1907

✓ 60% of colleagues believe we deal with team disagreements constructively, being close to the benchmarking group best of 63%.

	2021	2022
Your org	54.6%	59.6%
Best	65.0%	63.3%
Average	54.8%	55.5%
Worst	48.2%	47.9%
Responses	1637	1905

Line management

✓ All scores related to line management have improved since 2021 and are significantly better than the group average. Support, encouragement and engagement scores reflect the focus on supporting our managers through training and peer working.



✓ With 72% of colleagues saying their line manager takes a positive interest in their health and wellbeing. This is midway between the average of 67% and the best of 78%.

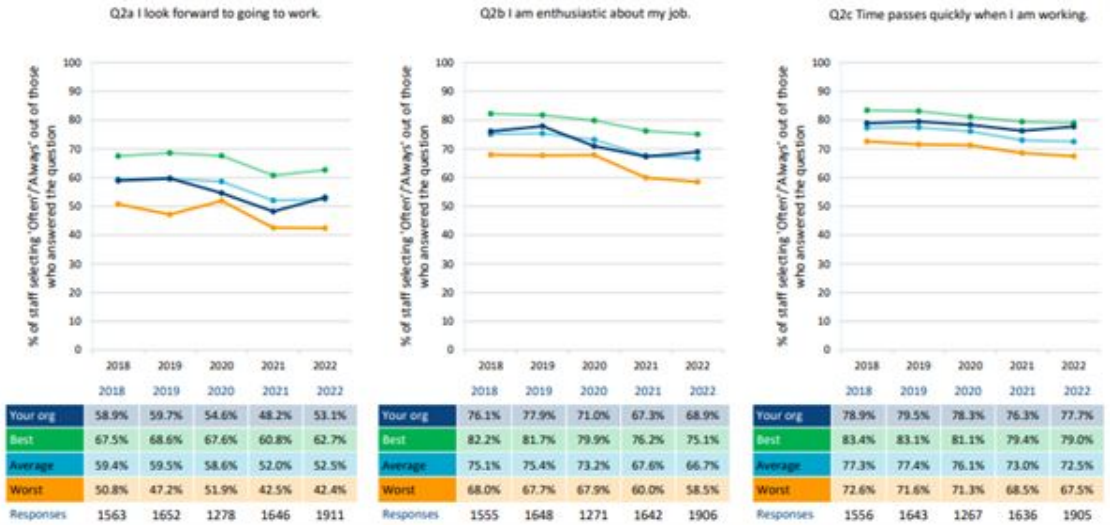
	2018	2019	2020	2021	2022
Your org	70.7%	72.2%	70.1%	68.1%	71.7%
Best	74.9%	77.7%	77.0%	75.4%	77.8%
Average	67.5%	68.6%	69.4%	66.4%	67.4%
Worst	57.7%	55.7%	61.7%	59.8%	59.4%
Responses	1556	1646	1280	1646	1912

9

THEME: STAFF ENGAGEMENT

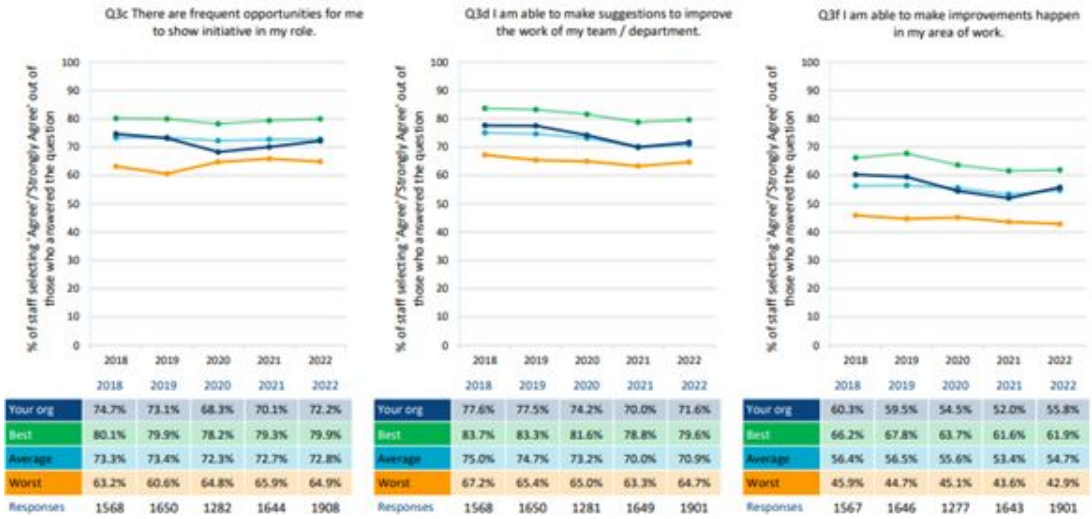
Motivation

✓ A positive upward trend across all three questions, moving ahead of the group average. The objective remains to have more good days at work. When we are feeling good we are able to deliver great care to our patients and service users.



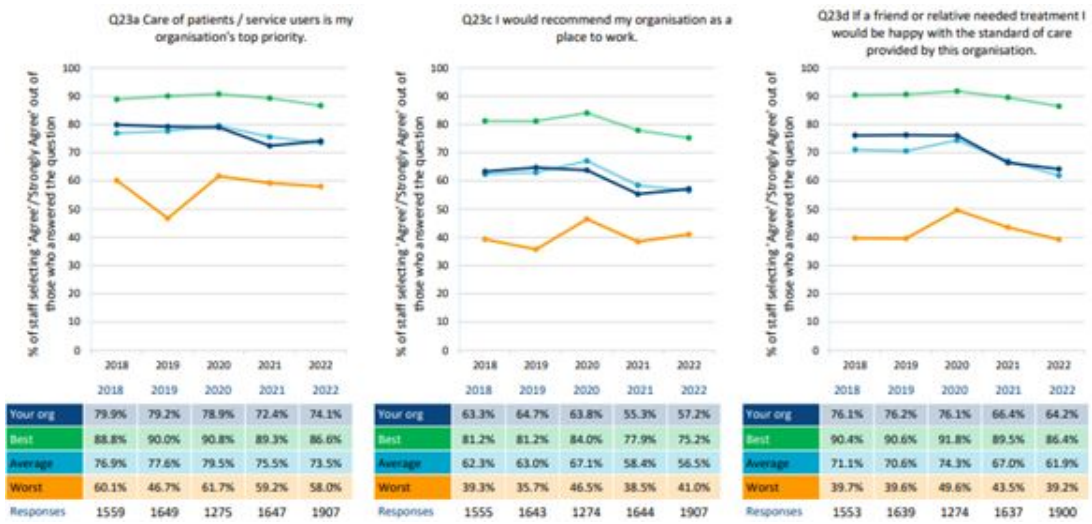
Involvement

- ✓ Showing an upward trend, indicating more opportunities to engage in discussions, projects, quality improvement initiatives, etc., where colleagues are able to make improvements. This is an ongoing focus and requires Listening at Our Best.



Advocacy

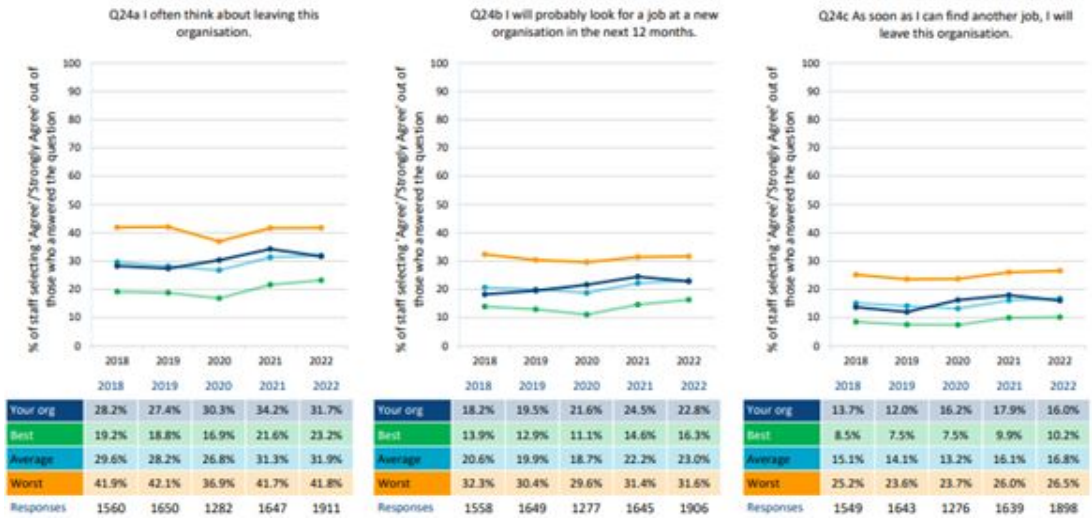
- ➢ Results are above the group average, but a long way from best in class. Progress has been made since 2021, with ongoing initiatives aiming to continue improving these drivers.



THEME: MORALE

Thinking about leaving

- ✓ Colleagues scored positively against these questions, with less people thinking about leaving that in 2021. Current numbers are still higher than pre-pandemic years and group best.



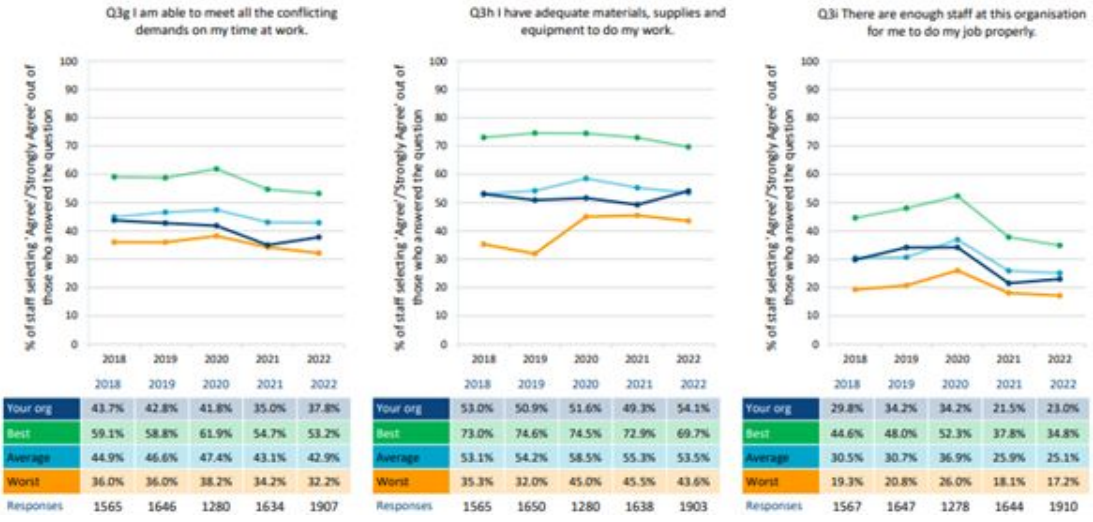
	2018	2019	2020	2021	2022
Your org	28.2%	27.4%	30.3%	34.2%	31.7%
Best	19.2%	18.8%	16.9%	21.6%	23.2%
Average	29.6%	28.2%	26.8%	31.3%	31.9%
Worst	41.9%	42.1%	36.9%	41.7%	41.8%
Responses	1560	1650	1282	1647	1911

	2018	2019	2020	2021	2022
Your org	18.2%	19.5%	21.6%	24.5%	22.8%
Best	13.9%	12.9%	11.1%	14.6%	16.3%
Average	20.6%	19.9%	18.7%	22.2%	23.0%
Worst	32.3%	30.4%	29.6%	31.4%	31.6%
Responses	1558	1649	1277	1645	1906

	2018	2019	2020	2021	2022
Your org	13.7%	12.0%	16.2%	17.9%	16.0%
Best	8.5%	7.5%	7.5%	9.9%	10.2%
Average	15.1%	14.1%	13.2%	16.1%	16.8%
Worst	25.2%	23.6%	23.7%	26.0%	26.5%
Responses	1549	1643	1276	1639	1898

Work pressure

- ✓ The trend over the last few years appears to have turned for the positive. These factors have been a key focus area for HDFT over the last 12 months and reflect a divergence from the trend within our benchmarking group.
- ➢ The conflicts on time, through lack of staff and resources, are still having a big impact and will continue to be receive priority focus across our organization.



	2018	2019	2020	2021	2022
Your org	43.7%	42.8%	41.8%	35.0%	37.8%
Best	59.1%	58.8%	61.9%	54.7%	53.2%
Average	44.9%	46.6%	47.4%	43.1%	42.9%
Worst	36.0%	36.0%	38.2%	34.2%	32.2%
Responses	1565	1646	1280	1634	1907

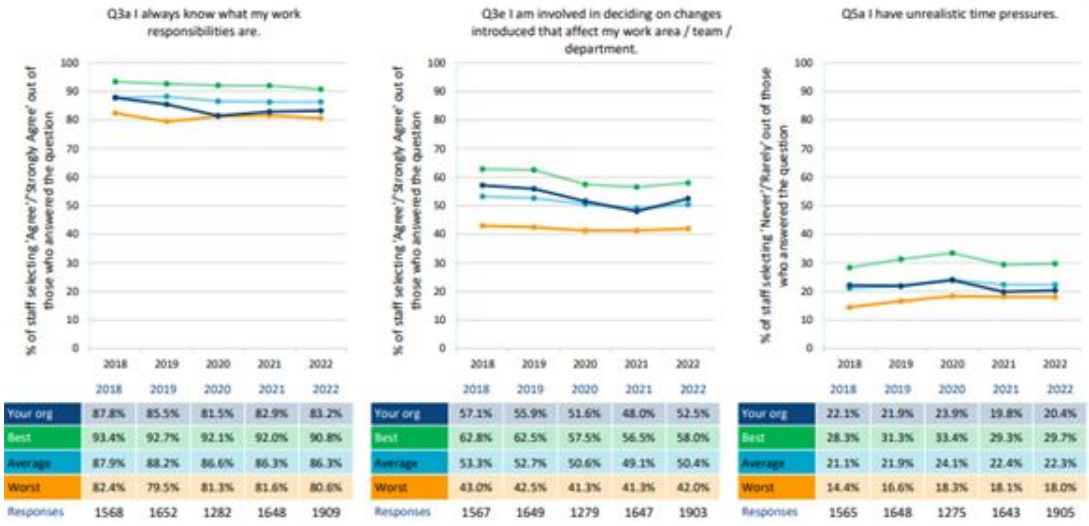
	2018	2019	2020	2021	2022
Your org	53.0%	50.9%	51.6%	49.3%	54.1%
Best	73.0%	74.6%	74.5%	72.9%	69.7%
Average	53.1%	54.2%	58.5%	55.3%	53.5%
Worst	35.3%	32.0%	45.0%	45.5%	43.6%
Responses	1565	1650	1280	1638	1903

	2018	2019	2020	2021	2022
Your org	29.8%	34.2%	34.2%	21.5%	23.0%
Best	44.6%	48.0%	52.3%	37.8%	34.8%
Average	30.5%	30.7%	36.9%	25.9%	25.1%
Worst	19.3%	20.8%	26.0%	18.1%	17.2%
Responses	1567	1647	1278	1644	1910

Stressors

- ➢ The unrealistic time pressures and always knowing the work responsibilities are again reflective of the staff and resources pressures.
- ✓ The trends, over the last year, are moving in the right direction with more improvements clearly needed.

- ✓ The positive response to being involved in changes affecting work area / team / department reflects the increase focus on quality improvement support and training of colleagues to identify and introduce effect improvements.

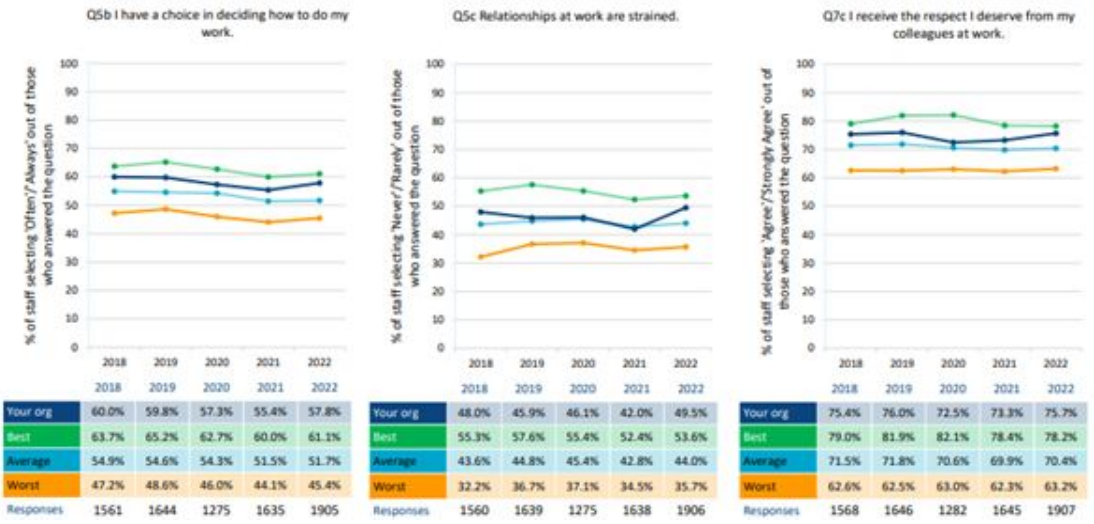


	2018	2019	2020	2021	2022
Your org	87.8%	85.5%	81.5%	82.9%	83.2%
Best	93.4%	92.7%	92.1%	92.0%	90.8%
Average	87.9%	88.2%	86.6%	86.3%	86.3%
Worst	82.4%	79.5%	81.3%	81.6%	80.6%
Responses	1568	1652	1282	1648	1909

	2018	2019	2020	2021	2022
Your org	57.1%	55.9%	51.6%	48.0%	52.5%
Best	62.8%	62.5%	57.5%	56.5%	58.0%
Average	53.3%	52.7%	50.6%	49.1%	50.4%
Worst	43.0%	42.5%	41.3%	41.3%	42.0%
Responses	1567	1649	1279	1647	1903

	2018	2019	2020	2021	2022
Your org	22.1%	21.9%	23.9%	19.8%	20.4%
Best	28.3%	31.3%	33.4%	29.3%	29.7%
Average	21.1%	21.9%	24.1%	22.4%	22.3%
Worst	14.4%	16.6%	18.3%	18.1%	18.0%
Responses	1565	1648	1275	1643	1905

- ✓ The impact of colleagues demonstrating our KITE values and behaviours are evident through the positive responses around relationships, integrity, and hwo we feel as a community.



	2018	2019	2020	2021	2022
Your org	60.0%	59.8%	57.3%	55.4%	57.8%
Best	63.7%	65.2%	62.7%	60.0%	61.1%
Average	54.9%	54.6%	54.3%	51.5%	51.7%
Worst	47.2%	48.6%	46.0%	44.1%	45.4%
Responses	1561	1644	1275	1635	1905

	2018	2019	2020	2021	2022
Your org	48.0%	45.9%	46.1%	42.0%	49.5%
Best	55.3%	57.6%	55.4%	52.4%	53.6%
Average	43.6%	44.8%	45.4%	42.8%	44.0%
Worst	32.2%	36.7%	37.1%	34.5%	35.7%
Responses	1560	1639	1275	1638	1906

	2018	2019	2020	2021	2022
Your org	75.4%	76.0%	72.5%	73.3%	75.7%
Best	79.0%	81.9%	82.1%	78.4%	78.2%
Average	71.5%	71.8%	70.6%	69.9%	70.4%
Worst	62.6%	62.5%	63.0%	62.3%	63.2%
Responses	1568	1646	1282	1645	1907

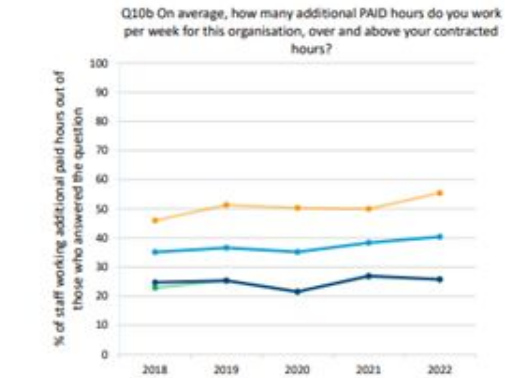
- ✓ Line management support has been clearly trending upward over recent years. The At Our Best leadership training is now running throughout all leadership training programmes and managers are supporting each other. Line manager encouragement at work reflects all the great work being done by our leadership teams.

	2018	2019	2020	2021	2022
Your org	71.7%	73.1%	67.5%	71.2%	74.8%
Best	77.2%	79.3%	77.3%	77.6%	79.2%
Average	68.7%	70.4%	69.5%	69.1%	69.7%
Worst	60.3%	56.9%	60.7%	62.0%	62.7%
Responses	1568	1645	1281	1649	1910

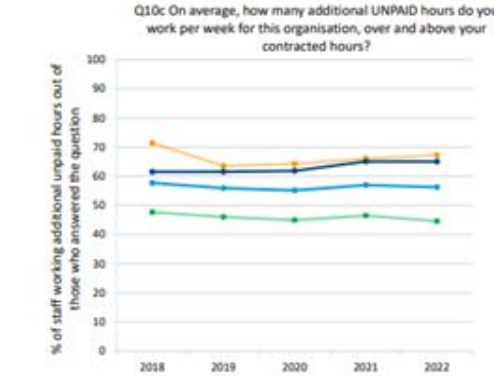
Additional Questions

ADDITIONAL HOURS WORKED

- HDFT colleagues reported additional paid hours aligned with the lowest in the group, and conversely unpaid additional hours aligned with the highest in the group.



	2018	2019	2020	2021	2022
Your org	24.7%	25.4%	21.5%	27.0%	25.8%
Lowest	22.9%	25.3%	21.5%	26.7%	25.8%
Average	35.1%	36.6%	35.2%	38.3%	40.4%
Highest	46.0%	51.3%	50.3%	50.0%	55.4%
Responses	1524	1619	1260	1578	1862



	2018	2019	2020	2021	2022
Your org	61.5%	61.6%	61.9%	65.1%	65.1%
Lowest	47.7%	46.0%	45.0%	46.5%	44.6%
Average	57.7%	55.9%	55.1%	57.0%	56.3%
Highest	71.4%	63.6%	64.2%	66.1%	67.3%
Responses	1532	1616	1258	1603	1865

DISCRIMINATION: % OF STAFF EXPERIENCING DISCRIMINATION BY:-

- Ethnic background: Worsening trend since 2021 but below average.

	2018	2019	2020	2021	2022
Your org	26.5%	26.1%	30.5%	26.3%	35.1%
Best	4.6%	19.8%	20.5%	19.2%	19.7%
Average	39.2%	41.9%	44.7%	46.4%	48.5%
Worst	70.5%	71.4%	76.6%	71.6%	73.0%
Responses	139	169	140	188	186

- Gender: Static trend slightly worse than average.

	2018	2019	2020	2021	2022
Your org	16.0%	22.2%	21.5%	22.7%	21.8%
Best	5.2%	10.0%	9.6%	6.0%	11.0%
Average	19.9%	20.1%	20.0%	20.6%	20.3%
Worst	31.6%	29.4%	28.7%	30.8%	30.1%
Responses	139	169	140	188	186

- Religion: Declining trend since 2021, worsening beyond the average.

	2018	2019	2020	2021	2022
Your org	1.5%	2.0%	2.0%	2.2%	5.4%
Best	0.0%	0.0%	0.0%	0.4%	0.8%
Average	3.6%	4.0%	3.7%	4.3%	4.3%
Worst	12.0%	15.4%	17.1%	14.6%	16.6%
Responses	139	169	140	188	186

- Sexual orientation: Improving trend closing the gap with best in the group.

	2018	2019	2020	2021	2022
Your org	2.8%	5.2%	3.8%	4.4%	2.2%
Best	0.0%	0.0%	0.0%	1.2%	1.4%
Average	3.3%	3.7%	3.6%	4.1%	3.9%
Worst	9.8%	9.2%	10.1%	23.4%	8.3%
Responses	139	169	140	188	186

- Disability: Improving trend over the last two years but still working towards the average.

	2018	2019	2020	2021	2022
Your org	7.4%	5.6%	12.5%	13.4%	11.2%
Best	1.2%	2.9%	2.8%	3.2%	3.8%
Average	7.0%	7.3%	8.1%	8.3%	8.7%
Worst	16.7%	13.8%	15.6%	19.3%	20.4%
Responses	139	169	140	188	186

- Age: Improving trend over the last two years, moving towards the average.

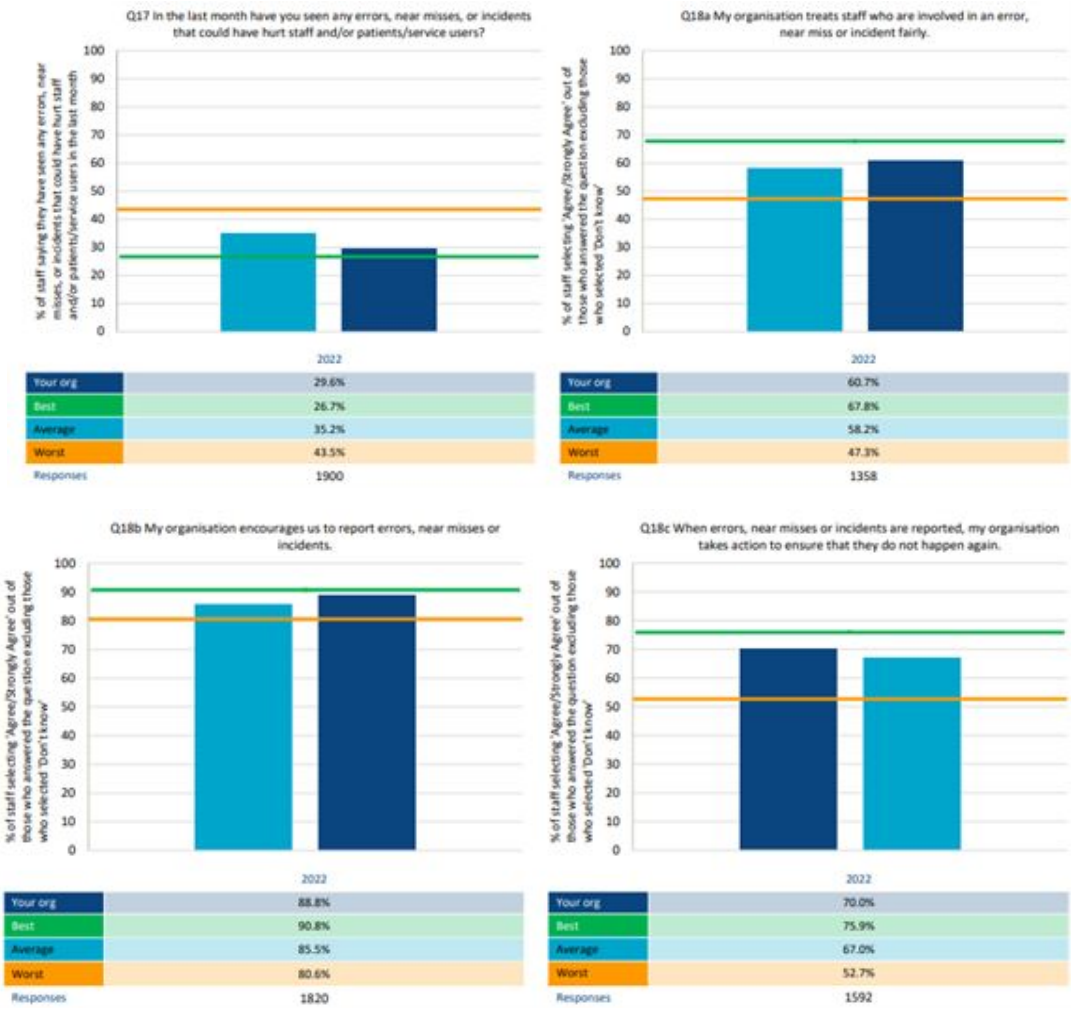
	2018	2019	2020	2021	2022
Your org	22.6%	21.4%	27.4%	22.2%	19.7%
Best	9.0%	4.5%	10.5%	11.7%	13.0%
Average	18.2%	19.0%	19.0%	18.9%	18.8%
Worst	29.8%	33.9%	27.4%	31.8%	28.1%
Responses	139	169	140	188	186

- Other: worsening trend over the last two years, drifting closer to the worst in the group.

	2018	2019	2020	2021	2022
Your org	40.2%	37.5%	31.5%	34.4%	34.2%
Best	19.1%	14.5%	15.5%	14.7%	15.2%
Average	31.9%	29.1%	27.6%	26.6%	24.4%
Worst	62.7%	43.6%	45.1%	45.4%	37.5%
Responses	139	169	140	188	186

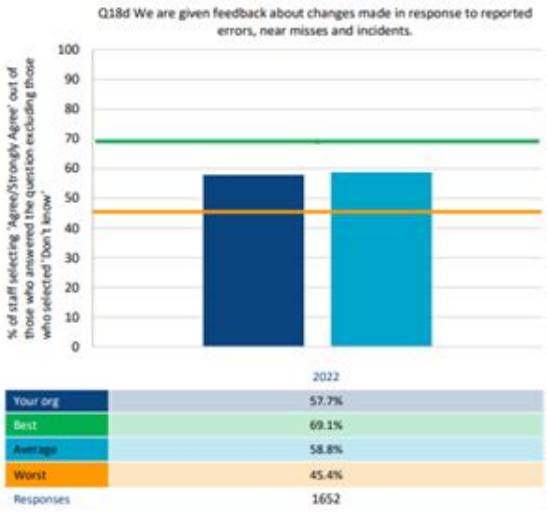
ERRORS AND NEAR MISSES

✓ Improvements and changes introduced by our Quality and Safety are having a positive impact on the number incidents being seen and the willingness to report these.



➢ There is more work required on providing feedback on changes made in response to reported errors, near misses and incidents

➢ More work is also required around reasonable adjustments to enable work to be carried out safely.



CONSIDERING LEAVING

- ✓ All questions related to likelihood of leaving showed a very similar response to other organisations in our benchmarking group.
- ➢ Retention and job satisfaction remains a priority for HDFT, as there is room for improvement.

9

Areas to celebrate

- ✓ Line management results have all moved upwards and are above average – steady improvements
- ✓ Teamworking results have all shown improvement in 2022
- ✓ Organisational support for home life balance, flexible working and flexible shift patterns have all increased and are above the benchmarking group average
- ✓ All questions related to learning development opportunities have shown improvement since 2021, with many reaching or exceeding the benchmarking group average
- ✓ Appraisals have improved in terms of numbers conducted and benefits of these, but it is worth noting the numbers are still below the levels achieved in 2018 and 2019

The most notable **differences from the benchmarking group average** are captured in the table below:

Theme		Question	HDFT 2021	HDFT 2022	Benchmark Avg. 2022
We are always learning: Development	1	Q22a This organisation offers me challenging work.	72.4%	74.6%	69.6%
We are a team: Teamworking	1	Q7c I receive the respect I deserve from my colleagues at work.	73.3%	75.7%	70.4%
We are a team: Line management	1	Q9a My immediate manager encourages me at work.	71.2%	74.8%	69.7%
We are a team: Line management	1	Q9d My immediate manager takes a positive interest in my health and well-being.	68.1%	71.7%	67.4%
We are safe and healthy: Negative experiences	6	Q13a In the last 12 months how many times have you personally experienced physical violence at work from...? Patients / service users, their relatives or other members of the public.	9.2%	7.9%	15.0%
We are safe and healthy: Negative experiences	5	Q14a In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from...? Patients / service users, their relatives or other members of the public.	26.1%	23.3%	28.1%
We are safe and healthy: Negative experiences	5	Q14c In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from...? Other colleagues.	20.7%	16.9%	20.0%
Staff engagement: Motivation	3	Q2c Time passes quickly when I am working	76.3%	77.7%	72.5%
Morale: Stressors	1	Q7c I receive the respect I deserve from my colleagues at work.	73.3%	75.7%	70.4%
Morale: Stressors	1	Q9a My immediate manager encourages me at work.	71.2%	74.8%	69.7%

1. % of staff selecting 'Agree'/'Strongly Agree' out of those who answered the question
2. % of staff selecting 'Never'/'Rarely' out of those who answered the question
3. % of staff selecting 'Often'/'Always' out of those who answered the question
4. % of staff selecting 'Yes, definitely' out of those who answered the question
5. % of staff saying they experienced at least one incident of bullying, harassment or abuse out of those who answered the question
6. % of staff saying they experienced at least one incident of violence out of those who answered the question

The most notable **improvements from 2021 to 2022** are captured in the table below:

Theme		Question	HDFT 2021	HDFT 2022	Benchmark Avg. 2022
We are always learning: Development	4	Q21a In the last 12 months, have you had an appraisal, annual review, development review, or Knowledge and Skills Framework (KSF) development review? *Note: in 2018 and 2019 we were above 90% for this*	71.4%	80.2%	81.4%
We are always learning: Development	4	Q21b It helped me to improve how I do my job. *Note: We are now back at our 2018, 2019 levels for this score*	17.1%	20.5%	21.5%

We are always learning: Development	1	Q22b There are opportunities for me to develop my career in this organisation.	46.3%	51.2%	53.4%
We are always learning: Development	1	Q22c I have opportunities to improve my knowledge and skills.	65.0%	69.9%	67.8%
We are always learning: Development	1	Q22d I feel supported to develop my potential.	48.0%	53.0%	53.8%
We are always learning: Development	1	Q22e I am able to access the right learning and development opportunities when I need to.	51.0%	57.6%	56.4%
We are safe and healthy: Negative experiences	6	Q13a In the last 12 months how many times have you personally experienced physical violence at work from...? Patients / service users, their relatives or other members of the public.	9.2%	7.9%	15.0%
We are safe and healthy: Negative experiences	5	Q14a In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from...? Patients / service users, their relatives or other members of the public.	26.1%	23.3%	28.1%
We are safe and healthy: Negative experiences	5	Q14c In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from...? Other colleagues.	20.7%	16.9%	20.0%
We work flexibly: Support for work-life balance	1	Q6b My organisation is committed to helping me balance my work and home life.	41.0%	46.1%	44.2%
We are a team: Teamworking	1	Q7b The team I work in often meets to discuss the team's effectiveness.	57.7%	63.7%	57.9%
We are a team: Teamworking	1	Q7g In my team disagreements are dealt with constructively.	54.6%	59.6%	55.5%
We are a team: Teamworking	1	Q8a Teams within this organisation work well together to achieve their objectives.	49.8%	54.8%	51.6%
Staff engagement: Motivation	1	Q2a I look forward to going to work.	48.2%	53.1%	52.5%
Staff engagement: Involvement	1	Q3f I am able to make improvements happen in my area of work.	52.0%	55.8%	54.7%
Morale: Work pressure	1	Q3h I have adequate materials, supplies and equipment to do my work.	49.3%	54.1%	53.5%
Morale: Stressors	1	Q3e I am involved in deciding on changes introduced that affect my work area / team / department	48.0%	52.5%	50.4%
Morale: Stressors	2	Q5c Relationships at work are strained.	42.0%	49.5%	44.0%
We are safe and healthy: Burnout	3	Q12f How often, if at all, do you feel that every working hour is tiring for you?	22.5%	18.6%	22.0%
We are safe and healthy: Burnout	3	Q12b How often, if at all, do you feel burnt out because of your work?	36.2%	31.6%	34.8%

1. % of staff selecting 'Agree'/'Strongly Agree' out of those who answered the question
2. % of staff selecting 'Never'/'Rarely' out of those who answered the question
3. % of staff selecting 'Often'/'Always' out of those who answered the question
4. % of staff selecting 'Yes, definitely' out of those who answered the question
5. % of staff saying they experienced at least one incident of bullying, harassment or abuse out of those who answered the question
6. % of staff saying they experienced at least one incident of violence out of those who answered the question

Areas to focus on: biggest gap below average

Conflicting demands

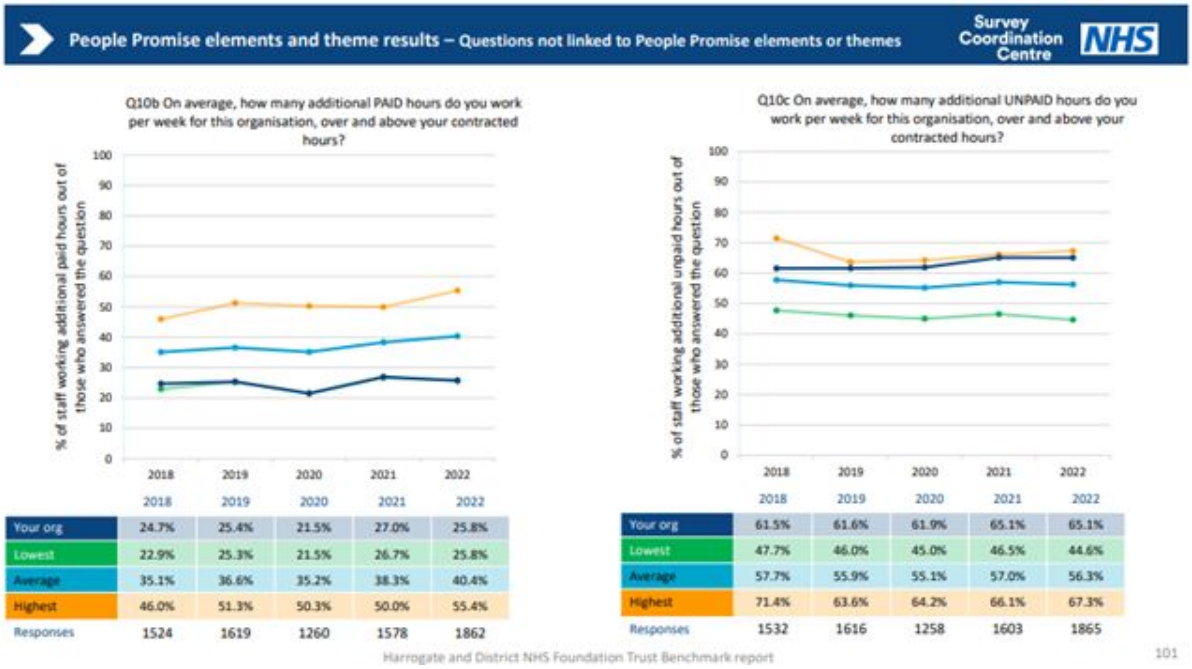
- The percentage of staff who feel able to meet the conflicting demands on their time has improved slightly to 37.8% in 2022 from 35.0% in 2021. This is well below the benchmarking group average of 42.9% in 2022

Discrimination

- ✘ Significant increase in ethnic discrimination from 26.3% in 2021 to 35.1% in 2022 (av. in 2022 is 48.5%)
- ✘ Increase in racial discrimination from 2.2% to 5.4% in 2022 (av. In 2022 is 4.3%)
- ✘ Other discrimination has remained static but is 10% higher than the average at 34.2% in 2022
- ✓ Small decrease in disability, age, gender and sexual orientation discrimination in 2022 compared to 2021

Working Additional Hours

- ✘ HDFT is notable in the discrepancy of staff working additional unpaid hours



	2018	2019	2020	2021	2022
Your org	24.7%	25.4%	21.5%	27.0%	25.8%
Lowest	22.9%	25.3%	21.5%	26.7%	25.8%
Average	35.1%	36.6%	35.2%	38.3%	40.4%
Highest	46.0%	51.3%	50.3%	50.0%	55.4%
Responses	1524	1619	1260	1578	1862

	2018	2019	2020	2021	2022
Your org	61.5%	61.6%	61.9%	65.1%	65.1%
Lowest	47.7%	46.0%	45.0%	46.5%	44.6%
Average	57.7%	55.9%	55.1%	57.0%	56.3%
Highest	71.4%	63.6%	64.2%	66.1%	67.3%
Responses	1532	1616	1258	1603	1865

Actions Taken

The results have been communicated via the Weekly bulletin, and directly to Directorates. In addition, the Senior OD Practitioner has presented to and discussed the results of each Clinical Directorate with their Directorate Triumvirates and in some cases their senior management teams.

In turn, Clinical Directorates presented to an Extended SMT meeting on 19 April 2023 a summary of staff survey-related actions they have taken over the preceding 12 months, and a summary of their key findings from the 2022 National Staff Survey and more recent Quarterly Inpulse Surveys.

It is planned for the Departments within the Corporate Directorate to share their actions taken and key survey findings at the June 2023 SMT meeting.

Next Steps

The five key areas of focus at a Trust level are:

Area of Focus	Actions
Managing work-related stress	Utilising the Health & Safety Executive (HSE) Management Standards, it is planned to implement the HSE's 3 step process, starting with an organization-wide risk assessment. This plan will be taken to the People and Culture Programme Board and to the Health and Safety Committee in June 2023 for approval.
Line manager training	Continue to deliver the core leadership programmes (eg Pathway to Management / First Line leader), and other leadership development programmes (eg BAME Leadership Development / Triumvirate Leadership Development Programmes). A review of the leadership development opportunities available at HDFT is being undertaken. One of the aims of this review is to provide greater clarity and awareness of what is available available, and to guide our leaders and managers (and those aspiring to leadership roles) to the most appropriate programme.
Health and wellbeing (HWB)	The NHSE/I Diagnostic Tool has been completed at HDFT, and an action plan arising from the diagnostic is under development. HWB Champions are being trained. A new Employee Assistance Programme is in place; its usage is increasing. A number of Staff Networks have been launched including Men's Health, Menopause, Neurodiversity, Disability & Long-Term Conditions.
Career progression	A business case for apprenticeships has been approved which creates opportunities for progression for internal band 4 registered nurse associates to achieve a band 5 registered nurse qualification. There are 10 spaces for the 20 month apprenticeship; the application process is underway. The programme is due to start in September 2023. Another business case for apprenticeships has been approved creating 8 spaces on an apprenticeship programme for band 2 healthcare support workers to qualify as registered nurses over a 3 year period. This cohort is due to start in February 2024; funding is available for the following year also. A project of work is being commissioned to review apprentice provision across the organisation.
Appraisal – quality and impact	A review is being undertaken of the training on the HDFT 4S Appraisal Process that was implemented / agreed.

The Board is asked to:

- Note the 2022 National Staff Survey results,
- Note the next steps being planned in response.

Paul Jefferson
Senior Organisational Development (OD) Practitioner

Board of Directors (Public)
31st May 2023

Title:	Freedom to Speak Up Guardian update
Responsible Director:	Emma Nunez – Executive Director of Nursing, Midwifery & AHP's
Author:	Joanna Cann, Speech & Language Therapist, FTSU Guardian

Purpose of the report and summary of key issues:	To provide The Trust Board with an update on Freedom to Speak Up at HDFT	
Trust Strategy and Strategic Ambitions	**The Patient and Child First** Improving the health and wellbeing of our patients, children and communities	
	Best Quality, Safest Care	√
	Person Centred, Integrated Care; Strong Partnerships	
	Great Start in Life	√
	At Our Best: Making HDFT the best place to work	√
	An environment that promotes wellbeing	
	Digital transformation to integrate care and improve patient, child and staff experience	
	Healthcare innovation to improve quality	
Corporate Risks	CRR5: Nursing shortages	
Report History:	Update provided to People & Culture Committee 31/05/23	
Recommendation:	Trust Board members are asked to receive this report for information.	

10

Board of Directors Meeting

Freedom to Speak Up Guardian update

1.0 Executive Summary

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

2.0 Background

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

3.0 Introduction

3.1 All NHS trusts are required to appoint a Freedom to Speak Up Guardian and an assessment of speaking up is at the heart of the well led domain of CQC inspections of NHS trusts.

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

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4.0 Quality Implications and Clinical Input

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

5.0 Equality Analysis

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

6.0 Risks and Mitigating Actions

6.1 Delay in substantive FTSUG getting into post on return from maternity leave, and subsequent protracted training and registration period.

7.0 Consultation with Partner Organisations

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

8.0 Monitoring Performance

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

9.0 Recommendation

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

10.0 Supporting Information

10.1 The following paper appended makes up this report:

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

Date: May 2023

Introduction

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

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

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

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

(The King's Fund: Improving NHS culture)

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

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

All Fairness Champions have been asked to complete the Speak Up and Listen Up training. Following the Mandatory Training Review Panel, all members of HIF and HDFT will be required to complete "Speak Up" and all people in a Line Management or Leadership position will be required to complete "Listen Up". The final module, "Follow Up" will be undertaken by members of the Senior Management Team. This is to raise the profile and awareness of FTSU across the organisation and also provide staff with opportunity to reflect and consider how they can support and promote a Just Culture.

This training roll out is now due to launch imminently across the Trust.

Local work

Freedom to speak up current data

The following table captures the numbers of cases received by the Freedom to Speak Up guardians between January – March 2023, common themes identified and a summary of learning points. Data is submitted to the National Guardian Office on a quarterly basis, this is the same quarterly basis for the below data.

Numbers of referrals to Freedom to Speak Up remain fairly low. However, it is evident that FTSU cases are brought to other members of the team, including the Executive Directors and therefore this data is not always captured and reported directly to the NGO. The FTSU and the Executive Team agreed that concerns raised directly will also be captured through the NGO data submission. However, the following data has been raised directly to FTSU, with one indirect contact raised through the Equality, Diversity and Inclusion Team.

Numbers of cases brought by professional level	Student Worker Manager Senior leader Not disclosed	1 7 including 3 colleagues who have left
Numbers of cases brought by professional group	Medical Registered Nurses, Midwives & AHPS Administration, Clerical & Maintenance/Ancillary Non-registered clinical support staff	8
Number of cases raised anonymously		0
Number of cases with an element of bullying or harassment		2
Response to the feedback question; 'Given your experience, would you speak up again?	Total number of responses The number of these that responded 'Yes'	All cases remain open / await feedback.
Common themes identified	HR processes not explained to staff involved adequately	

	Bullying/Harassment from line manager Concerns with leadership ability to fulfil role effectively Staff retention – team culture	
Summary of learning points	Communication around HR processes already ongoing.	

The Freedom to Speak Up Guardian role update

The allocation for the Guardian role is currently 7.5 hours per week. A scoping exercise is underway across the regional guardian network to establish comparative Freedom to Speak Up models and time allocation. This will be used to review the current model at HDFT, taking into consideration all proactive and reactive aspects of role.

The Guardian is now established within the Regional Guardian Network and attending regular network meetings and sharing best practice.

Next steps / Action Plan:

- Continue regular meetings with Executive Director of Nursing to capture anonymised data from the concerns raised directly to the Director team

- To continue to include the FTSU Guardian and Associate role in the current work on the organisational culture, values and behaviours –
    - Attended multiple staff engagement meetings and more planned.
        - Just and learning culture
        - Speak Up, Listen Up, Follow Up training modules.
        - Linking FTSU Champions monitoring and reporting with Well Being champions
        - Facilitating induction training
        - Facilitating Pathway to Management training

- To continue the rebrand of FTSU at HDFT 'Listening at Our Best' to embed FTSU into the #teamHDFT values and 'At our Best' programme, current project plan.

- One Associate Guardian is in situ and there is currently a vacancy for a second Associate Guardian. The Associate role is currently being defined, with a focus on Fairness Champions: recruitment, training and network events.

- The Fairness Champion directory is currently being updated: contact made with each Champion to ensure details are correct and up to date and that they want to remain a Champion. Applications are being accepted to become a champion and new recruits are being trained on a rolling basis. The recruitment process is being reviewed and updated with HR.

- The app has been further considered and discussed. It has been agreed that app based access to Freedom to Speak up cannot be supported at this time – largely due to risk of confidentiality not being able to be maintained given the initial proposal of it being a shared forum with other colleagues eg EDI Manager. It has been agreed that in time this can be revisited but is not under further development currently.

Next steps/Action Plan:

Action Required	Lead	Date for completion
To formalise and agree a job description for the associate role	FTSU Lead	July 2023
Continue with the launch of the visible "Pledge Wall" and other FTSU material	Giles Latham, Communication & Marketing Manager	July 2023
Review the NGO Gap Analysis and Just Culture Gap Analysis	FTSU Lead & HR / OD	July 2023
Launch the e - learning package as mandatory training	Learning & Development	May 2023
Update of Fairness Champions directory	FTSU Lead and Associate	July 2023
Regional scoping of comparative FTSU models	FTSU Lead via Regional Network	July 2023

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

Date	**4 April 2023**	**Location**	MS Teams
Chair	**Brendan Brown**	**Minutes prepared by**	Geraldine Morris
Attendees	Lucy Cole, Len Richards, Brendan Brown, Foluke Ajayi, Jonathan Coulter, Ben Roberts, Mel Pickup, Phil Wood Rob Webster (Item 3), Catherine Riley (Item 8), Asifa Ali (Item 9)		
Apologies			

Agenda

ITEM		WHO
1	Welcome and apologies	Chair
2	Minutes and Actions	All
3	CEO Updates and industrial action planning (Rob Webster joining)	All
4	Collaborative Report	LC
5	WY ICB • WY HCP Report • Review of Operating Model	LC All
6	Financial position • 22/23 • 23/24 • Capital	BR
7	NSO: Sheffield mutual aid	LR
8	Capital and Infrastructure Board • Role, governance, and process	Catherine Riley
9	Senior Leadership Development programme • Placements / projects • Mentors • Plan for 14 April workshop	AA
10	Draft CiC Agenda	LC
11	AOB	All
12	Close	Chair

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

By Agenda Item	Main Points and Decisions from Discussions	Agreed Actions
Review previous meeting minutes and action points	The minutes from the previous meeting were accepted as a true record. The action log was reviewed, and the following updates were given: • Actions 93, 94, 95, 96, 97, 100 and 103 were noted as closed. • Action 98: WYAAT Strategy draft – All to share any further comments on the draft strategy with LC. – In progress • Action 99: WYAAT Strategy draft – LC to invite national colleagues to future meetings. – In progress • Action 101: Endoscopy update – LC to ask Executive to chair steering and invite them to report back to Chief Executives. – In progress (May) • Action 102: Endoscopy update – Update to be scheduled for April 2023 meeting. – On today's Agenda as part of collaborative report.	
CEO Updates and industrial action planning (Rob Webster joining)	*Rob Webster (RW) joined the meeting.* RW gave an update on the wider concerns nationally and commented that NHSE is making changes which will have an impact on regions. The ICB will have running cost allowance reductions to make, so this is an opportunity for WYAAT to think about what it wants to do in the context of the changing ICB operating model. MP sought RW's view on the recently published Hewitt Review and implications for those ICSs to be given greater powers. RW said although he was unaware of the full detail currently, but as long as West Yorkshire ICS is able to manage financial and operational pressures, then it should be one of those ten granted greater powers. The group discussed the national workforce plan. RW noted that the draft he had seen was clear and quantified with requirements in specific areas. BB asked about the three-to-five-year plan for maternity. RW advised there are some short-term actions and maternity is an area included in the draft Workforce Plan. Foluke Ajayi (FA) asked if there was any reference in the Workforce Plan to the social care sector. RW said improvements in social care are slightly limited by what the plan covers, and this is the same with carers and volunteers. There are a number of references, but not many actions, so this is an area that's being focussed on. BB enquired about the financial position in respect of the ICB Operating Model and running cost allowance (RCA) reductions. RW replied that to be successful, investment is needed in dentistry, digital capacity and capability, as well as a reshape of some of the teams. RW also spoke of work being done around the operating model and the need to demonstrate a 30% reduction in running costs. Another consideration is what to invest the money in overall as there was	

	no expectation that the ICB allocation would be changed to reflect the RCA reduction. BB asked what we collectively cease doing to enable some of this work and whether more business intelligence was needed to support a sharper focus on priorities. RW was clear that the ICB's role is to coordinate and support collaboration across the ICS and that a review of the operating model was an opportunity to review and improve this. This included considering how WYAAT supported this and what functions or resource WYAAT might require to achieve success. RW asked about WYAAT's role in research and innovation, on quality and safety, productivity and sustainability and the role of clinical leadership within that. BB noted that there was a strong role for the trusts in their communities as well as within the boundaries of secondary care provision. The group discussed the WYAAT priorities in respect of the 'three tests' for working together and there was consensus that 'scale' and 'wicked issues' were the main drivers, and there was an opportunity to greatly expand on sharing best practice, knowledge and improvement and showcase this more effectively both across WYAAT trusts and at Place. MP also noted virtual wards as an area that there needed to be greater sharing of best practice, RW agreed that the 'join' between hospital and community services required greater focus. LC confirmed that these things featured heavily in the WYAAT Strategy for the next five years which is currently being finalised. The mechanics of this now needed consideration in light of the ICB Operating Model review. RW ended by saying that resources will always be put in the right place to deliver the changes needed and thanked LC for her work over recent weeks. RW also thanked all members for their work over the challenging winter, which was achieved through joint working and the leadership of the WYAAT Chief Operating Officers. The members thanked RW for coming today. *RW left the meeting.* The group reflected on the discussion and agreed that the operating model review needed to focus on how best to deliver functions across the ICS and have an effective ICB, rather than focus solely in reducing running costs by 30%. It was agreed that WYAAT needed to do further collective work on what its role should be and how that would influence the new operating model. There was equal support for ensuring that costs were reduced given the deficit position.	

	LC noted key areas in respect of supporting a collaborative approach to research and innovation and alignment of AHSN priorities and resource, a broader approach to procurement to drive collective negotiation and efficiencies across Place as well as providers, and expanding the work on quality and safety which has been highlighted by WYAAT Chief Nurses. LC noted that nearly all WYAAT exec groups were having time-outs to refocus collective priorities for 23/4 which would help to feed into the Operating Model discussion. FA identified that as a minimum, Trusts need to be involved in the strategic planning process. BB and LC agreed, with LC saying this doesn't need overcomplicating and can be done in a straightforward way. BB agreed. LC agreed to try and align today's discussion to the WYAAT strategy and feedback to members.	**LC to align strategic requirements to operating model review for discussion at the next meeting.**
Collaborative Report	LC presented the Collaborative Report. LC gave highlights from the Collaborative Report: • A haematology workshop has been organised for 27 April with a view to understanding priorities and developing a plan. LC will report back on this in May. • Neurology is progressing well with a preferred model emerging, with SU meeting with WYAAT assurance groups during April and May to brief and gain feedback on the work to date and next steps • The endoscopy steering group is being set up, with Rob Aitchison leading this. Self-assessments for the Regional Training Centre are being undertaken, which will generate a view on how to develop the model. • Pathology - the blood transfusion LIMS go-live happened last month in Airedale and Bradford – Leeds will take the module live next in May. Testing has been a challenge in blood sciences due to resourcing in the laboratory. It has been agreed that LTHT will be the first to take blood sciences and microbiology modules live in September 2023, with Airedale and Bradford exploring a full Joint Venture go live with Harrogate. • CDC revenue has now been approved which means that implementation can progress in all Places. • Aseptics – feedback from the regional team has been received on the business case which the team is responding to. Hoping that this will now progress to national approval. • Vascular Board met the previous day and have recommended a preferred option for the network structure. A paper will be brought to the next WYAAT Programme Executive for CEO agreement.	**LC to report back on haematology workshop in May.** **LC to report back on vascular board meeting in May.**
WY ICB	LC noted that most WY ICB items have been covered in the meeting already.	**PMO to schedule for next Programme Executive meeting in May.**

	BB suggested that members meet next Friday to discuss this. PW noted he'll be on leave. BB asked for PWs thoughts. PW said the key thing would be to work out the tension between the expanding role of Place and the role of WYAAT. *Asifa Ali (AA) joined the meeting.* BB thanked AA for joining the meeting and moved on to her item on the agenda.	
Financial Position	BR gave a report on finances (the report was distributed with the meeting papers). LR asked about the funding that had been made available so close to the end of the financial year. BR replied that trying to manage this with a month to go has been exceptionally difficult. It was noted that this may happen again at the end of 23/24, however this could not and had not been factored into planning assumptions. LC noted that this was an item for discussion at CiC at the end of the month and the key messages which CEOs wished to draw out for the Committee. JC noted that the focus should be on the 'true' productivity gap which had been calculated locally and actions to be taken to support closing the gap and improving productivity.	**BR to update finance paper for CiC meeting on 25 April.**
NSO: Sheffield mutual aid	LR and BB highlighted the issues with capacity currently faced by Sheffield to deliver breast oncology services. A recent meeting had been convened with other tertiary centres, including LTHT, to review options for mutual aid. A data analysis exercise had identified that the other centres were under similar demand and capacity pressures to Sheffield and therefore significant mutual aid could not be provided. PW confirmed that LTHT would take a transfer of a small number of complex patients from Sheffield in the first instance. Concern was expressed about destabilising the working arrangements in West Yorkshire and clinical capacity, balanced with the need to ensure patients had access to treatment.	
Capital and Infrastructure Board	*Catherine Riley (CR) joined the meeting.* BB thanked CR for joining the meeting and moved on to her item on the agenda. Catherine Riley (CR) explained her role supporting LR as SRO for the Capital and Infrastructure Board. CR explained the purpose of her visit today was stakeholder engagement and to obtain feedback on whether C&I Board is useful to stakeholders and determine its relevance. CR gave an overview of C&I, which was set up in 2018, and spoke of the overlap with other Boards, which leads to duplication. CR asked members if they thought the forum was necessary, what they'd like to see C&I doing and if it could be doing something different.	

	LR commented that C&I had thus far been reactive rather than proactive to things but felt it could still play a role. MP thought that C&I may no longer be required, unless the operating model review markedly changes things. LC remarked that there was overlap with a number of other groups including the ICS Capital Group, Sustainability Group, and the Directors of Estates and Facilities forum, that some of the functions of the C&I board may have been superseded. PW raised that as a provider collaborative, WYAAT thinks of uses for capital and infrastructure when it's presented, therefore it would be better to plan on matters that have been collectively agreed on, in the event of funds being made available. CR advised that NHS England (NHSE) have a pilot in each region for a capital infrastructure plan, which will be shared this year. CR closed by saying that if C&I was to change, it didn't want to lose something that was important to WYAAT. And invited members to contact C&I if assistance was needed on any work. *CR left the meeting.*	
Senior Leadership Development Programme	AA introduced herself and shared a presentation on the Senior Leadership Programme (SLP). The presentation gave an overview of the applications received, the number of applicants by Trust, the cohort skill mix, learning approach and the Programme's milestones to date. AA discussed the SLP launch event and its proposed agenda. *JC left the meeting.* AA informed members that the SLP had received good feedback from applicants already. AA informed members that a decision will be made on Thursday afternoon regarding rescheduling the 14 April launch date, which would need to be postponed due to proposed industrial action. LR said it would be important to get a session in quickly, with maximum flexibility in people's diaries. AA explained that evaluation is planned throughout the programme. SLP will use feedback to help shape any future programmes. BB agreed with LR regarding having flexibility in diaries, in that it would help in keeping the momentum going. BB thanked AA and team for their work so far on the SLP. *AA left the meeting.*	
Draft CiC Agenda	LC highlighted to members the agenda for the Committee in Common (CiC). LC discussed that she had met with all Executive Boards to discuss the WYAAT strategy, which should be okay. Should have an annual plan by July. Nothing for approval, so should be straightforward. Members were happy with the proposed agenda.	

	LC closed by suggesting that RW be invited back in July, for a continuum of discussion. The members agreed. BB thanked LC for her work on this.	
AOB	BB discussed that with Julian Hartley and Steve Russell's new roles nationally, it would be beneficial to invite them to a future Programme Executive meeting, to which the members agreed. LC informed members that she has an action to do that and will need to work through who can come when and will speak to Julian and Steve directly. BB discussed that place-based Race Equality Network (REN) leads will be released for full day paid leave for this work, agreed by the ICB. This has now been communicated that this will cover all Trust-based REN leads. BB confirmed that this was not his understanding of the decision and that he had noted that he could not commit to this on behalf of all WYAAT organisations. Members agreed that if the lead for this work (Fatima Khan-Shah) is keen to have a conversation about this, that it should be with WYAAT rather than individual trusts.	

OTHER ISSUES TO NOTE

N/A

NEW RISKS/ISSUES RAISED

N/A

Next Meeting	**WYAAT Programme Executive**		
Date	2 May 2023, 09:30-12:30	**Location**	Venue TBC (based on SLE location)

Humber and North Yorkshire
Health and Care Partnership

Collaborative of Acute Providers (CAP) Board Meeting
24th March 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
Simon Morritt (SM), CEO, York and Scarborough
Matt Graham (MG), Director of Strategy, Harrogate
Andy Bertram (SB), Chief Financial Officer, York
Ivan McConnell (IMc), Director of Strategic Development, NLaG
Kate Wood (KW) Chief Medical Officer (NLaG)

In Attendance: Shauna McMahon (SMcM) Chief Information Officer
Lynette Smith (LS) Deputy Managing Director CAP
Neil Wilson (NW), Head of Partnership and Alliances
Anil Vara (AV), Director of Elective Recovery

1	**Apologies:** Peter Reading (PR), CEO, NLaG Shaun Stacey (SS), COO (NLaG),	
2	**Minutes from last meeting** The Minutes from 27th February were approved	
3	**Action Log** The Action Log will be updated for the next meeting. No further items/actions to note.	
4	**CAP Work programme 23/24** WS presented the draft Plan on a Page for the Collaborative of Acute Providers work programmes. The overall programmes were acknowledged, with a request for further detail on the workforce element. WS briefed that additional HR posts were out to recruitment to support the Acute workforce priorities. It was agreed that the plan would be updated with more specific details for workforce as a basis for priority setting for the new roles. The Board discussed the role of capital within the CAP work programme and how this would be reflected. AB confirmed that the capital would remain as an ICB programme; however there would be a benefit in coming together to develop a set of capital priorities for the acute sector to support collective bids and strategy for resource allocation against the ICB capital programme. WS proposed that this could be added to the clinical service and configuration section. AB updated the Board of a commitment to a part time CAP finance post as part of the CAP resources, and this post could lead and coordinate the capital programme to help share and develop the priorities, this would help to develop a 'single voice' and for the acute sector to talk coherently as one network	

Humber and North Yorkshire Health and Care Partnership

	SM asked if the work programmes could reflect where they are leading, contributing, or responding to the ICS priorities. This would enable the CAP Board to be clear in our own operating model and the purpose for the work. WS explained the ICS requirement to have a Joint Forward Plan and the work coordinated through Penny Gray on behalf of the ICB Board to develop the Joint Forward Plan document by June 2023. WS presented the CAP contribution to the ICS Joint Forward Plan. CL noted that this was a helpful summary. LS noted to the Board that the Plan on the Page and Joint Forward Plan summary included the vision shared by PR. Action: **WS to further develop the workforce element of the programme to outline the workforce priorities of the programmes.** **WS/LS to set out the role of each programme in relation to the ICS priorities.** **Agreed: CAP Plan on a Page, with further refinement to the workforce section and Joint Forward Plan submission**	**WS**
5	**Resources** AB updated the Board on the work with Mark Bradley (Finance Director), Emma Sayner (Finance Director) and WS on the CAP proposed structure to support the programmes. The cost of the structure is £2.2m FYE, including an element of non-pay of around c£60k. This will be funded through a combination of existing contributions across providers, the £650k diagnostic underspend and contribution to the CAP from the ICS. The available budget is c£1.5m. A discussion ensued around the £1.5m for 2023/24 and impact on the programmes if not able to recruit to the programme proposals. AB informed the Board that due to delays in approval, and therefore associated delay in recruitment, the lag time would be managed in 23/24 to keep costs to £1.5m, with a view to the £2.2m for 24/25. This would result in an addition £750k into the forward plan for 24/25. AB outlined the proposed approach for CAP resources to be hosted through York and Scarborough THFT, with a collective risk share between the four providers and the ICS in relation to the risk of stranded costs. WS outlined options for cost reduction, including sharing costs around UEC and Clinical Network time as a contribution in kind. The Board discussed the resourcing options. CL proposed that the resource profile was accepted by the group with a view to consider the cost of the £750k contributions across the providers in 24/25. JC agreed to support the resourcing proposals, to live within the current balance for 23/24 and focus on delivery. CL stated that the funded backfill for clinical time to support the networks was a symbolic commitment. SM supported the collective agreement with a view to the ongoing discussion with NHSE and ICS on capacity to support delivery. In response to the resource commitment WS confirmed she would bring back more detailed programme plans to the CAP Board. CL thanked WS and AB for their progress with this work. **Agreed: Resourcing proposal for CAP and commitment to the full year costs in 24/25. CAP posts to be hosted through York and Scarborough Teaching Hospital FT with an associated employment liabilities risk share between the four providers and the ICS.**	

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Health and Care Partnership

6	**Finance and Procurement Update** AB updated the Board on the financial position for 22/23 and confirmed that the ICB were planning to deliver a balanced plan. AB noted that the three Trust Board's had now approved the procurement business case and work was now progressing, with recruitment underway. The CAP Board will receive updates on the progress of the collaborative approach and AB requested that the Board played a role in unblocking any challenges to delivery. This was agreed. AB shared the developing conversations about the Quality, Efficiency and Productivity plan, with the expectation that efficiency plans are developed to support the financial position. Wendy Pollard at York and Scarborough Teaching Hospital NHS FT has been working with a group under the direction of the Finance Director's Group to identify shared efficiency plans and opportunities for North Yorkshire, and the group would look to extend this across the Humber.	
7	**EPR Update** SMcM introduced the team to provide an update on the Pre-Tender Market Engagement. AW shared the presentation on the EPR convergence principles, including that it must be a cloud based solution and a minimum of two Trusts. HDFT and YSTH must be the first to progress based on the current digital position. The solution must also mitigate risks from a 'big bang' deployment. The costing approach has been to identify the cost per trust and a discount for a collective approach. AW shared the findings of the pre-tender market engagement with 6 suppliers responding. A discussion on the findings followed. AW briefed the CAP Board that the next steps were to test implementation plans with suppliers through confirm and challenge sessions with all 6 providers to explore the answers to the pre-market tender engagement in more detail. This will provide helpful material to inform the next steps in developing the business case. AW outlined that as the investment levels would be different across the Trusts, they may recommend alternatives and they will be Trust level business cases for each Board. AW updated on the timetable for outline business case and invitation to tender. The Board discussed the alignment challenges around an enterprise EPR in comparison to a modular option across Trusts, and the broader opportunities a single EPR system could bring on unwarranted variation and overall cost of ownership. SMcM shared examples of enterprise approaches in Manchester and other jurisdictions and recommended the development of a collective digital strategy, which would support clinical transformation. JC raised the modular approach given the levels of digital maturity across the system and capacity to deliver change. AW concurred that there is a challenge to identify the right size for economies of scale and deliverability, and how that aligns with the availability of national resource to drive digital improvements. CL reflected that the programme needed to be supported by organisational development work (OD) to support changes in clinical pathways. CL asked if there was a 'right of veto' in relation to the tender process, AW confirmed that there no a veto, but the tenders must be compliant with the design principles. CL asked if the scope of the EPR work included the Community Interest Companies and primary care. AW confirmed that there were out of scope for this, with one funding stream for the acute sector and one for mental health provider. The Board noted that three of the four acute trusts were also community providers so a solution would need to be suitable. SMcM proposed a more detailed session to discuss key issues and a steer from the Board between ambition and	

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	pragmatism, noting there was still a year to go before a decision would be made. It was agreed a session would be set up for a future CAP Board. **Action: Session on EPR ambitions to be arranged.**	**SMcM**
8	**Programme Highlights** Clinical Networks NW presented the paper on Clinical Networks, outlining the purpose of paper to review the process, audits and governance around the range of networks in the system, and highlighting the recommendations to recognise the importance of networks; to stocktake the networks and develop a directory and improve two way communications to networks, to improve alignment to system priorities and seek expert advice and signposting. This work will be actioned through the Clinical and Professional group within the ICS. WS shared that the audit to date had identified 52 networks, 30 within Humber and North Yorkshire, 12 regional, 2 national and 8 unknown geographic. The work was noted by the group and CL reflected the importance of supporting the clinical networks that CAP have commissioned. The paper was endorsed. Peri-operative business case AN presented the peri-operative programme and outcomes of the work to date. The proposal is for York and Scarborough Teaching Hospitals to test the peri-operative case as part of the regional programme and for HNY to develop the business case and options appraisal. SMcM asked about the alignment to the EPR work and broader digital strategy in relation to the Value for Money for additional digital developments. It was agreed this would be further discussed before progressing. 78 week position AV informed the Board that there were 368 patients waiting more than 78 weeks at the end of March, an improvement on the expected trajectory and a 77% reduction in the risk compared to January 2023, reflecting the hard work of the operational and clinical teams. Programme Highlight Reports WS raised the Programme Executive Committee Terms of Reference for approval. CL requested comments by Friday 31st March and then to establish. IMc updated on the CDC capital schemes, with £19.46m bid for Scunthorpe hub to be operational by 1st April 2025 and has shared the template workbook for the submission with AB to support the Scarborough resubmission. It has been agreed with the national team that the spokes cases for Hull and Grimsby will be submitted in Q1. **Agreed: Clinical Network paper recommendations approved.** **Action: AV/WS/SMcM to discuss the peri-operative proposal**	**AV**
13	**Any Other Business** CL noted his apologies for the next meeting.	
	Date and Time of the Next Meeting 24.04.23 10.00 – 12.00 via teams	

Board of Directors
31st May 2023

Title:	**NHS Provider Licence Self Assessment**
Responsible Director:	Jonathan Coulter Chief Executive Officer
Author:	Kate Southgate Associate Director of Quality and Corporate Affairs

Purpose of the report and summary of key issues:	This paper provides the Board with the annual self certification for the NHS Provider Licence.	
Trust Strategy and Strategic Ambitions	**The Patient and Child First** Improving the health and wellbeing of our patients, children and communities	
	Best Quality, Safest Care	X
	Person Centred, Integrated Care; Strong Partnerships	X
	Great Start in Life	X
	At Our Best: Making HDFT the best place to work	X
	An environment that promotes wellbeing	X
	Digital transformation to integrate care and improve patient, child and staff experience	X
	Healthcare innovation to improve quality	X
Corporate Risks	N/A	
Report History:	The Board receives and approves the annual declaration each May.	
Recommendation:	The Board is asked to approve the self assessment as detailed in the report.	

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TRUST BOARD

NHS Provider Licence Annual Self-assessment

1. Background

Each year, the Trust is required to self-certify compliance with certain conditions against its licence as issued by "Monitor". ("Monitor" was the independent regulator of NHS Foundation Trusts whose functions are now undertaken by NHS England / Improvement).

The specific conditions we are required to self-certify against are:

- General Condition G6
- Foundation Trust Condition FT4
- and Continuity of Services Condition CoS7

In addition, there is a requirement to self-certify that it has met its legal (Section 151(2) of the Health and Social Care Act 2012) and Constitutional (paragraph 14.2) obligation to "…take steps to secure that the governors are equipped with the skills and knowledge they require in their capacity as such."

This report is aimed to provide information to determine if the Committee can confirm compliance against these conditions.

Appendix 1 provides an overview of all licensing requirements.

2.0 The Timetable for Board Sign-off

The table below provides a description of each condition and the deadline date for sign-off by the Board:

NHS provider licence conditions

Condition G6(3)	The Trust has taken all precautions to comply with the licence, NHS acts and NHS Constitution	By 30 June
Condition G6(4)	Publication of condition G6(3) self-certification	By 30 June
Condition FT4(8)	The Trust has complied with required governance arrangements	By 30 June

NHS E/I provides a template to assist the recording of self-certifications, should the Trust be audited. This template is no longer mandatory but it can be used to illustrate compliance with the process and maintained for record keeping.

3.0 Condition G6(3)

Condition G6(3) requires NHS providers to confirm or not confirm that they have processes and systems that:

- Identify risks to compliance with their licence, NHS Acts and the NHS Constitution
- Guard against those risks occurring.

3.1 The Board's determination of compliance with General Condition G6

The question that this condition asks is if the Trust has identified the risks to compliance and if it has taken steps to mitigate such risks.

Evidence to support compliance against this condition is provided in Appendix 2.

4.0 Condition FT4(8)

Condition FT4(8) is regarding systems and processes for good governance and if the Trust has governance systems and processes in place to achieve compliance against condition FT4.

Having taken into account the well-led framework for governance reviews, NHS Foundation Trust Code of Governance and the Single Oversight Framework, Appendix A references evidence to support the Board's determination of compliance against FT4(8).

Evidence to support compliance against this condition is provided in Appendix 3.

5.0 Continuity of Services Condition 7

Only NHS Foundation Trusts that are designated as providing Commissioner Requested Services (CRS) are required to self-certify under condition CoS7(3).

What is CRS designation?

CRS are services commissioners consider should continue to be provided locally even if the provider is at risk of failing financially and, as such, are subject to closer regulation by NHS Improvement. Providers can be designated as providing CRS because:

- There is no alternative provider close enough
- Removing the services would increase health inequalities
- Removing the services would make other related services unviable

The Trust has received confirmation that its acute services have been confirmed as CRS by its commissioners as part of the annual contract review process.

Under this requirement the Trust is required to confirm one of three statements below and to provide supporting narrative explaining the reasons for the chosen statement:

a. The required resources will be available for 12 months from the date of the statement;
b. The required resources will be available over the next 12 months, but specific factors may cast doubt on this; or
c. The required resources will not be available over the next 12 months.

The Trust would like to confirm against (a) above, which was considered as part of its annual planning process, we are assured that that required resources will be available for acute services for 12 months from the date of the statement.

6.0 Other Self-certifications

6.1 Training of Governors

NHS Foundation Trusts are required to review if their Governors have received enough training and guidance to carry out their roles.

Throughout the year Governors have been continually communicated and engaged through in person and virtual formal and informal meetings, in addition to this induction training is offered, there are opportunities to join local and national network events with presentations and information by Directors and officers provided throughout the year.

7.0 Recommendation

The Board is asked to:

1. Note the certified compliance against condition G6 (3) and that the Trust has taken all precautions to comply with the licence, NHS Acts and NHS Constitution;

2. Note the certified compliance against Condition FT4(8) governance arrangements;

3. Note certified compliance against Continuity of Services Condition 7 (3) that require resources will be available for acute services for 12 months from the date of the statement;

4. Note certified compliance against the Training of Governors obligation; and

5. Note and approve the plans in place to publish compliance against condition G6 (3) on the Trust's website by 30 June 2023.

Kate Southgate
Associate Director of Quality and Corporate Affairs
May 2023

This template may be used by Foundation trusts and NHS trusts to record the self-certifications that must be made under their NHS Provider Licence.
You do not need to return your completed template to NHS Improvement unless it is requested for audit purposes.

Self-Certification Template - Conditions G6 and CoS7

Harrogate and District Hospitals NHS Trust *Insert name of organisation*

NHS Improvement

Foundation Trusts and NHS trusts are required to make the following self-certifications to NHS Improvement:

Systems or compliance with licence conditions - in accordance with General condition 6 of the NHS provider licence
Availability of resources and accompanying statement - in accordance with Continuity of Services condition 7 of the NHS provider licence (Foundation Trusts designated CRS providers only)

These self-certifications are set out in this template.

How to use this template
1) Save this file to your Local Network or Computer.
2) Enter responses and information into the yellow data-entry cells as appropriate.
3) Once the data has been entered, add signatures to the document.

Worksheet "G6 & CoS7"

Financial Year to which self-certification relates 2022-2023 Please complete the explanatory information in cell

Declarations required by General condition 6 and Continuity of Service condition 7 of the NHS provider licence

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

1 & 2 General condition 6 - Systems for compliance with licence conditions (FTs and NHS trusts)

1	Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.	Confirmed	OK

3 Continuity of services condition 7 - Availability of Resources (FTs designated CRS only)

EITHER:

3a	After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.		Please Respond

OR

3b	After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.		Please Respond

OR

3c	In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate.		Please Respond

Statement of main factors taken into account in making the above declaration

In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

[e.g. key risks to delivery of CRS, assets or subcontractors required to deliver CRS, etc.]

Signed on behalf of the board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name		**Name**	
Capacity	[job title here]	**Capacity**	[job title here]
Date		**Date**	

Further explanatory information should be provided below where the Board has been unable to confirm declarations under G6.

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This template may be used by Foundation trusts and NHS trusts to record the self-certifications that must be made under their NHS Provider Licence.
You do not need to return your completed template to NHS Improvement unless it is requested for audit purposes.

Self-Certification Template - Condition FT4

Harrogate and District NHS Foundation Trust

Insert name of organisation

Foundation Trusts and NHS trusts are required to make the following self-certifications to NHS Improvement:

Corporate Governance Statement - in accordance with Foundation Trust condition 4 (Foundations Trusts and NHS trusts)
Certification on training of Governors - in accordance with s151(5) of the Health and Social Care Act (Foundation Trusts only)

These self-certifications are set out in this template.

How to use this template

1) Save this file to your Local Network or Computer.
2) Enter responses and information into the yellow data-entry cells as appropriate.
3) Once the data has been entered, add signatures to the document.

Worksheet "FT4 declaration" | **Financial Year to which self-certification relates** | 2022-23 | Please Respond

Corporate Governance Statement (FTs and NHS trusts)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements, setting out any risks and mitigating actions planned for each one

	Corporate Governance Statement	Response	Risks and Mitigating actions	
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Confirmed	[including where the Board is able to res• Strong corporate governance processes and procedures are in place to ensure the Board and all its Sub-Committees and operational groups operated with the highest regard of sound governance principles. Within year, there have been no areas of escalation or concern to indicate this has been breached. • Strong and effective Board and Sub-Committees are in place with six assurance committees implemented including the newly established Innovation Committee to represent the ever expanding digital and continuous improvement work streams • Clear reporting lines of the governance framework are detailed within the Terms of Reference of Committees, Constitution and Scheme of Delegation • Clear management reporting lines are in place across the organisation which have been strengthen in 2022-23 with the development of clinical triumvirate working across specialities • The Annual Governance Statement outlines in detail the governance framework that has operated during 2022-23 • The Trust has a rating of "Good" from the Care Quality Commission Well-Led Review in 2018 • The Board's infrastructure includes Board scrutiny/assurance Committees and various operational groups, to ensure that the Board of Directors can be assured that the organisation's decisions and business are monitored effectively and efficiently pond 'Confirmed']	#REF!
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed	As per statement 1	#REF!
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	Confirmed	As per statement 1	#REF!
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.	Confirmed	• An approved Audit Programme is in place, overseen by the Audit Committee. • The Trust has produce a Quality Account in accordance with regulatory requirements. • Systems of internal control are in place and are subject to regular audit on an annual basis through the Trust's internal audit programme and by external auditors. • The Resource Committee and Audit Committee are the principal Committees that maintain oversight on this area. It is determined that there are robust systems and processes in place to monitor and oversee all CIP schemes. • The Trust has a good track record of effective financial management and of achieving its statutory financial duties. • The Board and Committee meeting dates are scheduled to allow the most up-to-date information to be provided to meetings for scrutiny and assurance. • The Standing Orders for the Practice and Procedure of the Board of Directors enable the Chairman to call a meeting of the Board at any time. • The Trust has an approved Risk Policy in place, the Board Assurance Framework (BAF) and Corporate Risk Register provide the framework through which risks are considered, reviewed and managed. • The Board receives a summary of the Corporate Risk Register/Board Assurance Framework at each of its meetings. • The Trust has an Annual Planning process that ensures future business plans are developed and supported by appropriate engagement across the organisation. The Annual Plan is discussed in detail at the Resource Committee and by the Board before this is approved. • The governance, risk and control processes in place ensures that any risks to legal requirements are considered to ensure the Trust remains compliant. • SMT and supporting groups scrutinise key areas of performance including quality, workforce, finance, operational and contractual. The Committees review performance and risk by exception (and in accordance with Terms of Reference) at each meeting and subsequently provide assurance to the Board of Directors through the Chair's reports highlighting any key recommendations or key risks identified. • The Quality Committee uses the Quality Report to review quality performance indicators, as well as overseeing the implementation of improvement programmes for the Trust's strategic quality priorities. The Committee also oversees compliance with the registration with the Care Quality Commission	#REF!
5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Confirmed	• There are appraisal processes in place to support Board members individually and collectively. The outcome of appraisals are reported to the Remuneration Nomination and Conduct Committee for Non-executive Directors, including the Chair and to the Remuneration Committee for the Executive Directors including the Chief Executive. • There are QIA and EIA processes in place to support decision making processes for any service development or changes and any impact on the quality of care is carefully considered. • The Quality Governance Management Committee supports the monitoring of information on the quality of care; the monthly SMT receive a quality performance report from the Director of Nursing, Midwifery and AHPs and the Quality Committee consider a detailed quality report. • The Quality Committee Chair reports any key decisions, risks and escalations to the Board.	#REF!
6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Confirmed	As per statement 5	#REF!

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature _____ **Signature** _____

Name _____ **Name** _____

Further explanatory information should be provided below where the Board has been unable to confirm declarations under FT4.

A | #NAME?

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Worksheet "Training of governors" | **Financial Year to which self-certification relates** | 2022-2023 | Please Respond

Certification on training of governors (FTs only)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements. Explanatory information should be provided where required.

Training of Governors

1	The Board is satisfied that during the financial year most recently ended the Licensee has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.	Confirmed	OK

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name		**Name**	
Capacity	[job title here]	**Capacity**	[job title here]
Date		**Date**	

Further explanatory information should be provided below where the Board has been unable to confirm declarations under s151(5) of the Health and Social Care Act

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