COUNCIL OF GOVERNORS' MEETING (held in PUBLIC)

Tuesday 6 June 2023 from 4.00 – 5.30pm
To be held at the Crown Plaza, Harrogate
AGENDA

Agenda items listed in blue text are to be received for information / assurance with no discussion time allocated within the agenda.
Papers for these items may be found within the Supplementary paper pack

Item No.	Item	Lead	Action	Paper
1.0	**Welcome and apologies for absence**	Sarah Armstrong Chair	Note	Verbal
2.0	**Declarations of Interest**	Sarah Armstrong Chair	Note	Verbal
3.0	**Minutes of the meeting held on 7 March 2023**	Sarah Armstrong Chair	Approve	Attached
4.0	**Matters arising and Action Log**	Sarah Armstrong Chair	Note	Attached
5.0	**Chair's update**	Sarah Armstrong Chair	Note	Verbal
6.0	**Non-Executive Directors Briefings**	Non-Executive Directors	Note	Verbal
7.0	**Chief Executive and Executive Director strategic and operational update**	Executive Directors	Note	Attached
7.1	Corporate Risk Register	Executive Directors & NEDs	Note	Blue Box Item
7.2	Integrated Board Report	Executive Directors & NEDs	Note	Blue Box Item
8.0	**Elections Update**	Sarah Armstrong Chair	Note and approve	Attached
9.0	**Quality Account**	Emma Nunez & Kate Southgate	Note	Attached
10.0	**EPR Update**	Jackie Andrews	Note	Verbal
11.0	**Annual Review: Governor Code of Conduct**	Kate Southgate	Approve	Attached
12.0	**Questions from Governors**	Sarah Armstrong Chair	Note	Verbal
13.0	**Any other relevant business not included on the agenda**	Sarah Armstrong Chair	Note	Verbal
14.0	**Evaluation of meeting**	Sarah Armstrong Chair	Note	Verbal
15.0	**Date and Time of Next Meeting** Tuesday, 5 September 2023 4:00-5:30pm Venue: TBC	Sarah Armstrong Chair	Note	Verbal

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COUNCIL OF GOVERNORS' MEETING (HELD IN PUBLIC)
7th March 2023
The Crowne Plaza Hotel, Harrogate

Present:
Sarah Armstrong, Chair
Ian Barlow, Public Governor (IB) via Teams
Councillor Nick Brown, Stakeholder Governor (CB)
Tony Doveston, Public Governor (TD)
Mike Dunn, Public Governor (MDu)
Kathy Gargan, Public Governor (KG) via Teams
Jackie Lincoln, Public Governor (JL)
Kathy McClune, Staff Governor (KM) *from item 7.4*
Richard Owen-Hughes, Public Governor (ROH)
Karen Stansfield, Stakeholder Governor (KS)
Richard Sweeney, Public Governor (RSw)
Steve Treece, Public Governor (ST)
Stuart Wilson, Staff Governor (SW)

In attendance:
Jeremy Cross, Non-Executive Director (JCr)
Laura Robson, Non-Executive Director (LR)
Kama Melly, Non-Executive Director via Teams (KM)
Jonathan Coulter, Chief Executive
Jackie Andrews, Executive Medical Director
Jordan McKie, Director of Finance
Russell Nightingale, Chief Operating Officer
Emma Nunez, Deputy CEO & Executive Director of Nursing, Midwifery and Allied Health Professionals (AHPs)
Angela Wilkinson, Director of Workforce & Organisational Development
Kate Southgate, Associate Director of Quality and Corporate Affairs
Giles Latham, Communications Manager

Item No.	Item
COG/3/7/1 **1.1**	**Welcome and apologies for absence** The Chair welcomed everyone to the meeting and extended a warm welcome to new governors.
1.2	Apologies for absence were received from: Clare Illingworth, Lead Governor, Sue Eddleston, Public Governor, Donald Coverdale, Public Governor, Martin Dennys, Public Governor, Chiara Debiase, Non-Executive Director, Andy Papworth, Non-Executive Director, Richard Stiff, Non-Executive Director, Matt Graham, Director of Strategy, Azlina Bulmer, Associate Non-Executive Director, Julia Weldon, Non-Executive Director.
1.3	Thanks were expressed from the Council of Governors to Councillor Mann, Stakeholder Governor for his contribution during his time on the Council. The Council also provided a warm welcome to Councillor Brown as Stakeholder Governor.
COG/3/7/2 **2.1**	**Declarations of Interest** No declarations of interest were noted.

COG/3/7/3 **3.1**	**Minutes of the previous Council of Governors (Public) meeting held on 5th December 2022** **Resolved:** The minutes of the last meeting held on 5th December 2022 were agreed as an accurate record.
COG/3/7/4 **4.1** **4.2**	**Matters Arising and Action Log** The following matters arising and actions were noted: • It was confirmed that the session with NHS Statistical Team was in the process of being arranged • The Board Assurance Framework session would be taking place 9th March 2023 via Teams • The Chief Operating Officer provided an updated on Glaucoma. It was noted that in 2020 3,000 Glaucoma Patients remained on the waiting list. This had reduced to a current position of 650. All patients sit within the amber and green pathway, and no patients were on the red pathway ie no high risk patients. The trajectory was 0 patients by June 2023. The action would remain open until the backlog had been eradicated. **Resolved:** Actions were agreed as above.
COG/3/7/5 **5.1** **5.2** **5.3** **5.4** **5.5** **5.6** **5.7**	**Overview by the Chair** The Chair noted that it had been a busy start to the year. Thanks were express to Remuneration, Nomination and Conduct Committee (RNCC) members for all of their hard work since the beginning of the year. A significant amount of work had been undertaken by the Committee including a review of constituencies which had culminated in the proposal on the agenda. Thanks were also expressed to Steve Treece and Mike Dunn, Public Governors for agreeing to be interim Deputy Lead Governors. The Chair had met with the Friends of Harrogate Hospital and the Friends of Ripon Hospital. Thanks were expressed for their hard work and support to the Trust. In January 2023, the Chair had unveiled a plaque in Hampstwhaite for Laura Sobey-Veal Yorkshire's First Female Doctor. An update was provided on system working including a recent visit from Board members of the ICS. This was noted as an informative session for all parties. The Chair also reminded Council that the Trust played an active part in two systems. It was noted that a Board Workshop had taken place in February 2023 and WYAAT had joined the session to discuss the relationship between the Trust and WYAAT. It was noted that WYAAT was a strong example of collaborative system working. The workshop also discussed staff survey results however, it was noted that these were currently embargoed.

5.8	An Informal Governor meeting had recently taken place. The Chair noted that if Governors had ideas for topics then these could be shared with the Associate Director of Quality and Corporate Affairs.
5.9	**Resolved:** The Chair's report was noted.
COG/3/7/6	**Non-Executive Director Briefing**
6.1	The Chair noted that a new Innovation Committee was now in place. The Chair of the Committee, Wallace Sampson, Non-Executive Director provided the Council with an overview of the Committee.
6.2	It was noted that two meetings had now been held and it was noted as a bi-monthly meeting. Terms of Reference had been agreed as had membership which included three Non-Executive Directors, the Executive Medical Director and the Director of Strategy. Key colleagues across the organisation also attended on a regular basis.
6.3	The Committee has a strong focus on innovation, research, digital and continuous improvement. The focus is on looking to the future and the Committee members have a strong emphasis on transformation.
6.4	A significant amount of work has already taken place in the short period of time it has been operating. For example an Innovation Manager had been appointed, with further members of the team being recruited to as well as an Innovation Hub being created near Knaresborough which includes colleagues from across a range of organisations.
6.5	**Resolved:** The Non-Executive Directors update was noted.
COG/3/7/7	**Constituency Review**
7.1	The Chair provided an overview of the purpose of the constituency review, this included ensuring the Council was representative of the population the Trust serves.
7.2	The Chair provided a summary of the paper that had been circulated with the agenda.
7.3	The Public Governor (ROH) queried why there was a difficulty in recruiting staff governors. Staff Governor (SW) noted that there was potentially a misconception about what a governor was and what the role entailed. It was recommended that further information should be provided to colleagues across the organisation to promote the role. The Chair also noted that at a recent Staff Governor session discussions had been held on how to promote the role.
7.4	*Kathy McClune joined the meeting.*
7.5	The Non-Executive Director (WS) noted that the Governors represented all sectors of the region and queried why the Voluntary Sector had been removed. The Chair confirmed that the role had never been filled and difficulties had been raised regarding who would represent this group proactively and ensuring that the full voluntary sector was represented. It was also noted that consideration was being given to link roles for governors to help represent the voluntary sector.

	The Chair noted that concerns had been raised regarding the removal of the voluntary sector seat. The decision to remove the seat would be paused and RNCC would review this seat further.
7.6	The Public Governor (RSw) raised if a Care Home constituency could be created. The Chair noted that RNCC would consider if the Care Home seat could be a possibility moving forward.
7.7	The Public Governor (IB) noted that members were not fully aware of who their governors were. The Public Governor (MDu) noted that a change in strategy was needed in terms of communication with members as well as the wider organisation. This would be something that the Membership Engagement and Development Committee would be focusing on for 2023.
7.8	The Public Governor (TD) noted the importance of the notice boards with Governors photographs, at the entrance to the hospital. It was also noted that it is important that Senior Managers in the organisation should promote the role of the governors and to increase the communication and promotion of the role.
7.9	The Staff Governor (KM) queried the need to reduce the number of Nursing and Midwifery to 1 governor. The Chair noted the difficulty with recruiting into this group. It was also confirmed that within seats like the 0-19 seat, this could be a clinician. The Chair raised with the Council whether the seats should remain at 2 seats. It was agreed that it would reduce to 1, however, would remain under review following the recruitment process of the new staff constituencies.
7.10	**Resolved:** The following decisions were made:
7.11	<u>Public Constituencies</u> (i) Increase the Public Constituency Seats by 1 from 13 to 14, (ii) The removal of the Rest of England Public Constituency (iii) The introduction of the Rest of England North – 1 Seat and the Rest of England South – 1 Seat
7.12	<u>Staff Constituencies</u> (iv) Increase the Staff Constituency Seats by 1 from 5 to 6 (v) Reduce the Nursing and Midwifery seat from 2 to 1 (vi) Rename the Nursing and Midwifery seat to Nursing, Midwifery and AHPs (vii) The introduction of the 0 – 19 seat (viii) The introduction of the community services seat
7.13	<u>Stakeholder Constituency</u> (ix) Combine the North Yorkshire Council and Harrogate Borough Council seats to form a new Local Authority Seat x 2 (x) Rename the University of Bradford seat to Further Education seat (xi) The removal of the Voluntary Sector seat would be paused for further review by RNCC (xii) Consideration would be given by RNCC to the inclusion of a Care Home seat
7.14	<u>Deputy Lead Governor</u> (xiii) To confirm a Deputy Lead Governor(s) be recruited to a maximum of two Governors
7.15	<u>Overall</u>

	(xiv) To confirm that the constituency be update accordingly with the proposals as outlined in recommendations 1 – 12
COG/3/7/8 **8.1**	**Annual Planning** The Chief Executive provided an overview of the Annual Planning process and included information on the NHS England Planning Guidance as well as the Trust's approach and timeline.
8.2	Details on the development of the strategic ambitions and priorities for 2023-24 were highlighted.
8.3	The Public Governor (ST) queried where the plan would be shared. The Chief Executive confirmed that an easy read version would be developed and circulated widely.
8.4	The Public Governor (ST) queried if governors would have a role in setting the quality priorities for 2023-24. The Chief Executive noted that quality priorities had been set for three years and would remain for 2023-24 as per the 2022-23 priorities. It was also noted that the Quality Accounts would be shared with Governors in draft form in May / June 2023.
8.5	**Resolved:** The Update was noted.
COG/3/7/9 **9.1**	**Chief Executive and Operational Update** The Chief Executive provided the Council with an update on industrial action.
9.2	The Chief Executive noted that the CQCs inspection of Maternity report had not been received following the Trust's submissions on the draft report.
9.7	Performance within the Emergency Department was noted as an average of 77% in recent months. It was noted, that there was a review of the ambulance boundary with York taking place. Mutual aid was highlighted and examples given of the types of mutual aid that had been provided to support other system partners. An update on elements of performance including constitutional standards was also provided.
9.8	The Chief Executive noted that the Staff Survey would be released from embargo later in the week and would be shared with Governors as soon as possible.
9.9	Information was shared on system working and it was noted that leadership within the system from the Trust was being provided.
9.10	It was noted that the Corporate Risk Register had been circulated to Governors for information. The Chief Executive highlighted a number of risks included the risk related to Qualified in Service (QIS) staffing. The Director of Nursing, Midwifery and AHPs provided a further update to the Council of the current position. This included the challenges that the organisation and nationally were facing in relation to recruitment. Rosters were compliant with QIS requirements, however, risks were noted in relation to any potential short term sickness. The recruitment trajectory would provide further resilience by May 2023.

COG/3/7/10 **10.1**	**Questions from Governors** The Chair thanked Governors for the questions submitted in advance of the meeting. She also advised on the revised arrangements for submitting questions. The Chair noted that the questions submitted by governors prior to the meeting had been circulated to all Governors. The Chair read the questions to Council and the responses to each question were as follows:
10.2	Q1: Public Governor Steve Treece Could governors please be advised how virtual wards will operate, including how patients will be supervised, how the Trust will build on current activity in this respect, and how NEDs will assure themselves of a good patient experience and outcomes.
10.3	The Executive Medical Director provided a response. The virtual ward was part of HDFTs Care at Home approach which included step up and step down services. Information on this service would be included within the new Clinical Strategy. It was confirmed that virtual wards means acute care that is provided outside of the inpatient acute setting. There are currently 45 virtual beds at HDFT and this would increase to 55 by the end of 2023. The wards are focused on frailty and acute respiratory infection services. From a governance perspective patients are cared for by the same team as they would be if they were an inpatient. The Non-Executive Director (LR) noted that the Quality Committee reviews trends and themes and these included virtual wards.
10.4	Q2: Public Governor Martin Dennys I now understand what a failed discharge is. I think it would be helpful for the Governors to understand the broader trust wide frequency of these, what lessons are learnt and how the trust is looking to reduce them. How do the NEDs see these stats and response plans? Which committee are they reported to? What is the trend of these?"
10.5	Q3: Public Governor Steve Treece Could governors please be advised how patient discharge processes are working and of patient/family feedback received on these, including how consistency of messages across teams and with patients' families are ensured; and how NEDs obtain assurance on discharge processes
10.6	Question 2 and 3 were taken together and the Chief Operating Officer provided a response. It was noted that the Trust had a strong discharge process and information was provided on the policies and procedures that were in place. The Quality Committee and the Resource Committee monitored this via the readmission performance indicators. The Director of Nursing, Midwifery and AHPs provided further information to the Council on the Red to Green process. This was a scheme that reviews the time wasted or delays in the system to expedite discharge. It was highlighted, that no themes or trends had been noted on discharge processes. The Non-Executive Director (LR) noted that Quality Committee were vigilant with reviewing themes and trends in relation to discharge.
10.7	**Action:** The Red to Green video noted by the Director of Nursing, Midwifery and AHPs to be circulated to Council members.

10.8	Q4 Public Governor Steve Treece Update on EPR, programme plans and how governors will be involved.
10.9	The Executive Medical Director confirmed the governance arrangements for EPR. It was noted that two Governors were on the Innovation Committee where EPR was reviewed at a Board level. Information was provided on the procurement of the EPR system. Governors would be involved once a shortlist of providers had been identified.
10.10	Q5 Public Governor Donald Coverdale Signage in the corridors of Harrogate Hospital continues to be unsatisfactory. Evidently steps have been taken to remove words from signs and to use numerical codes instead. This is not user-friendly and it is confusing to service users and members of the public who are visiting the Hospital. Will steps be taken to remove the confusing coded signs and reinstate properly worded signs?
10.11	The Chief Operating Officer confirmed that the alpha numeric design would remain in place. A trial had been undertaken in Section D of the Hospital and views were sought from staff, patients and carers and positive feedback had been received. The signage was rolled out across the organisation as a result. There had not been a trend in complaints or concerns regarding the change in the signage.
10.12	Q6 Public Governor Tony Doveston With the levels of staff sickness there has been an increased need for the use of 'agency' staff. How do NEDs get assurance that the heavy costs involved are correctly managed and authorised and are HDFT staff also undertaking 'agency' work in addition to their normal duties and do they require employer authorisation to do so?'
10.13	The Director of Finance provided a response. Agency spend had increased in recent years. Controls were in place including the health roster system, cascade approach of agency use and sign off arrangements. Checks and balances were also noted including the role of the counter fraud team. Sickness rates had increased slightly in recent years and this had an impact on the use of agency. Information was reviewed through the Resource Committee to provide Non-Executive Directors with an overview an assurance. The Non-Executive Director (JC) noted that triangulation was undertaken in relation to gaps due to sickness and the use of agency staff. The Director of Finance also noted that some clinics and procedures were contracted to other providers but took place within the HDFT footprint.
10.14	Q7 Public Governor Kathy Gargan I would like to understand what actions are being taken to improve the performance of York Hospital Foundation Trust as I note that their challenges are having an effect on our performance as we are grouped together as such for targets/funding etc.
10.15	The Chief Executive provided a response. It was confirmed that some system partners required mutual aid from the Trust. It was confirmed that, on occasion,

	this could add additional pressure on the organisation providing the support. It was noted, however, from a patient safety and experience perspective it is a scheme that HDFT were committed to. Regulators, commissioners and the national team continue to support organisations to ensure improvements are made with Trusts that are requiring significant mutual aid.
10.16	Q8 Public Governor Richard Sweeney The footprint of Harrogate and District Foundation Trust covers multiple Integrated Care Systems. How does HDFT ensure that it is able to work collaboratively with, and positively influence, the different Integrated Care Boards and Partnerships? Governors have a statutory responsibility to ensure that the Foundation Trust Board have considered the consequences of their decisions on other partners within their Integrated Care Systems and the public at large. Should all relevant decisions made by the Board include an Integrated Care System Impact Assessment which would then be included in the minutes of the meeting?
10.17	The Chief Executive provided a response on the role HDFT have in multiple systems. In terms of the HNY ICB all executive directors are engaged in leadership roles within the system. In terms of WYAAT there is a Committee In Common structure, the minutes of those meetings are included in the Public Board papers to ensure transparency. Work is ongoing with HNY to ensure the required governance arrangements are in place.
10.18	**Action:** An overview of the ICB systems that the Trust was involved with would be included at a future Informal Governors meeting.
10.19	Q9 Public Governor Jackie Lincoln Please could we have an update on the risk highlighted in December re Autism assessment (CRR34) and children potentially not getting access to the right level of support without a formal diagnosis?
10.20	The Chief Operating Officer provided a response. 450 assessments have been commissioned this year however, there are 818 patients on the waiting list currently. There is a demand and capacity issue within the system. Discussions are ongoing with commissioners in terms of a long term, sustainable solution.
10.21	**Action:** An update to be provided at the next Council meeting.
10.22	Q10 Public Governor Jackie Lincoln Acknowledging that SEND is currently a national issue for children, young people and their families and difficulties with EHCPs (Education and Healthcare plans) what policies and practices are actively in place through HDFT to support early identification of potential additional needs and timely advice and support?
10.23	The Director of Nursing, Midwifery and AHPs provided an update on the work that is ongoing with the 0-19 team and the local authority. Within the 0-19 team there are strong learning and best practice forums that are influencing the national agenda. The SEND inspections that have taken place have highlighted the strong communication approach between the 0-19 team and the local authority.

10.24	**Resolved:** Governor Questions and responses were noted.
COG/3/7/11 **11.1**	**Any Other Business** No further business was received.
COG/3/7/12 **12.1**	**Evaluation of the Meeting** Any comments to be circulated to the Chair.
COG/3/7/13 **13.1**	**Date and Time of Next Meeting** The next meeting would take place on Tuesday, 6th June 2023 with venue and timings to be confirmed.

Council of Governors (held in Public) Action Log for June 2023							
Minute Number	**Date of Meeting**	**Subject**	**Action Description**	**Responsible Officer**	**Due Date**	**Comments**	**Status -** completed is defined as confirmation received from ED responsible lead that the proposed action is completed as described in the comments column. Completed actions will not be closed until the Board has confirmed that action taken is satisfactory.
COG/12/2021/10	06 December 2021	Glaucoma	Glaucoma waiting times to be reviewed and noted	Chief Operating Officer	01 December 2023	Regular updates provided at each Council of Governors meeting since December 2021. Last update in March 2023 noted that . All patients sit within the amber and green pathway, and no patients were on the red pathway ie no high risk patients. The trajectory was 0 patients by June 2023.	Ongoing
COG/12/5/9.5	05 December 2022	Integrated Board Report	Governors to be invited to a training session from the NHS England Statistical Team	Associate Director of Quality and Corporate Affairs	01 July 2023	Ongoing: To be arranged following revisions to the IBR	Ongoing
COG/12/5/9.6	05 December 2022	Board Assurance Framework	A training session on the Board Assurance Framework to be arranged for Governors.	Associate Director of Quality and Corporate Affairs	01 May 2023	Completed - Session held on Thursday, 9th March 2023	Closed
COG/3/7/10.7	07 March 2023	Red to Green Pathway	The Red to Green video noted by the Director of Nursing, Midwifery and AHPs to be circulated to Council members.	Executive Director of Nursing, Midwifery and AHPs	01 April 2023	Completed - Circulated in the Governors Briefing	Closed
COG/3/7/10.18	07 March 2023	ICB	An overview of the ICB systems th	Chief Executive	01 August 2023	Ongoing: To be held in the Summer Informal Governor Sessions	Ongoing
COG/3/7/10.21	07 March 2023	Autism Assessment	An update to be provided at the next Council of Governors meeting regarding	Chief Operating Officer	01 June 2023	Completed - On the agenda	Closed

COUNCIL OF GOVERNORS' MEETING (held in PUBLIC)
6 June 2023

Title:	Chief Executive's report
Responsible Director:	Chief Executive
Author:	Chief Executive

Purpose of the report and summary of key issues:	The report provides the Trust Board with key updates and actions since the previous meeting. The report highlights key challenges, activity and programmes currently impacting on the organisation.	
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	All	
Report History:	Previous updates submitted to Public Board meetings.	
Recommendation:	The Board is asked to note this report, and identify any areas in which further assurance is required, which is not covered in the Board papers.	

HARROGATE AND DISTRICT NHS FOUNDATION TRUST
COUNCIL OF GOVERNORS' MEETING (HELD IN PUBLIC)
JUNE 2023

CHIEF EXECUTIVE'S REPORT

National and system issues

1. On 18 May, the Board of NHS England announced that the NHS would be stepping down from its level three incident (regionally led) response to CoVid-19. This came one year after the national level four incident was stepped down and follows the World Health Organisation's recent announcement that CoVid-19 is no longer a Public Health Emergency of International Concern.

2. This is a significant milestone for all of us and good news for the NHS and the whole population. How the NHS responded over the three years since the outbreak in early 2020 has been magnificent, from the initial response, through the various waves, and onto the ongoing management of the virus.

3. This is not to forget the impact that this has had on so many people, or the legacy that remains in terms of delayed treatments, mental health concerns, safeguarding levels, long CoVid, and other issues across society, but we should recognise that without the NHS responding as it has done, the impact would have been even more severe.

4. At this significant moment, I would like to thank all colleagues across HDFT for their contribution and commitment in what has been an unprecedented health emergency.

5. Two significant publications have been issued since our last Board meeting. These are the maternity delivery plan, and the primary care recovery plan, both of which were trailed in the government's autumn statement settlement for the NHS. These sit alongside the planned care and unplanned recovery plans, with the final document promised last autumn – the long term workforce strategy for the NHS – due to be issued shortly.

6. We have also heard this week the outline aims of the Labour Party in respect of the NHS, which focus on improving access, reducing deaths, prevention and out of hospital care, integration of health and social care, and reform alongside any resource commitments.

7. All of these proposals and issued plans are absolutely in line with our agreed strategy and strategic objectives, and give us the continued confidence that our focus on improving health, supported by our ambitions, and underpinned by our KITE values, is what we should be looking to do over the coming months and years.

8. The final piece of recent correspondence for the Board to be aware of is a letter in respect of delivering improved elective care standards and asks Boards to be assured about the actions we are taking. We will review this checklist and present this to Resource Committee next month.

9. In relation to our local systems, there have been a number of significant leadership changes recently. Hull University Teaching Hospital Trust (HUTH) and North Lincolnshire and Goole NHS Foundation Trust (NLAG) have appointed Jonathan Lofthouse as their

joint Chief Executive. Jonathan is currently a site Chief Executive as part of Kings College Hospitals Trust in London.

10. Rod Barnes has announced that he is leaving his role as Chief Executive of Yorkshire Ambulance Service (YAS). He is to be replaced in the interim by Peter Reading, formally Chief Executive of NLAG.

11. York and Scarborough Teaching Hospitals Trust (Y&SFT) have announced that their Chair, Alan Downey, is stepping down. He has been replaced in the interim by Mark Chamberlain whilst they recruit a permanent replacement.

12. These are some fairly significant leadership changes in a short space of time, and we will continue to offer support to all across the system whilst recognising the impact in the short term of some of the understandable disruption.

13. We have been part of discussions in both of our acute collaboratives about the future role and strategy of these partnerships. A recent timeout for the ICB has also informed discussions about the future operating model of the system. The ICB has now set up a senior leadership forum as a regular way of bringing people together, and I'll be attending the first session in early June.

14. We have submitted a final system financial plan for 2023/24 as we discussed at our Board workshop last month. This has a level of financial risk for the system but has been agreed by the national team.

15. In practical developments, we have now agreed the permanent boundary divert between Harrogate and York, which will mean that YAS will bring people to Harrogate from an extended geography. It is estimated that this will represent around 800 ambulances a year, and should therefore reduce significantly the level of ad hoc requests that we have experienced over the last year. This is an example of strong partnership working that will ensure improved patient outcomes and experience.

16. We have also now started theatre lists at Wharfedale Hospital, with the first list at the end of April. This is part of our WYAAT partnership with Leeds Teaching Hospitals Trust, and will improve access times for patients as part of the elective care recovery programme.

17. We have had discussions with a number of Local Authorities in respect of funding available to meet the recent pay award costs. There are national concerns about the impact that this could have on the Public Health Grant funding. We have raised this through NHS Providers and also the NHS regulatory system, and will endeavour to use the fact that we are the largest 0-19 service provider nationally to influence a fair funding outcome.

HDFT issues

Introduction

18. As always, there are challenges that collectively we have to manage and deal with on a daily basis. And again, as always, we will try and focus on improvement, being positive, supporting colleagues, and reflecting our values. This is vitally important if we want to deliver improvements to our patients and population. It is also crucial that we continue to

deliver what we say we will deliver, as this will ensure we have the confidence of the system and the freedom to act that results from that confidence.

Our people

19. Since our last Board meeting we have had a further period of industrial action from both our Junior Doctors and our nurses who are a part of the RCN. As before we were able to support our colleagues to appropriately take the action that they wanted to, whilst maintaining the services to patients safely across the strike period.

20. There is a financial cost to the Trust as a result of covering strike action, but the bigger issue is the opportunity cost of the time spent by colleagues ensuring that we can continue to provide safe services during these times.

21. Many colleagues were involved in planning, supporting, and delivering the services during the course of the industrial action, and as well as highlighting the opportunity cost of this work, I would like to thank all involved.

22. There is a further Junior Doctor strike planned for mid-June, and currently the RCN are balloting members about further industrial action. We will continue to support, plan, and organise our services in response to these challenges.

23. The Board will be aware that negotiations with the other health unions in respect of pay have concluded and the pay award for Agenda for Change colleagues has been accepted by the NHS staff council and is therefore being implemented. This will be paid in June. We are offering colleagues who are in receipt of Universal Credit (and for whom receiving a backdated lump sum could cause difficulties in respect of their benefit claims) the option to receive the award in smoother payments.

24. The latest Inpulse survey results have now been received. Staff engagement and positive emotions have improved, but as always, there will be teams within HDFT that require further help and support. This will be reviewed through the People and Culture Committee, and Directorates are using this feedback to target improvement.

25. Earlier this month we had a successful staff network day. Over 200 people attended through the day, and this has helped to raise the profile of our staff networks, which are there to provide support to colleagues.

26. The winter vaccine programme planning has started and we will be aiming to improve the uptake of staff vaccinations this year. We will report progress as we go through the autumn period.

Our Quality

27. Over the last two months we have reviewed both our CoVid testing guidelines and our mask wearing guidelines, in line with new guidance published nationally. Other than in particular circumstances, mask wearing is now significantly reduced, as is testing. This is consistent with the stepping down of the level three incident and in line with managing CoVid-19 as we would any respiratory virus.

28. We have submitted our action plan in response to the CQC Maternity inspection. We are well underway in delivering the agreed actions and we will oversee this through our quality governance processes and the Quality Committee. As you will read in the maternity staffing report, we continue to have a strong level of staffing within our maternity unit, which is positive.

29. Work in respect of Health and Safety continues to be a priority, with a focus on fire risk assessment and any necessary action that follows. Work has also been undertaken in respect of management of contractors and also RAAC assessments. The Health and Safety Committee is now working well and is providing the necessary challenge of the arrangements we have in place. In some areas this is raising risks and issues that need to be resolved, but the significant work of knowing where our risks and concerns are is much more progressed than previously.

Our Services

30. As referenced earlier, our 0-19 services continue to deliver very strong performance across all of our geographic footprint. This is despite the operational and staffing challenges that we have been managing recently. Recent visits to our newest 0-19 services recently (Wakefield and Northumberland) have been positive and demonstrated the commitment and quality of service within these areas.

31. Our urgent care pathway performance continues to improve. This is particularly illustrated by our performance against the 4 hour Emergency Department standard and the fact that we had no 60-minute ambulance handover breaches in April. As noted earlier, we have formalised our system support and will continue to offer mutual aid to others in the system as and when needed and when we have the ability to support.

32. As reported in previous meetings, our cancer service standard remains below where we would like to see it, and remains a key area of focus. We do have improvement plans and performance has improved in some areas, but again as discussed previously, the variability and resilience of our cancer delivery is the concern. We have changed some of the internal management arrangements for cancer and recently appointed a new clinical lead for cancer, to help us improve our performance.

33. We continue to deliver our elective recovery plan. We have no over 78 week waiters, and we are on track in respect of our reduction to below 65 weeks for all patients, despite some impact of the recent industrial action. Russell continues to provide strong leadership to both the WYAAT and the HNY system in respect of improved elective care performance.

Our money

34. As you will read in the report from the Finance Director, our month 1 financial position is behind plan. We have agreed a financial plan as our recent Board meeting, and it is important that we address any issues that we might have early in the financial year.

35. Whilst the industrial action will have been an additional pressure, there are other areas that we need to focus on with Directorates and Care Groups.

36. Our cash position remains positive and we are making progress against our capital programme

Other

37. Since our last Board meeting we have begun our continuous improvement programme that was identified as one of our key strategic objectives for 2023/24. We have had an extended SMT senior leaders' session to outline the programme, for which there is enthusiasm. A readiness assessment is currently underway which will inform how the programme progresses and is organised to maximise the benefit over the next 18 months.

38. Also in mid-April, there was a national launch of the NHS continuous improvement programme, with the aim of ensuring that all organisations within the NHS have structured improvement methodologies. This completely aligns with the work we have already initiated.

39. In the papers for the private board is the outline business case for our new Electronic Patient Record. This is a significant milestone and once we have had approval from the national team we will begin the process of procurement. In parallel, we have initiated a series of enabling projects and investments so that the new EPR system is aligned to improved processes and robust infrastructure. This EPR programme is a part of the system-wide programme, for which Jackie Andrews is the clinical SRO, alongside Simon Morritt (Y&SFT) as the Chief Executive lead. It is important that we work across the system to enable shared records whilst also ensuring that we as an organisation have an EPR that is fit for purpose, and we are working with colleagues across HNY to ensure that these objectives align.

40. An innovation introduced locally by one of our Trauma and Orthopaedic Consultants has been generating interest both regionally and nationally, and we are in discussions about the potential roll-out across organisations in the NHS.

41. The Royal College of Occupational Therapy visited in early May, and were very impressed with the service, in particular the Adult Community ARCHS team.

42. As you will read through the Board papers and hear from discussions, whilst there are the usual challenges that we need to manage, we are focused on delivering better care and outcomes for the patients and population. Given the national pressure, it is really important that we continue to deliver well for patients and the population and maintain the ability and headroom to continuously improve and focus on the future and well as the now. This has been emphasised very positively through our SMT, and we know that our freedom to act is linked to how we are performing. We don't make any apology for having high standards and being ambitious for the organisation, and we know that by supporting colleagues and living our values we are best placed to achieve our ambitions.

Jonathan Coulter
Chief Executive
June 2023

	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**

				<table><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></table> 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) <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></table>	positively impact the RN vacancy position next month. Initially impacting the HCSW position. Summary 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.			
An Environment that promotes wellbeing	CRR75: Health and Safety	**CHS1** **CHS2** **CHS3** **CHS4** **CHS8**	See indicators below	Overall Position for CRR75	Summary position for CRR75	**4 x 5 (20)**	**2 x 4 (8)**	**4 x 4 (16)**
	CRR75: Health and Safety	**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.	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	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.	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 Summary	**4 x 5 (20)**	**4 x 2 (8)**	**4 x 3 (16)**

			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.			

Harrogate and District NHS Foundation Trust

Council of Governors' Meeting - held in Public
6 June 2023

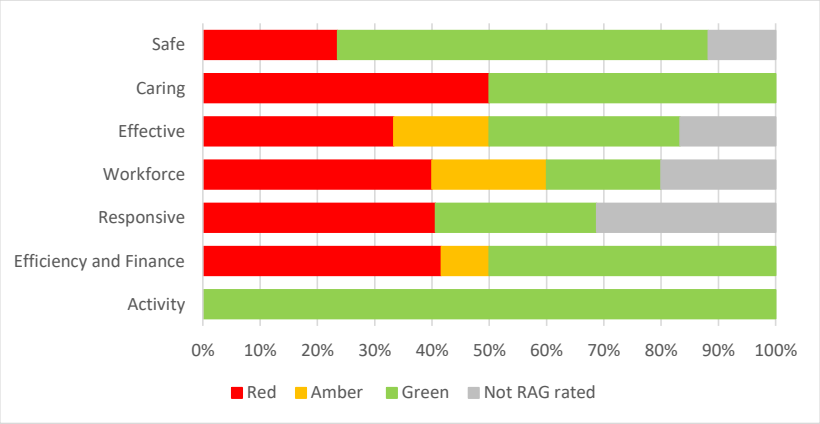
Title:	***Integrated Board Report***
Responsible Director:	Executive Directors
Author:	Head of Performance & Analysis

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

Integrated Board Report - Summary of indicators - April 2023

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

		RAG ratings			
Domain	**Total indicators**	**Red**	**Amber**	**Green**	**Not RAG rated**
Safe	17	4	0	11	2
Caring	4	2	0	2	0
Effective	6	2	1	2	1
Workforce	5	2	1	1	1
Responsive	32	13	0	9	10
Efficiency and Finance	12	5	1	6	0
Activity	5	0	0	5	0
Total	**81**	**28**	**3**	**36**	**14**



Integrated Board Report - Summary of April 23 performance

Domain	Indicator number	Indicator name	Latest position
Safe	1.1	Pressure ulcers - hospital acquired - cat 3 or above - per 1,000 bed days	0.84
Safe	1.2	Pressure ulcers - community acquired - cat 3 or above - per 1,000 patient contacts	0.94
Safe	1.3	Inpatient falls per 1,000 bed days	4.4
Safe	1.4	Infection control - C.diff hospital acquired cases due to a lapse in care	0
Safe	1.5	Infection control - MRSA hospital acquired cases due to a lapse in care	0
Safe	1.6	Incidents - ratio of low harm incidents	112.50
Safe	1.7.1	Incidents - comprehensive serious incidents (SI)	2
Safe	1.7.2	Incidents - Never events	0
Safe	1.8.1	Safer staffing levels - fill rate	96.1%
Safe	1.8.2	Safer staffing levels - CHPPD	9.1
Safe	1.9	Maternity - % women seen by a midwife (or healthcare professional) by 12w 6d	97.4%
Safe	1.10	Maternity - % women with Continuity of Care pathway	
Safe	1.11	Infant health - % women smoking at time of delivery	5.1%
Safe	1.12	Infant health - % women initiating breastfeeding	88.0%
Safe	1.13	VTE risk assessment - inpatients	93.7%
Safe	1.14.1	Sepsis screening - inpatient wards	95.2%
Safe	1.14.2	Sepsis screening - Emergency department	92.6%

Domain	Indicator number	Indicator name	Latest position
Caring	2.1.1	Friends & Family Test (FFT) - Patients	94.0%
Caring	2.1.2	Friends & Family Test (FFT) - Adult Community Services	90.0%
Caring	2.2.1	Complaints - numbers received	19
Caring	2.2.2	Complaints - % responded to within time	79%
Effective	3.1	Mortality - HSMR	113.59
Effective	3.2	Mortality - SHMI	1.039
Effective	3.3.1	Readmissions to the same specialty within 30 days - following elective admission	1.8%
Effective	3.3.2	Readmissions to the same specialty within 30 days - following non-elective admission	8.2%
	3.4	Returns to theatre	7
Effective	3.5	Delayed Transfer of Care	21.3%
Workforce	4.1	Appraisal rate - Non Medical and Medical Staff	84.4%
Workforce	4.2	Mandatory and Essential Skills Training rate	94.0%
Workforce	4.3	Staff sickness rate	4.55%
Workforce	4.4	Staff turnover rate	15.1%
Workforce	4.5	Vacancies	8.75%

Domain	Indicator number	Indicator name	Latest position
Responsive	5.1.1	RTT Incomplete pathways performance - median	12
Responsive	5.1.2	RTT Incomplete pathways performance - 92nd centile	43
Responsive	5.1.3	RTT Incomplete pathways - total	25951
Responsive	5.1.4	RTT Incomplete pathways - 52-<104 weeks	998
Responsive	5.1.5	RTT Incomplete pathways - 104+ weeks	0
Responsive	5.2.1	RTT waiting times - by ethnicity	
Responsive	5.2.2	RTT waiting times - by level of deprivation	
Responsive	5.2.3	RTT waiting times - learning disabilities	
Responsive	5.3	Diagnostic waiting times - 6-week standard	54.2%
Responsive	5.5	Data quality on ethnic group - inpatients	90.5%
Responsive	5.6	A&E 4 hour standard	83.3%
Responsive	5.7	Ambulance handovers - % within 15 mins	95.1%
Responsive	5.8	A&E - number of 12 hour trolley waits	4
Responsive	5.9.1	Cancer - 62 day wait for first treatment from urgent GP referral to treatment	76.9%
Responsive	5.9.2	Cancer - 62 day wait for first treatment from urgent GP referral to treatment - number of 104 days waiters	6
Responsive	5.10	Cancer - 14 days maximum wait from urgent GP referral for all urgent suspect cancer referrals	63.1%
Responsive	5.11	Cancer - 28 days faster diagnosis standard (suspected cancer referrals)	66.9%
Responsive	5.12	Cancer - 31 days maximum wait from diagnosis to treatment for all cancers	96.3%

Domain	Indicator number	Indicator name	Latest position
Responsive	5.13.1	Children's Services - 0-12 months caseload	1855
Responsive	5.13.2	Children's Services - 2-3 years caseload	2101
Responsive	5.14	Children's Services - Safeguarding caseload	1148
Responsive	5.15	Children's Services - Ante-natal visits	91.5%
Responsive	5.16	Children's Services - 10-14 day new birth visit	95.5%
Responsive	5.17	Children's Services - 6-8 week visit	92.1%
Responsive	5.18	Children's Services - 12 month review	96.3%
Responsive	5.19	Children's Services - 2.5 year review	95.0%
Responsive	5.20	Children's Services - % children with all 5 mandated contacts	
Responsive	5.22	Children's Services - OPEL level	1/2/3
Responsive	5.23	Community Care Adult Teams - performance against new timeliness standards	
Responsive	5.26	Community Care Adult Teams - OPEL level	3
Responsive	5.27	Out of hours - telephone clinical assessment for URGENT cases within 20 minutes of call prioritisation	36.0%
Responsive	5.28	Home visit: Face to face consultations started for URGENT cases within 2 hrs	93.4%

Domain	Indicator number	Indicator name	Latest position
Efficiency and Finance	6.1	Agency spend	£ 544
Efficiency and Finance	6.2	Surplus / deficit and variance to plan	-£ 1,650
Efficiency and Finance	6.3	Capital spend	£ 2,158
Efficiency and Finance	6.4	Cash balance	£ 35,645
Efficiency and Finance	6.5.1	Long stay patients - stranded (>7 days LOS)	118
Efficiency and Finance	6.5.2	Long stay patients - superstranded (>21 days LOS)	49
Efficiency and Finance	6.6	Occupied bed days per 1,000 population	50.8
Efficiency and Finance	6.7.1	Length of stay - elective	2.12
Efficiency and Finance	6.7.2	Length of stay - non-elective	4.55
Efficiency and Finance	6.8	Avoidable admissions	238
Efficiency and Finance	6.9	Theatre utilisation (elective sessions)	81.2%
Efficiency and Finance	6.10	Day case conversion rate	1.6%

Domain	Indicator number	Indicator name	Latest position
Activity	7.1	GP Referrals against 2019/20 baseline	95.4%
Activity	7.2	Outpatient activity (consultant led) against plan (new and follow up)	144.0%
Activity	7.3	Elective activity against plan	109.9%
Activity	7.4	Non-elective activity against plan	106.9%
Activity	7.5	Emergency Department attendances against plan	103.1%

Integrated Board Report - List of indicators

Domain	Indicator number	Indicator name	Clinical Directorate(s) metric is applicable to	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	Exec Lead	Committee reported to:	Monthly RAG thresholds: Red	Amber	Green
Safe	1.1	Pressure ulcers - hospital acquired - cat 3 or above - per 1,000 bed days	PSC, LTUC	1.11	1.08	0.32	0.90	0.82	0.93	0.30	1.13	0.78	0.48	1.12	1.45	0.84	EN	Quality	>0		0
Safe	1.2	Pressure ulcers - community acquired - cat 3 or above - per 1,000 patient contacts	LTUC	1.95	1.02	2.24	2.45	2.22	1.93	2.01	0.90	1.19	1.33	2.28	0.93	0.94	EN	Quality	>0		0
Safe	1.3	Inpatient falls per 1,000 bed days	PSC, LTUC	6.9	6.1	6.5	6.1	8.7	7.1	7.1	7.0	7.4	8.7	7.5	7.1	4.4	EN	Quality	above HDFT average for 2022/23 (7.2)	0-20% below HDFT average for 2022/23	>20% below HDFT average for 2022/23 (5.76)
Safe	1.4	Infection control - Hospital acquired C.difficile cases, lapse in care identified	All	0	0	0	0	0	0	0	0	2	0	0	0	0	JA	Quality	TBC		TBC
Safe	1.5	Infection control - Hospital acquired MRSA cases, lapse in care identified	All	0	0	0	0	0	0	0	0	0	0	0	0	0	JA	Quality	>0 YTD		0 YTD
Safe	1.6	Incidents - ratio of low harm incidents	All	48.71	51.63	74.38	43.52	44.91	40.91	50.62	50.11	79.20	45.23	56.47	92.50	112.50	EN	Quality	HDFT in bottom 25% of Acute Trusts (<26.5)	HDFT in middle 50% of Acute Trusts	HDFT in top 25% of Acute Trusts (>69.4)
Safe	1.7.1	Incidents - comprehensive serious incidents (SI)	All	5	4	3	3	0	4	1	1	0	1	1	2	2	EN	Quality	>0		0
Safe	1.7.2	Incidents - Never events	All	0	1	1	0	0	1	0	0	0	0	0	0	0	EN	Quality			
Safe	1.8.1	Safer staffing levels - fill rate	All	81.1%	87.0%	89.2%	85.8%	89.1%	88.4%	88.0%	93.3%	89.8%	93.2%	95.4%	96.5%	96.1%	EN	Quality	<80%	80% - 95%	>=95%
Safe	1.8.2	Safer staffing levels - CHPPD	All	6.9	7.4	7.6	7.1	7.2	6.3	7.3	7.5	7.3	7.4	7.9	8.2	9.1	EN	Quality	tbc		
Safe	1.9	Maternity - % women seen by a midwife (or healthcare professional) by 12w 6d	PSC	98.6%	97.6%	96.6%	95.4%	96.2%	96.0%	93.1%	98.7%	96.1%	87.8%	92.8%	96.3%	97.4%	EN	Quality	<90%		>=90%
Safe	1.10	Maternity - % women with Continuity of Care pathway	PSC														EN	Quality			
Safe	1.11	Infant health - % women smoking at time of delivery	PSC	5.8%	6.4%	3.7%	3.5%	2.3%	3.9%	7.4%	3.5%	5.2%	5.6%	2.1%	1.7%	5.1%	EN	Quality	>15%		<=15%
Safe	1.12	Infant health - % women initiating breastfeeding	PSC	82.9%	84.6%	81.8%	75.2%	81.8%	84.0%	82.5%	90.8%	82.6%	75.0%	83.7%	82.2%	88.0%	EN	Quality	<75%		>=75%
Safe	1.13	VTE risk assessment - inpatients	PSC, LTUC	96.1%	96.3%	95.6%	95.1%	96.2%	96.0%	95.9%	95.7%	94.8%	94.6%	93.8%	93.1%	93.7%	JA	Quality	<95%		>=95%
Safe	1.14.1	Sepsis screening - inpatient wards	All	88.6%	93.0%	93.8%	89.8%	88.2%	95.4%	94.0%	92.7%	93.5%	89.7%	94.5%	96.2%	95.2%	EN	Quality	<90%		>=90%
Safe	1.14.2	Sepsis screening - Emergency department	LTUC	94.0%	92.2%	92.6%	95.6%	92.3%	93.4%	90.6%	91.6%	94.1%	91.8%	93.0%	91.4%	92.6%	EN	Quality	<90%		>=90%
Caring	2.1.1	Friends & Family Test (FFT) - All Patients	All	94.1%	92.7%	92.2%	92.3%	79.5%	80.9%	92.2%	92.3%	93.1%	94.1%	94.7%	94.2%	94.0%	EN	Quality	<90%		>=90%
Caring	2.1.2	Friends & Family Test (FFT) - Adult Community Services	CC	94.4%	91.9%	90.6%	93.9%	95.9%	90.9%	95.7%	93.5%	81.8%	96.5%	90.9%	92.3%	90.0%	EN	Quality	<90%		>=90%
Caring	2.2.1	Complaints - numbers received	All	17	10	9	12	10	13	9	7	12	16	15	14	19	EN	Quality	above HDFT average for 2022/23 (12)		On or below HDFT average for 2022/23 (12)
Caring	2.2.2	Complaints - % responded to within time	All	72%	79%	70%	50%	45%	58%	80%	75%	100%	64%	83%	88%	79%	EN	Quality	<95%		>=95%
Effective	3.1	Mortality - HSMR	All	118.15	117.26	117.4	113.81	114.71	115.9	113.67	112.42	111.96	113.14	113.59			JA	Quality	Higher than expected		Within expected range or below expected
Effective	3.2	Mortality - SHMI	All	1.097	1.103	1.085	1.085	1.066	1.063	1.021	1.024	1.030	1.039				JA	Quality	Higher than expected		Within expected range or below expected
Effective	3.3.1	Readmissions to the same specialty within 30 days - following elective admission - as % of all elective admissions	All	1.8%	2.1%	2.0%	1.5%	1.6%	2.0%	2.2%	1.8%	2.2%	2.3%	2.0%	1.8%		RN	Resources	> 3%	2% - 3%	<= 2%
Effective	3.3.2	Readmissions to the same specialty within 30 days - following non-elective admission - as % of all non-elective admissions	All	8.6%	6.8%	7.9%	7.1%	6.7%	7.4%	7.8%	7.6%	7.5%	8.3%	8.6%	8.2%		RN	Resources	> 10%	8% - 10%	<= 8%
Effective	3.4	Returns to theatre	PSC												7		RN	Resources	tbc		
Effective	3.5	Delayed Transfer of Care - % inpatients not meeting the criteria to reside	LTUC	30.9%	24.5%	28.1%	38.3%	36.9%	37.5%	29.4%	29.8%	27.5%	24.6%	20.8%	23.0%	21.3%	RN	Resources	> 17.5%	15% - 17.5%	<= 15%
Workforce	4.1	Appraisal rate - Non Medical and Medical Staff	All	56.9%	63.7%	60.8%	61.6%	61.7%	61.6%	63.3%	65.2%	68.0%	71.2%	77.0%	82.1%	84.4%	AW	People and Culture	<70%	70% - 90%	>=90%
Workforce	4.2	Mandatory and Essential Skills Training rate	All	85.0%	87.0%	90.0%	90.0%	89.0%	89.0%	90.0%	91.0%	91.0%	92.0%	94.0%	92.0%	94.0%	AW	People and Culture	<50%	50% - 75%	>=75%
Workforce	4.3	Staff sickness rate	All	5.90%	4.44%	4.96%	5.32%	4.59%	4.84%	4.88%	4.88%	5.65%	5.16%	4.98%	4.57%	4.55%	AW	People and Culture	>3.9%		<=3.9%
Workforce	4.4	Staff turnover rate	All	15.7%	16.0%	16.3%	16.4%	15.9%	15.8%	15.9%	15.8%	15.6%	15.3%	15.5%	15.4%	15.1%	AW	People and Culture	>15%		<=15%
Workforce	4.5	Vacancies	CC	5.84%	6.04%	6.25%	6.55%	5.97%	5.80%	6.66%	8.06%	8.36%	8.46%	8.00%	8.01%	8.75%	AW	People and Culture	tbc		

Domain	Indicator number	Indicator name	Clinical Directorate(s) metric is applicable to	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	Exec Lead	Committee reported to:	Monthly RAG thresholds: Red	Amber	Green
Responsive	5.1.1	RTT Incomplete pathways performance - median	All	10	10	11	11	11	12	12	11	13	13	12	11	12	RN	Resources	>10	08 - 10	<=8
Responsive	5.1.2	RTT Incomplete pathways performance - 92nd centile	All	44	43	44	44	44	45	44	42	44	44	43	42	43	RN	Resources	>24	18 - 24	<=18
Responsive	5.1.3	RTT Incomplete pathways - total	All	24714	25384	25134	25629	25564	25490	25437	25388	24951	24846	25139	25504	25951	RN	Resources	>15,000	14,000 - 15,000	<=14,000
Responsive	5.1.4	RTT Incomplete pathways - 52-<104 weeks	All	1176	1193	1260	1297	1297	1350	1285	1201	1228	1124	1112	997	998	RN	Resources	>0		0
Responsive	5.1.5	RTT Incomplete pathways - 104+ weeks	All	11	3	1	0	0	0	0	0	0	0	0	0	0	RN	Resources	>0		0
Responsive	5.2.1	RTT waiting times - by ethnicity	All														RN	Resources			
Responsive	5.2.2	RTT waiting times - by level of deprivation	All														RN	Resources			
Responsive	5.2.3	RTT waiting times - learning disabilities	All														RN	Resources			
Responsive	5.3	Diagnostic waiting times - 6-week standard	All	66.0%	69.2%	59.8%	58.9%	55.3%	50.4%	62.0%	67.9%	62.7%	59.8%	62.9%	60.8%	54.2%	RN	Resources	<99%		>=99%
Responsive	5.5	Data quality on ethnic group - inpatients	All	93.7%	93.4%	92.5%	92.1%	92.3%	91.5%	91.4%	92.0%	91.5%	90.9%	91.0%	90.7%	90.5%	RN	Resources	<97%		>=97%
Responsive	5.6	A&E 4 hour standard	LTUC	66.2%	68.1%	71.5%	71.4%	66.7%	63.9%	68.0%	66.2%	63.4%	77.9%	80.9%	78.5%	83.3%	RN	Resources	<76% (from April 2023)		>=76% (from April 2023)
Responsive	5.7	Ambulance handovers - % within 15 mins	LTUC	90.3%	89.2%	83.2%	89.0%	88.6%	78.6%	66.8%	74.3%	69.1%	81.1%	88.1%	88.9%	95.1%	RN	Resources	<90%	90-95%	>=95%
Responsive	5.8	A&E - number of 12 hour trolley waits	LTUC	43	18	15	37	82	60	72	67	153	115	16	45	4	RN	Resources	>0		0
Responsive	5.9.1	Cancer - 62 day wait for first treatment from urgent GP referral to treatment	LTUC	78.3%	86.3%	80.9%	78.3%	82.5%	71.4%	79.7%	79.7%	81.6%	71.7%	78.2%	88.5%	76.9%	RN	Resources	<85%		>=85%
Responsive	5.9.2	Cancer - 62 day wait for first treatment from urgent GP referral to treatment - number of 104 days waiters	LTUC	8	4	5	4	3	5	8	4	2	7	3	6	6	RN	Resources	>0		0
Responsive	5.10	Cancer - 14 days maximum wait from urgent GP referral for all urgent suspect cancer referrals	LTUC	85.9%	89.6%	73.6%	70.4%	47.3%	47.7%	47.5%	56.8%	75.1%	71.5%	59.4%	60.0%	63.1%	RN	Resources	<93%		>=93%
Responsive	5.11	Cancer - 28 days faster diagnosis standard (suspected cancer referrals)	LTUC	79.4%	76.1%	79.7%	74.6%	68.0%	54.4%	62.0%	72.3%	74.8%	70.9%	69.9%	67.3%	66.9%	RN	Resources	<70%	70-75%	>= 75%
Responsive	5.12	Cancer - 31 days maximum wait from diagnosis to treatment for all cancers	LTUC	97.3%	98.2%	97.4%	98.9%	98.9%	96.7%	98.9%	99.2%	100.0%	100.0%	100.0%	99.0%	96.3%	RN	Resources	<96%		>=96%
Responsive	5.13.1	Children's Services - 0-12 months caseload	CC	1531	1591	1726	1684	1728	1787	1852	1698	1842	1934	1693	1742	1855	RN	Resources	tbc		
Responsive	5.13.2	Children's Services - 2-3 years caseload	CC	1701	1806	1628	1788	1606	1703	1663	1734	1731	1864	1614	1866	2101	RN	Resources	tbc		
Responsive	5.14	Children's Services - Safeguarding caseload	CC	910	1177	1103	1094	938	988	875	948	989	1284	1154	1570	1148	RN	Resources	tbc		
Responsive	5.15	Children's Services - Ante-natal visits	CC	83.1%	86.2%	87.9%	90.9%	90.9%	89.5%	89.9%	92.3%	94.9%	88.2%	91.4%	94.0%	91.5%	RN	Resources	<75%	75% - 90%	>=90%
Responsive	5.16	Children's Services - 10-14 day new birth visit	CC	95.4%	94.7%	95.7%	97.3%	96.8%	96.4%	95.9%	97.0%	97.1%	97.3%	97.5%	97.3%	95.5%	RN	Resources	<75%	75% - 90%	>=90%
Responsive	5.17	Children's Services - 6-8 week visit	CC	92.1%	93.8%	94.9%	95.2%	95.0%	93.6%	94.5%	92.8%	92.6%	94.1%	94.7%	93.8%	92.1%	RN	Resources	<75%	75% - 90%	>=90%
Responsive	5.18	Children's Services - 12 month review	CC	89.9%	91.2%	91.7%	93.2%	92.7%	94.6%	95.5%	95.5%	95.5%	95.2%	96.3%	96.7%	96.3%	RN	Resources	<75%	75% - 90%	>=90%
Responsive	5.19	Children's Services - 2.5 year review	CC	92.7%	91.6%	93.9%	95.6%	94.2%	94.1%	95.7%	95.7%	95.7%	95.1%	92.6%	96.8%	95.0%	RN	Resources	<75%	75% - 90%	>=90%
Responsive	5.20	Children's Services - % children with all 5 mandated contacts	CC														RN	Resources	<75%	75% - 90%	>=90%
Responsive	5.22	Children's Services - OPEL level	CC	1/2/3	1/2/3	1/2/3	1/2/3	1/2/3	1/2/3	1/2/3	1/2/3	1/2/3	2/3	1/2/3	1/2/3	1/2/3	RN	Resources	tbc		
Responsive	5.23	Community Care Adult Teams - performance against new timeliness standards	CC														RN	Resources	tbc		
Responsive	5.26	Community Care Adult Teams - OPEL level	CC	3	3	3	3	3	3	3	3	3	3	3	3	3	RN	Resources			
Responsive	5.27	Out of hours - telephone clinical assessment for URGENT cases within 20 minutes of call prioritisation	LTUC	30.8%	33.6%	32.0%	36.0%		32.7%	32.5%	30.5%	19.4%	34.4%	37.6%	37.6%	36.0%	RN	Resources	<95%		>=95%
Responsive	5.28	Home visit: Face to face consultations started for URGENT cases within 2 hrs	LTUC	97.2%	93.6%	93.1%	85.7%		82.9%	81.5%	96.2%	80.8%	78.1%	85.4%	86.7%	93.4%	RN	Resources	<95%		>=95%

Domain	Indicator number	Indicator name	Clinical Directorate(s) metric is applicable to	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	Exec Lead	Committee reported to:	Monthly RAG thresholds: Red	Amber	Green
Efficiency and Finance	6.1	Agency spend	All	£ 654	£ 752	£ 890	£ 798	£ 798	£ 980	£ 991	£ 934	£ 873	£ 938	£ 1,068	£ 993	£ 544	JC	Resources	>3% of pay bill	1% - 3%	<= 1%
Efficiency and Finance	6.2	Surplus / deficit and variance to plan	All	-£ 265	-£ 471	£ 157	-£ 282	£ 6	-£ 916	-£ 732	-£ 980	-£ 1,761	£ 453	£ 2,240	£ -	-£ 1,650	JC	Resources	>1% behind plan	0 - 1% behind plan	On plan
Efficiency and Finance	6.3	Capital spend	All	£ 500	£ 905	£ 1,506	£ 1,915	£ 1,829	£ 2,244	£ 2,974	£ 3,225	£ 4,728	£ 7,025	£ 10,478	£ 22,359	£ 2,158	JC	Resources	>25% behind plan	10% - 25% behind plan	On plan or <10% behind plan
Efficiency and Finance	6.4	Cash balance	All	£ 40,077	£ 40,671	£ 43,156	£ 38,660	£ 35,921	£ 36,042	£ 37,476	£ 36,067	£ 28,449	£ 24,308	£ 19,972	£ 35,366	£ 35,645	JC	Resources	>10% behind plan	0 - 10% behind plan	On plan
Efficiency and Finance	6.5.1	Long stay patients - stranded (>7 days LOS)	All	167	165	147	164	158	158	155	149	155	160	153	143	118	RN	Resources	>90	70-90	<=70
Efficiency and Finance	6.5.2	Long stay patients - superstranded (>21 days LOS)	All	83	79	67	76	74	77	69	58	71	70	75	62	49	RN	Resources	>40	30-40	<=30
Efficiency and Finance	6.6	Occupied bed days per 1,000 population	All	60.2	61.7	57.0	61.2	59.4	59.2	61.2	59.4	62.5	63.1	54.6	58.9	50.8	RN	Resources	>60	55-60	<=55
Efficiency and Finance	6.7.1	Length of stay - elective	All	2.25	1.84	2.56	2.41	2.94	2.85	2.49	2.41	2.72	2.58	2.47	1.93	2.12	RN	Resources	>2.75	2.5-2.75	<=2.5
Efficiency and Finance	6.7.2	Length of stay - non-elective	All	5.86	5.52	5.05	4.92	5.69	5.61	5.33	4.85	5.21	5.02	4.86	4.92	4.55	RN	Resources	>4.5	4-4.5	<=4.0
Efficiency and Finance	6.8	Avoidable admissions	All	261	256	261	211	216	243	231	293	409	314	220	238		RN	Resources	>270		<=270
Efficiency and Finance	6.9	Theatre utilisation (elective sessions)	PSC	79.8%	79.4%	85.0%	78.4%	79.4%	81.4%	80.0%	83.5%	81.2%	81.5%	82.8%	79.4%	81.2%	RN	Resources	<85%	85%-90%	>=90%
Efficiency and Finance	6.10	Day case conversion rate	PSC	1.8%	1.8%	2.4%	1.7%	1.9%	1.4%	1.5%	1.6%	1.5%	1.8%	1.8%	1.7%	1.6%	RN	Resources	>2%	1.5%-2%	<=1.5%
Activity	7.1	GP Referrals against 2019/20 baseline	All	99.5%	108.7%	110.9%	98.6%	115.1%	110.9%	103.0%	113.3%	101.6%	102.7%	109.7%	170.5%	95.4%	RN	Resources	<95%		>=95%
Activity	7.2	Outpatient activity (consultant led) against plan (new and follow up)	All	112.6%	133.5%	122.1%	76.3%	88.9%	89.5%	78.9%	99.5%	85.9%	90.6%	96.2%	116.8%	144.0%	RN	Resources	<95%		>=95%
Activity	7.3	Elective activity against plan	All	123.2%	111.8%	111.1%	70.5%	90.2%	102.8%	72.4%	80.0%	80.2%	74.2%	78.4%	110.2%	109.9%	RN	Resources	<95%		>=95%
Activity	7.4	Non-elective activity against plan	All	100.5%	98.5%	104.3%	89.8%	95.9%	97.9%	97.1%	102.3%	97.8%	101.9%	101.2%	114.4%	106.9%	RN	Resources	<95%		>=95%
Activity	7.5	Emergency Department attendances against plan	LTUC	92.1%	92.7%	91.3%	96.1%	91.0%	92.6%	90.9%	92.4%	90.2%	89.1%	92.6%	100.5%	103.1%	RN	Resources	<95%		>=95%

Integrated Board Report - April 2023

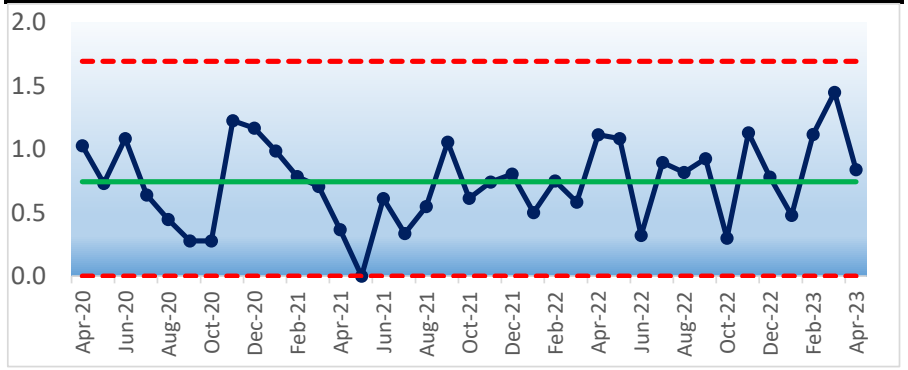
Domain 1 - Safe

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.

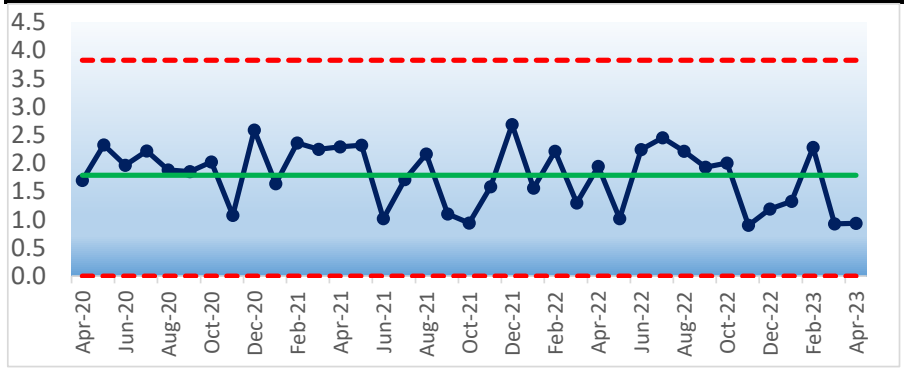
The new quality assurance process for reviewing pressure ulcers acquired in HDFT care was launched on 1st April 2023 and now includes the involvement of Directorate Heads of Nursing and Quality Assurance leads (QAL). Learning identified through this process is monitored by QAL to ensure robust and meaningful 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.

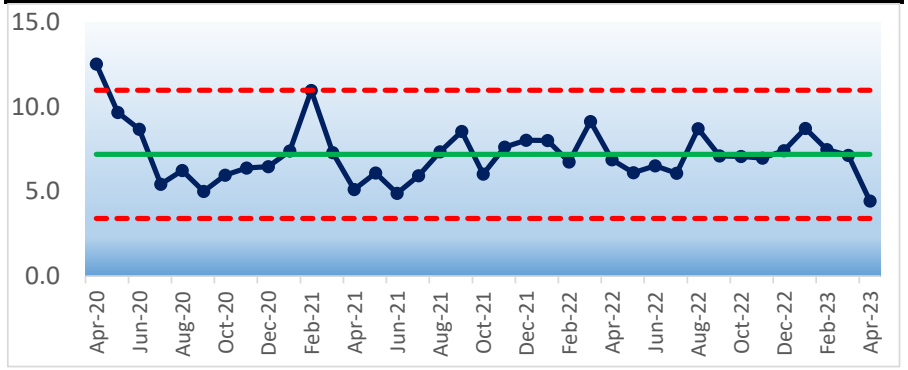
The TVN team continues to provide support and expert advice to patients receiving care from adult community services. This support also extends to those in nursing homes, GP practices and 0-19 children's services.

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

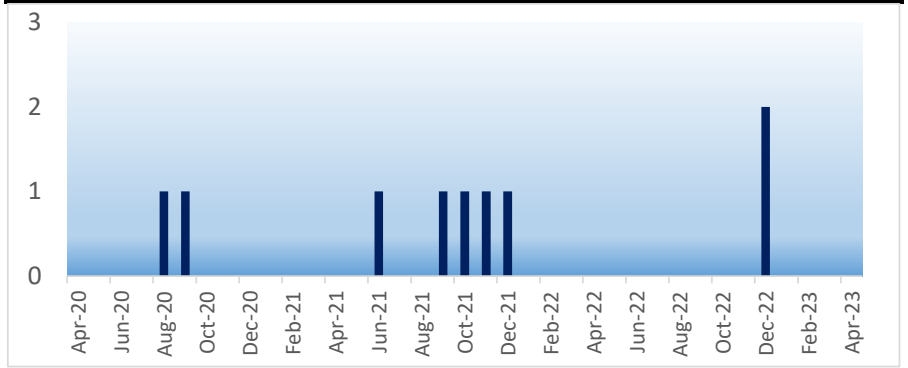
Falls continue to decrease, lowest point on the SPC chart since April 2020. As previously reported, the Trust has implemented a target of 85% compliance with lying and standing blood pressure recorded for all patients aged 65 and over. In order to support monitoring, a new report is in development that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

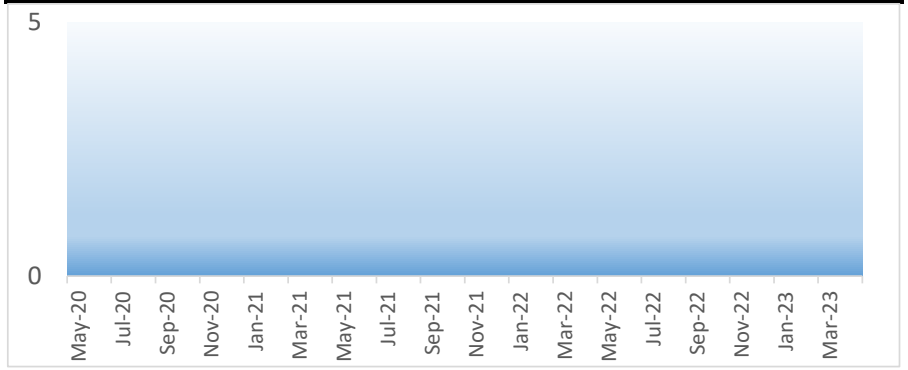
The remaining RCAs for the 2022/23 cases have also been completed and agreed with the CCG. The final position for 2022/23 was 27 hospital acquired cases in total, with 2 cases deemed to be avoidable (due to inappropriate antibiotic prescribing) and 25 cases deemed to be unavoidable. 1 case was removed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

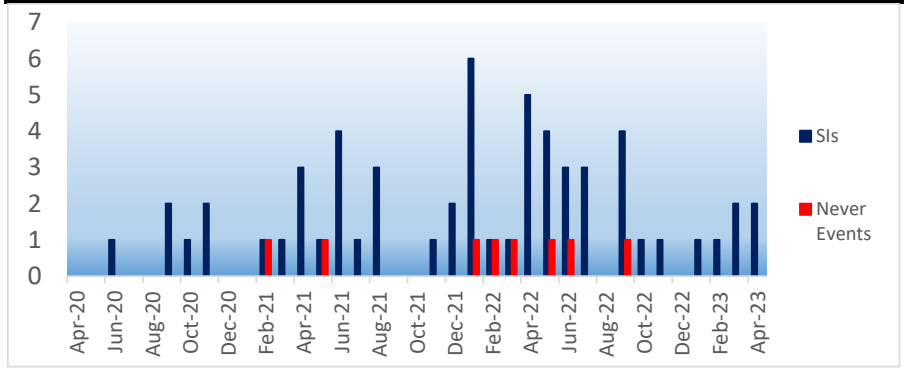
This compares to a ratio of 92 in March 2023.

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.

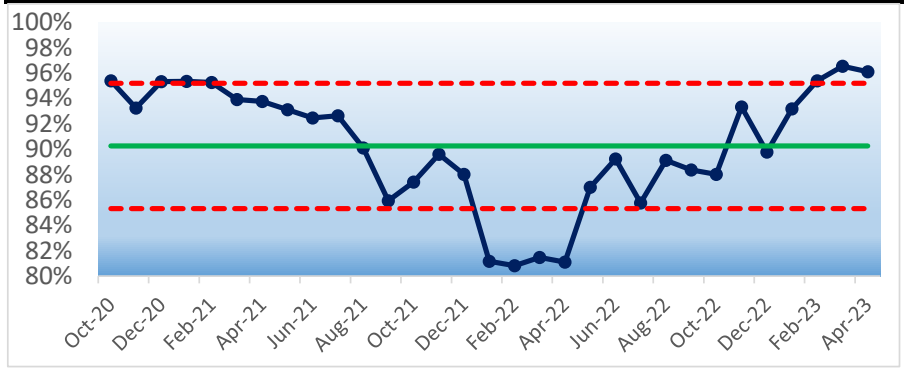
The serious incidents data now includes HSIB (Healthcare Safety Investigation Branch) investigated serious incidents, with effect from April 2023.

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.

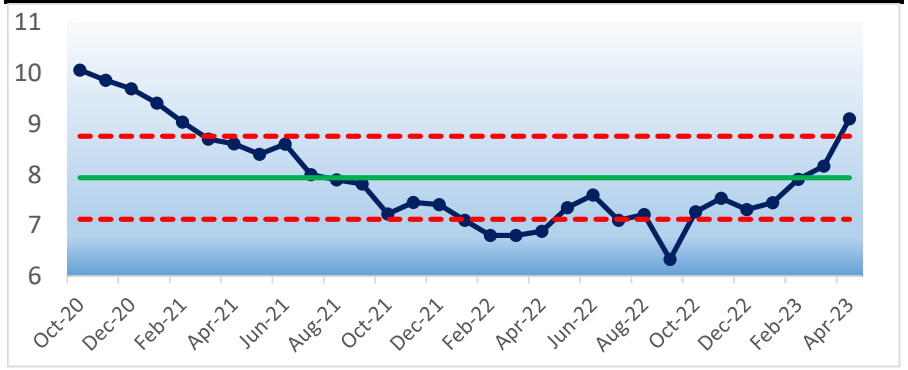
The data also shows increased fill generated by enhanced care HCSW's.

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

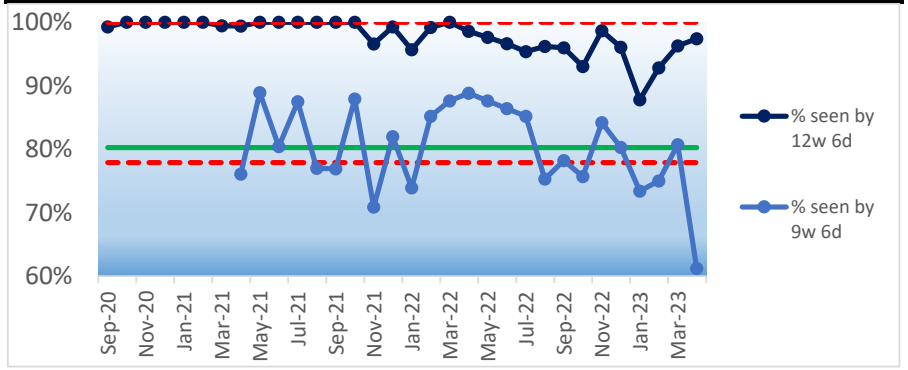
The current data correlates with the fill rates that are being achieved via improved NHSP fill rates. It also is reflective of the increased use of Enhanced Care support workers. This is alongside the increased International Recruits. The caveat being that the reduced occupancy within Critical Care and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

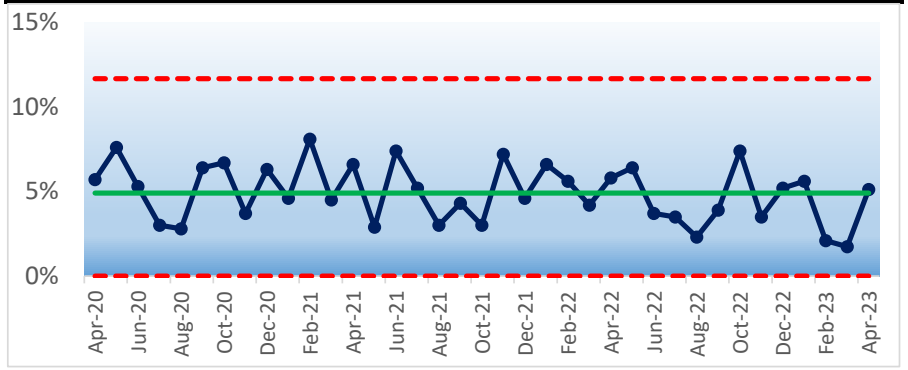
Narrative
We continue to review the implementation of the Continuity of Care Team. The Trust provides continuity during the antenatal and postnatal periods but not intrapartum at the present time.

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%

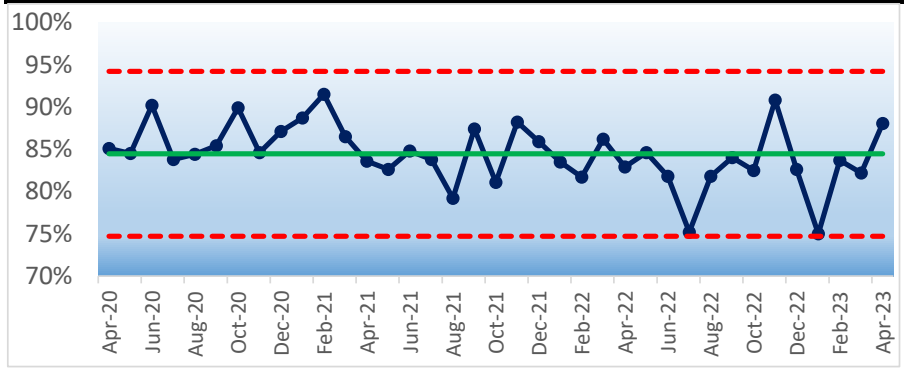
Indicator description

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%

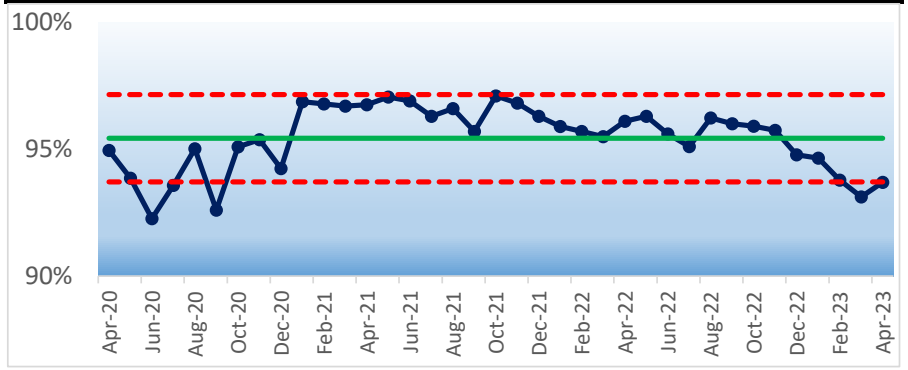
Indicator description

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

Narrative

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

SPC chart

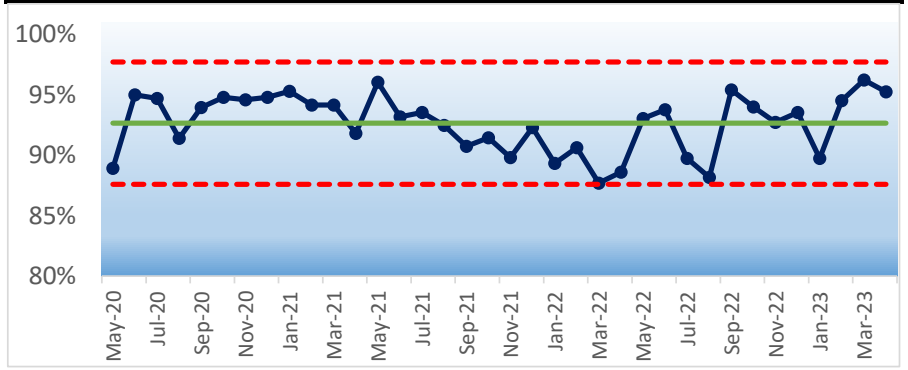


Indicator	**1.14 - Sepsis screening - inpatient wards**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Apr-23
Value / RAG rating	95.2%

Indicator description

The percentage of eligible inpatients who were screened for sepsis.

SPC chart



Narrative

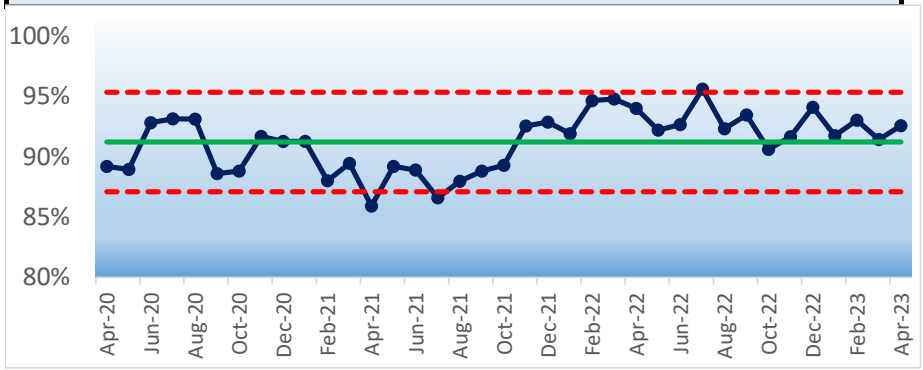
Performance remains above 95%. We continue to maintain a focus on this and datix any omissions so we learn ,understand and improve.

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

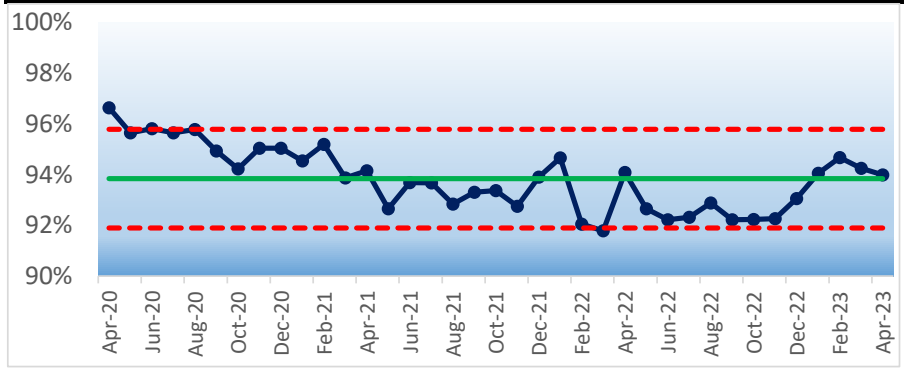
Domain 2 - Caring

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.

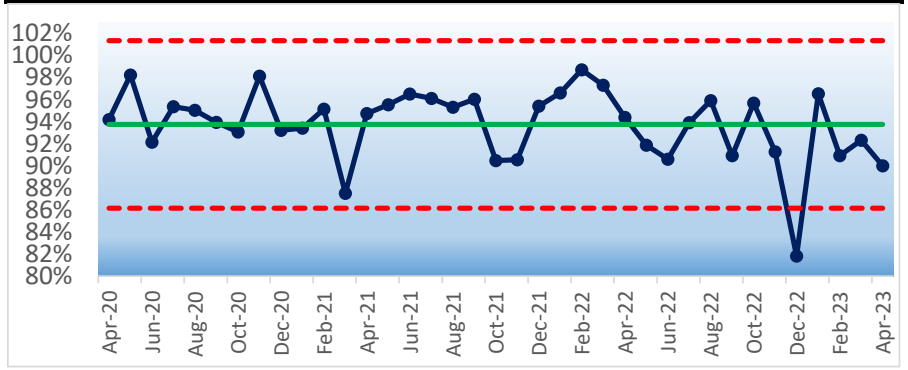
Less positive feedback was once again themed around waiting times, communication and signage in the hospital.

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

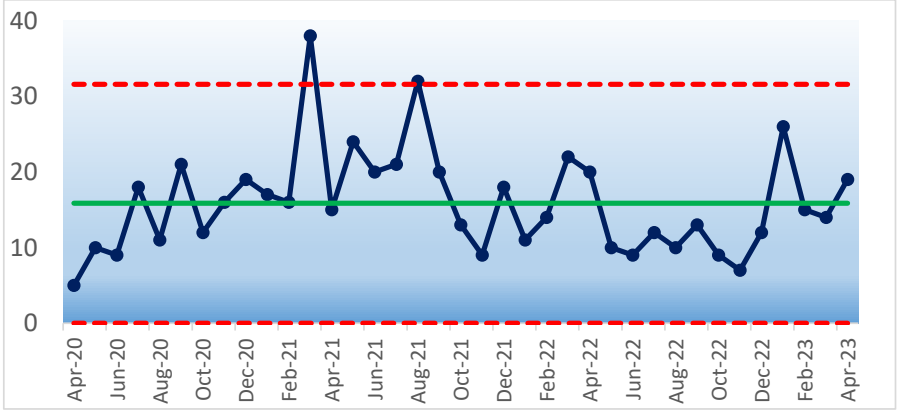
Performance against this standard continues to fluctuate but overall remains over 90% which is positive.

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

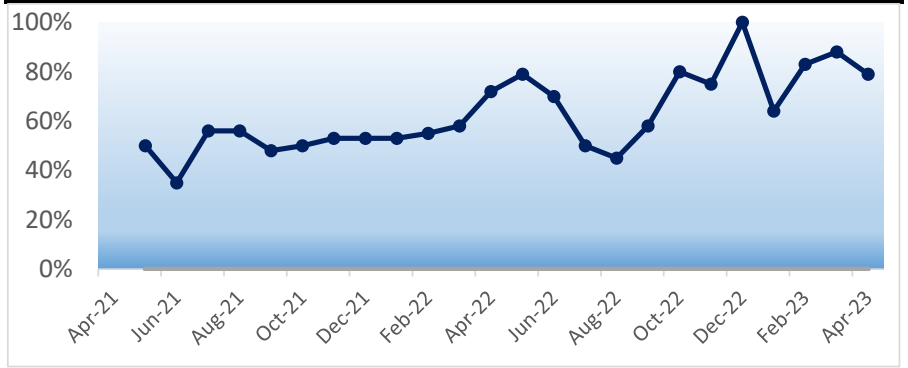
In total, there were 19 standard complaints received in April. 2 complaints came under Community and Children's Directorate, 11 complaints came under Long Term and Unscheduled Care (LTUC) and 6 under Planned and Surgical Care (PSC). In addition, there were 2 multi-agency complaints received, both for 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.

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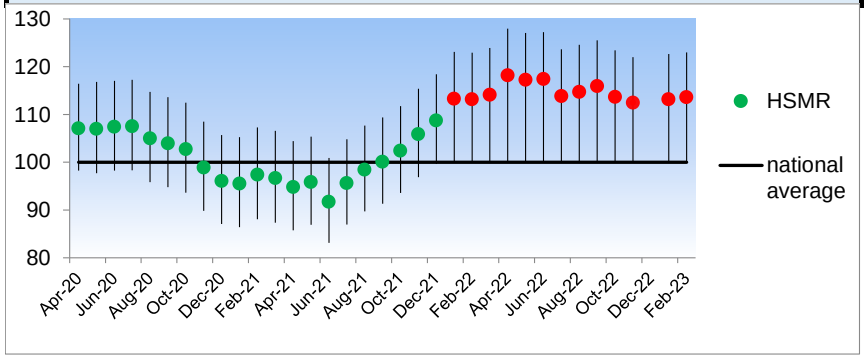
Domain 3 - Effective

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

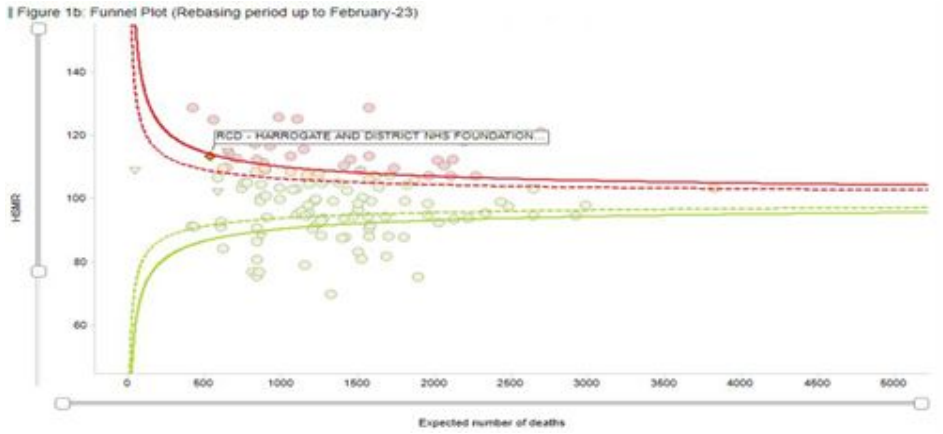
The HSMR looks at the mortality rates for 56 common diagnosis groups that account for around 80% of in-hospital deaths and standardises against various criteria including age, sex and comorbidities. The measure also makes an adjustment for palliative care.

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.

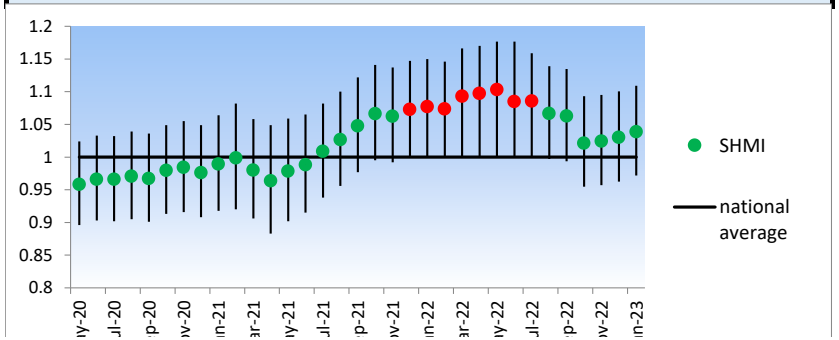


Indicator	**3.2 - Summary Hospital Mortality Index (SHMI)**
Executive lead	Jacqueline Andrews, Medical Director
Board Committee	Quality Committee
Reporting month	Jan-22
Value / RAG rating	1.039

Indicator description

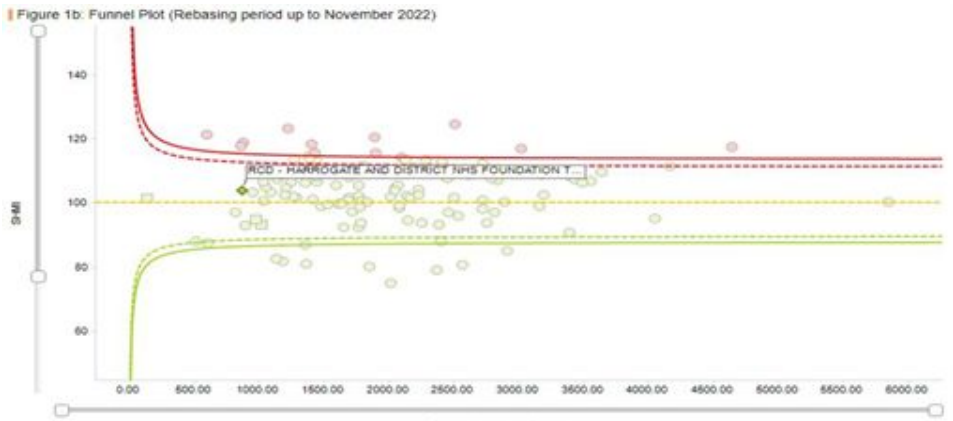
The SHMI looks at the mortality rates for all diagnoses and standardises against various criteria including age, sex and comorbidities. The measure does not make an adjustment for palliative care.

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.

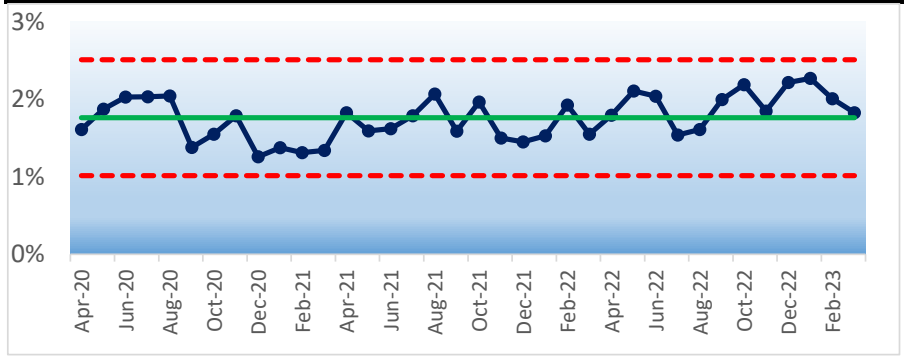


Indicator	**3.3.1 - Readmissions to the same specialty within 30 days - following elective admission**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Mar-23
Value / RAG rating	1.8%

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

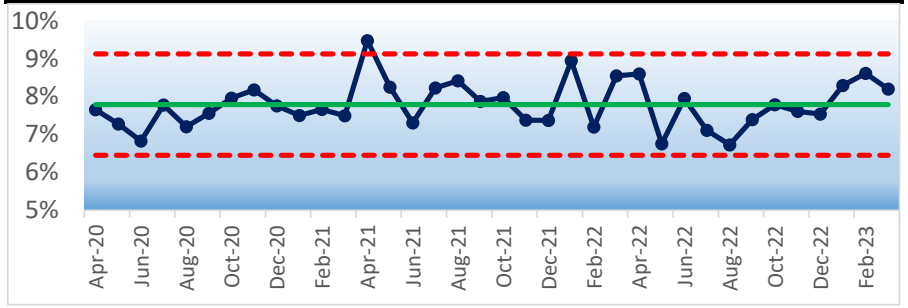
Readmissions following an elective admission decreased to 1.8% in March and remain within control limits and less than national average.

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

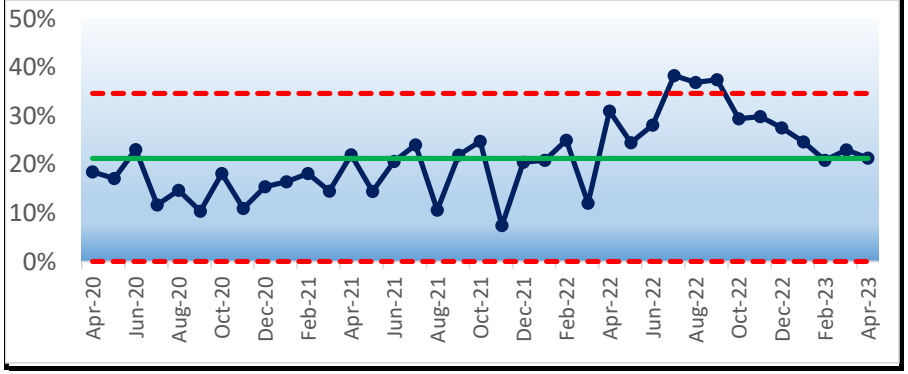
A process has been developed that will allow us to report on this metric going forward. March data has been reviewed and 7 cases of unexpected returns to theatre within 30 days were identified.

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.

Integrated Board Report - April 2023

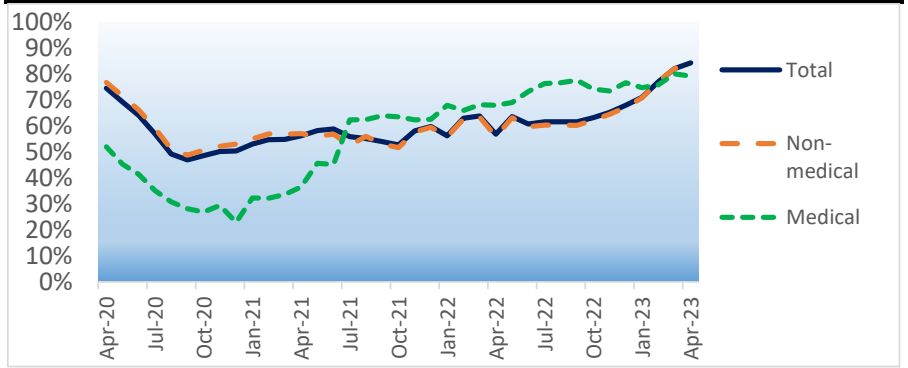
Domain 4 - Workforce

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%)

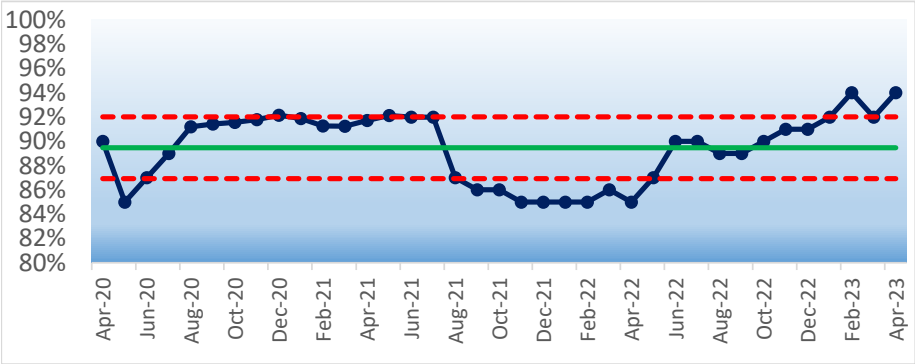
All clinical Directorates have appraisal rates above 84% in April, with LTUC seeing the greatest compliance of 87.1% this month. Corporate Services has the lowest compliance, with a rate of 74.8% in April, however the Directorate did see the greatest increase compared to the previous month, which was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

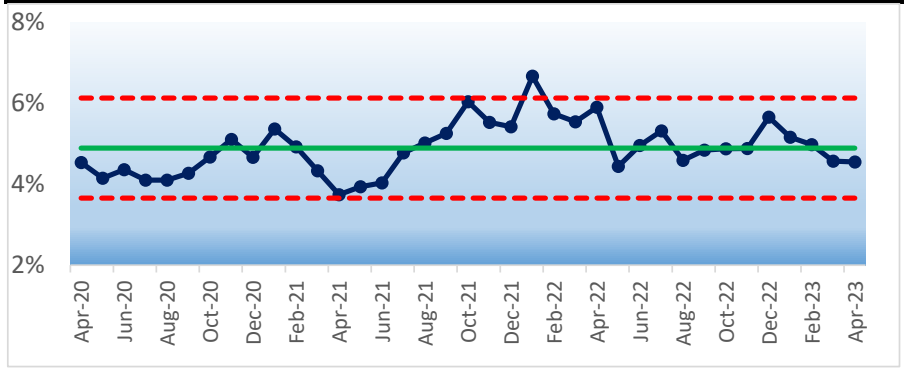
The overall compliance for Mandatory Core and Role Based Training for Trust substantive staff is currently 90%.

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.

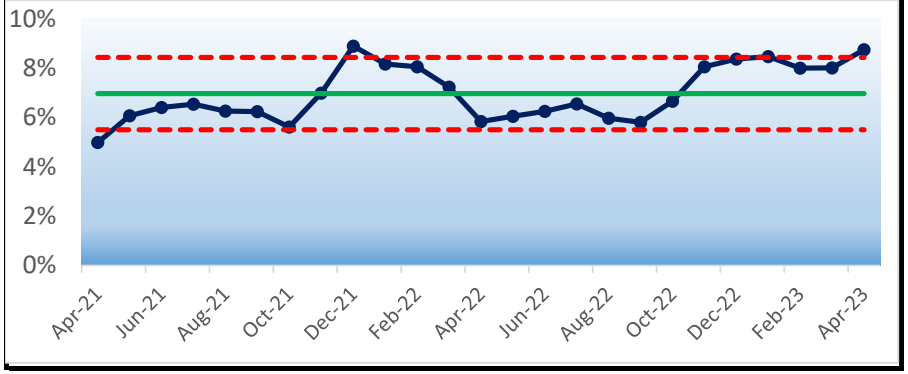
LTUC and PSC Directorates saw a decrease in turnover rates this month, with LTUC decreasing from 13.5% to 12.5% and PSC from 17.3% to 16.3%. Health Visitor turnover has seen a general increasing trend over the last year, with turnover increasing from 16.0% in May 2022 to 19.7% in April 2023. This staff 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%).

Integrated Board Report - April 2023

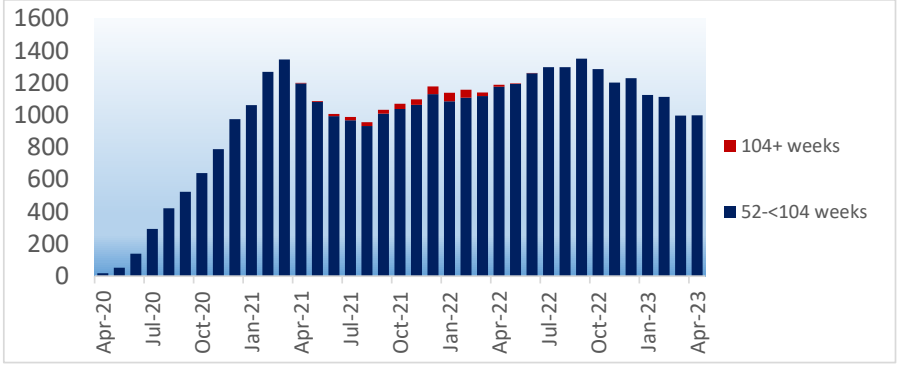
Domain 5 - Responsive

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.

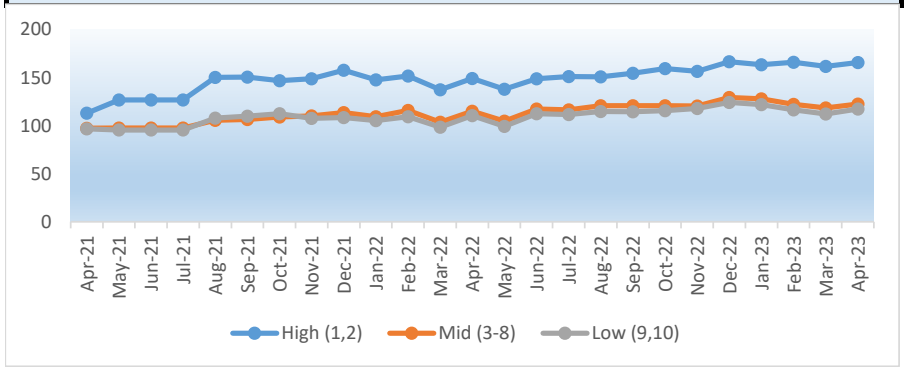
The focus on clearing the longest waiters continues and we currently report zero over 78 weeks. At the end of April, there are 5 patients delayed beyond 78 weeks due to patient choice. The number of patients waiting over 65 weeks was 202, significantly below the plan of 470. The Trust continues to report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

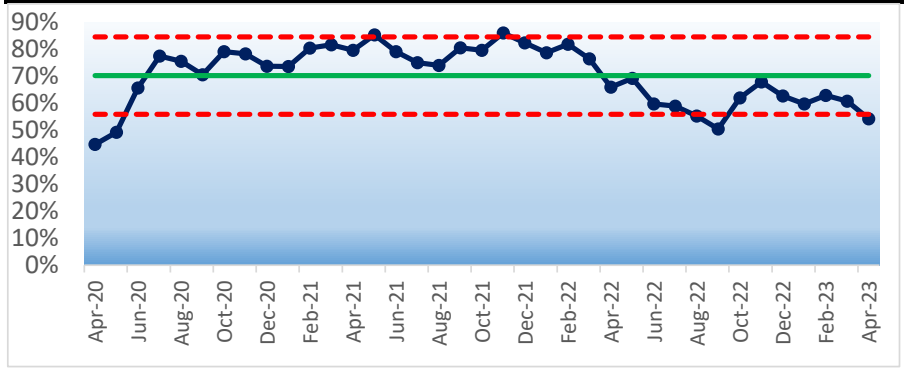
Work also continues in improving the recording of ethnicity and use of the learning disabilities flag across our clinical systems (this will improve further with the reinstatement of patient kiosks).

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.

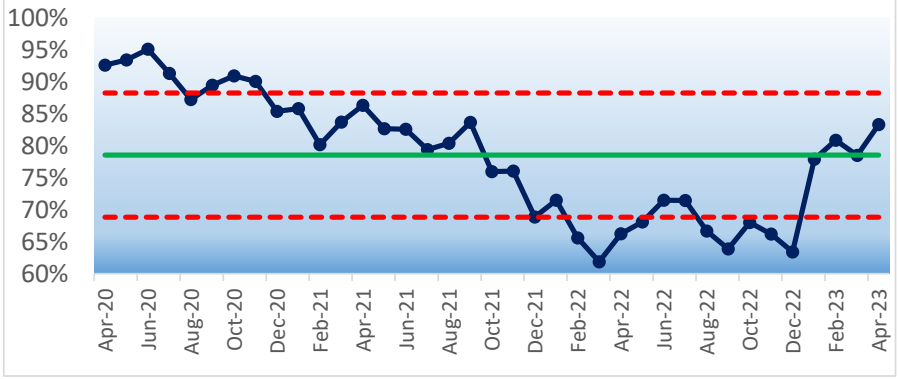
- Made contact with the lead at Central London Community NHS Trust (CLCH) who have improved their ethnicity recording rates on their patient records – they are organising a webinar to talk through their actions
- Reminded staff of the process regarding the collection of this data including reception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

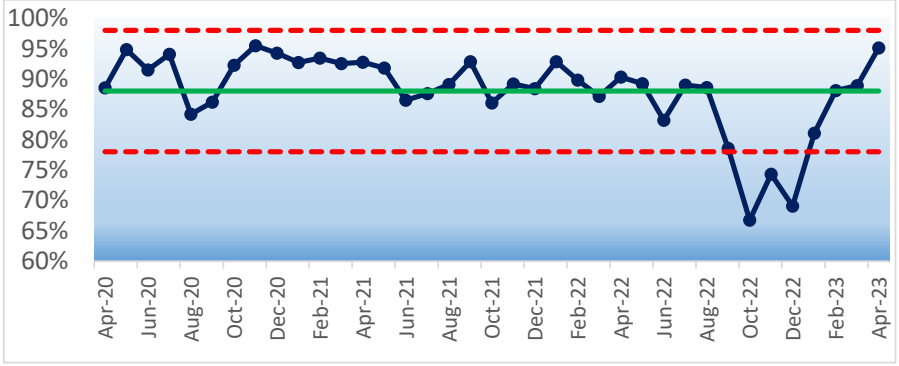
- delivering 7 day SDEC service and a direct to SDEC pathway with YAS;
- streaming of minors at the front door (now in place);
- utilising Criteria to Reside flow software to identify patients no longer requiring hospital care;
- developing a 2 hour crisis response service, expanding ARCH in-reach to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

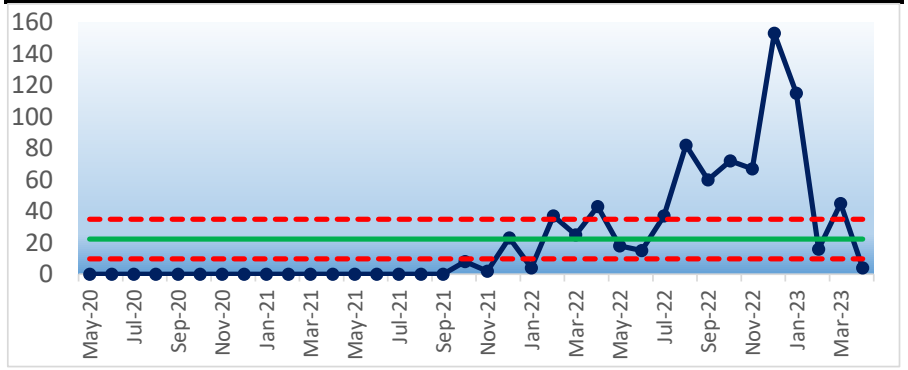
95% of ambulance handovers took place within 15 minutes in April, a continued improvement on recent months. There were no over 30-minute handover breaches in April, a significant improvement. Prevention of ambulance handover delays continues to be a focus with the Trust operational processes being shared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

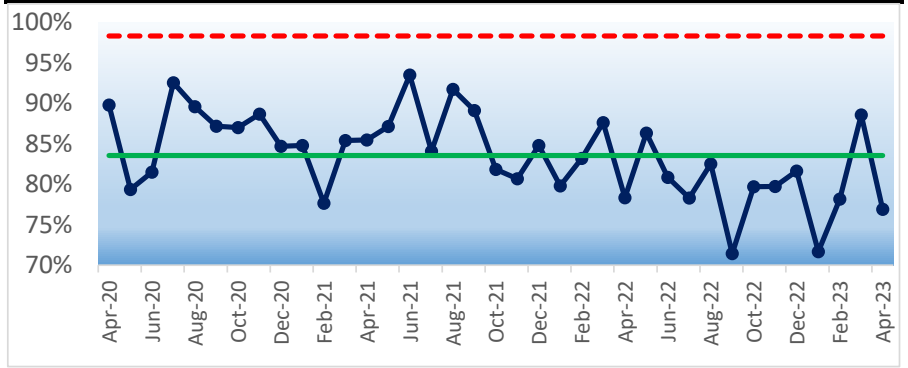
4 over 12 hour trolley waits were reported in April, a significant improvement on recent months. RCAs have commenced and will be reviewed at internal quality and performance meetings.

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.

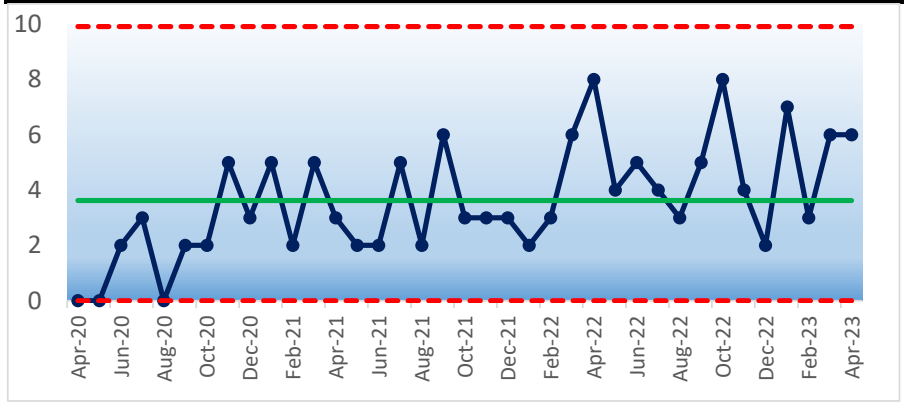
The latest published provisional data reports that national performance for the 62 day standard for all providers was at 63.5% in March. Of 141 providers, HDFT was the 10th best performing Trust. 118 of these providers had 50 or more accountable treatments, and of these, HDFT was the 3rd best peforming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

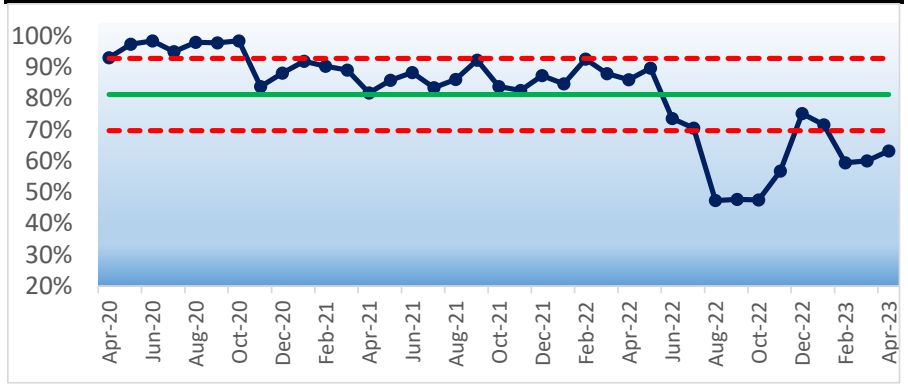
All patients have now received treatment. Following the implementation of a new cancer system in October (Somerset Cancer Registry) and the time constraints on the tracking team, it has been agreed to stand down breach panel meetings until further notice.

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

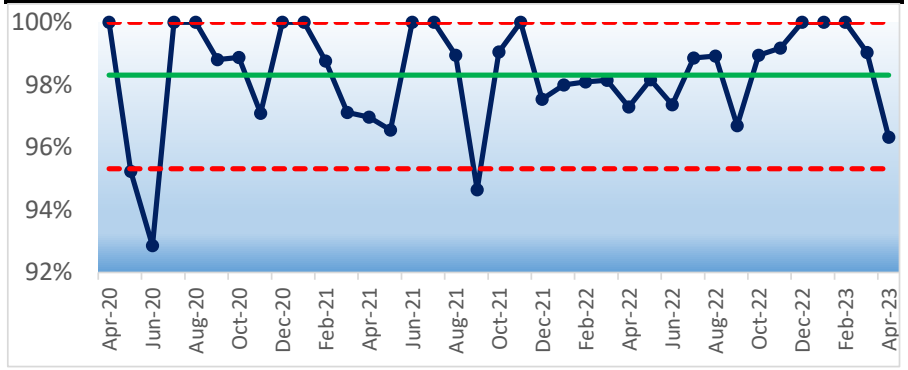
Provisional data indicates that in April combined performance for the three 28 days standards (2WW suspected cancer, 2WW non-cancer breast symptoms, Screening) continued to be below the proposed operational standard of 75% at 66.9% (2WW cancer – 70.6%; 2WW Breast Symptoms – 95.7%; Screening – 12.6%). 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	

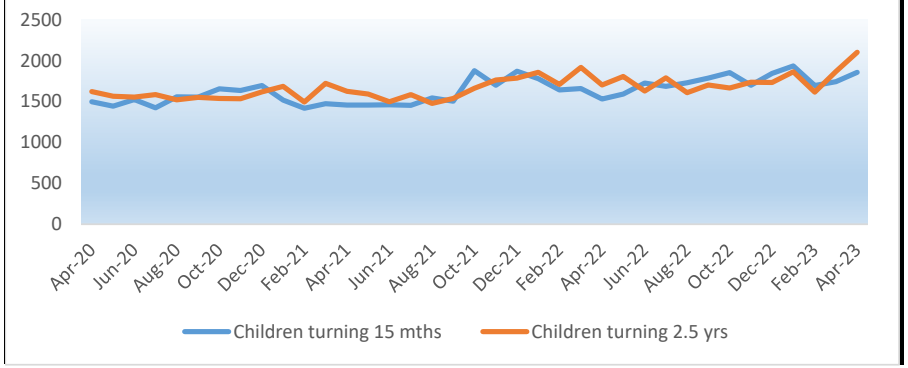
Indicator description

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

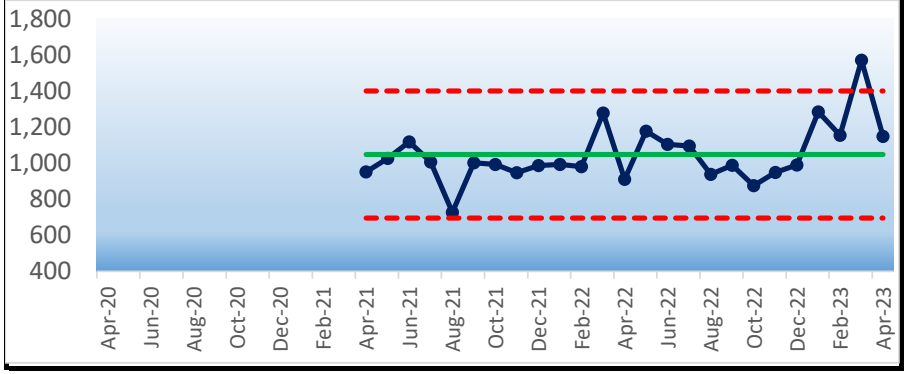
Indicator description

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.

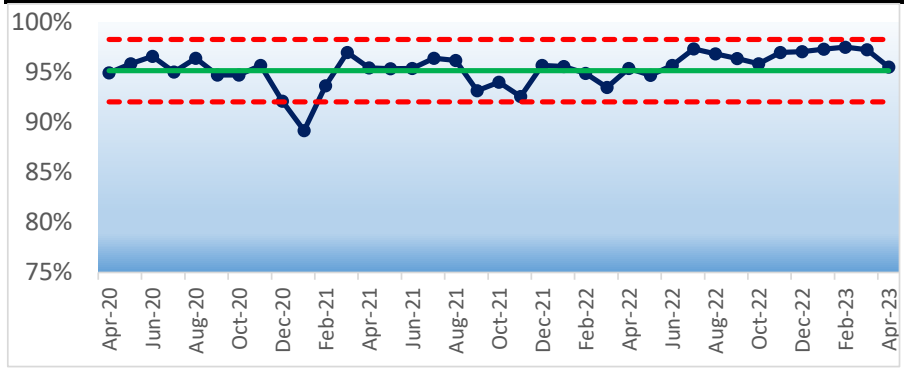
SPC chart

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.

SPC chart



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.

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%

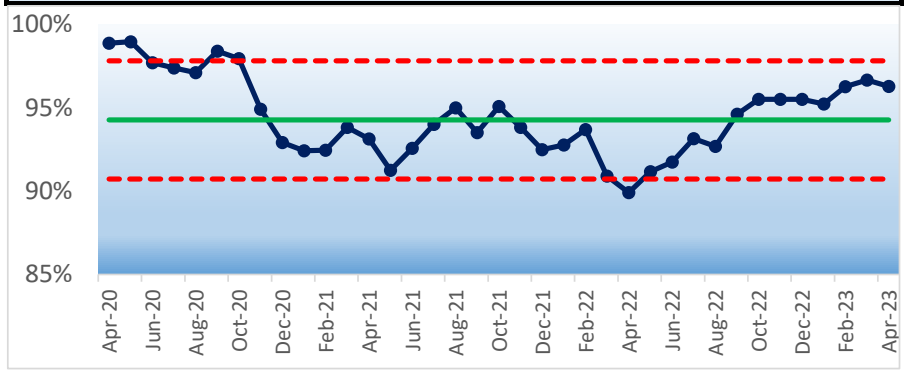
Indicator description

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

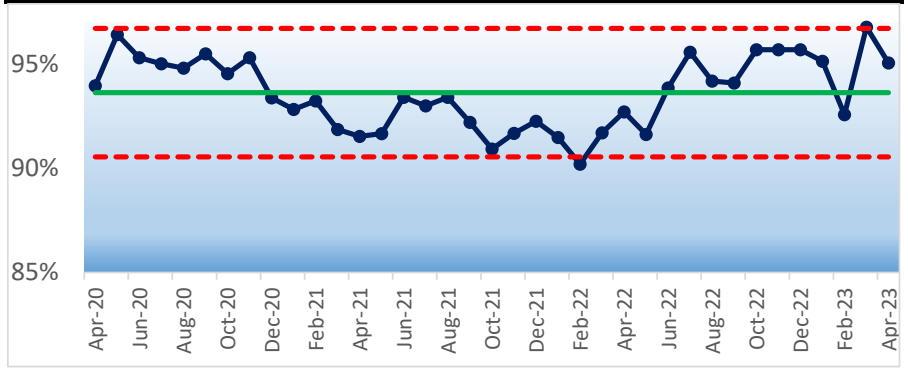


Indicator	**5.19 - Children's Services - 2.5 year review**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Apr-23
Value / RAG rating	95.0%

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

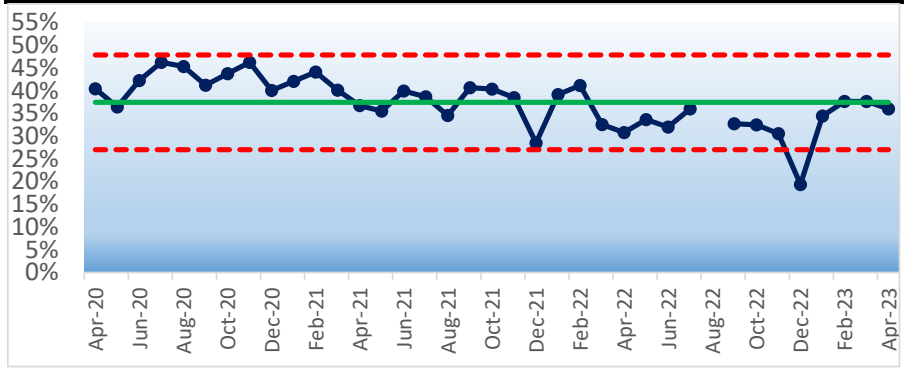
CC Directorate have started to discuss and record OPEL levels for Adult Community Services at their Safety and Governance huddles. The overall position for April remained at level 3.

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.

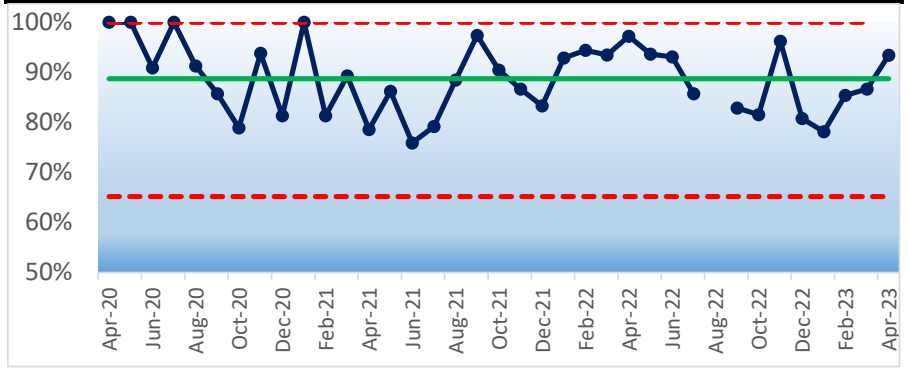
In April, 36% of urgent cases received a telephone clinical assesment within 20 minutes of call prioritisation, a reduction on last month.

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

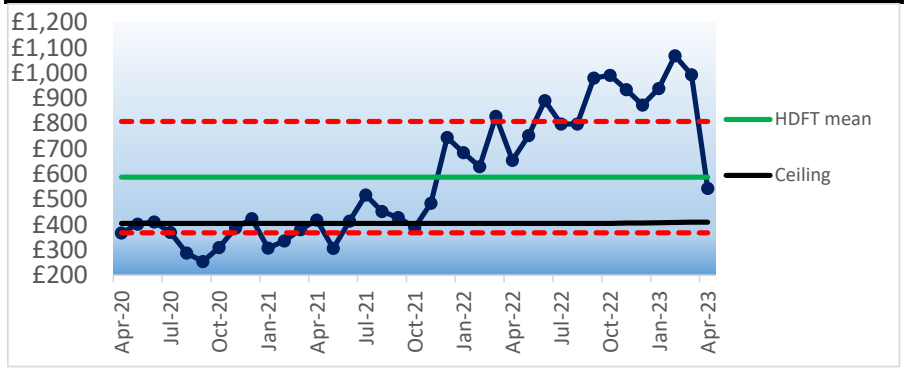
Domain 6 - Efficiency and Finance

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

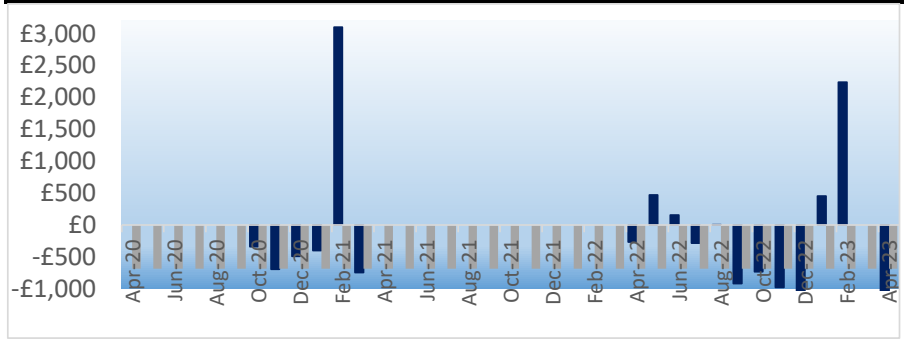
Month 1 expenditure on agency is £544k. This is £200k below plan mainly due to an adjustment relating to last year which has since reversed in month. Agency spend is being monitored via the directorate performance review meetings.

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

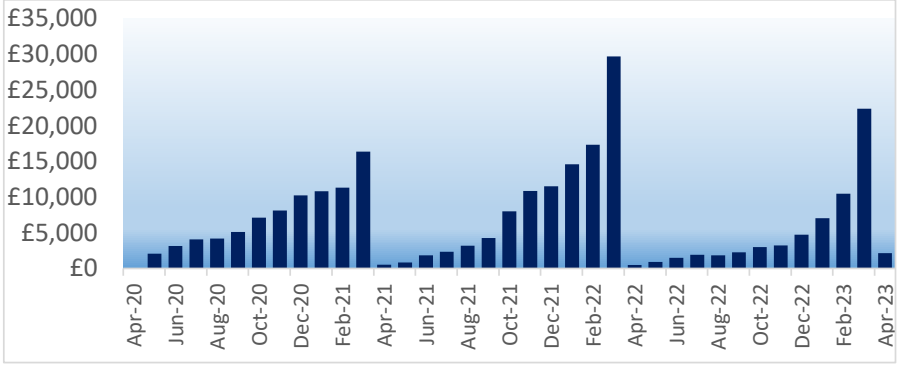
The reported position of £1.65k deficit in-month actual variance. This mainly reflects unachieved CIP including stretch targets set to support the system. There has also been one off pressures relating to back dated pay for waiting list initiatives and industrial action costs.

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

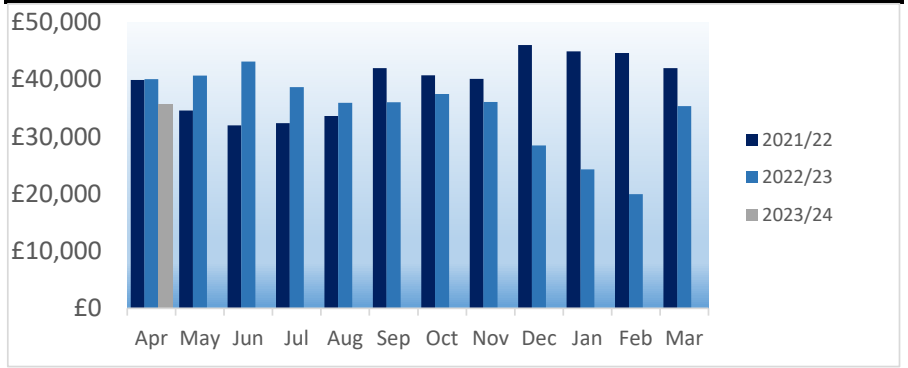
Indicator description

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

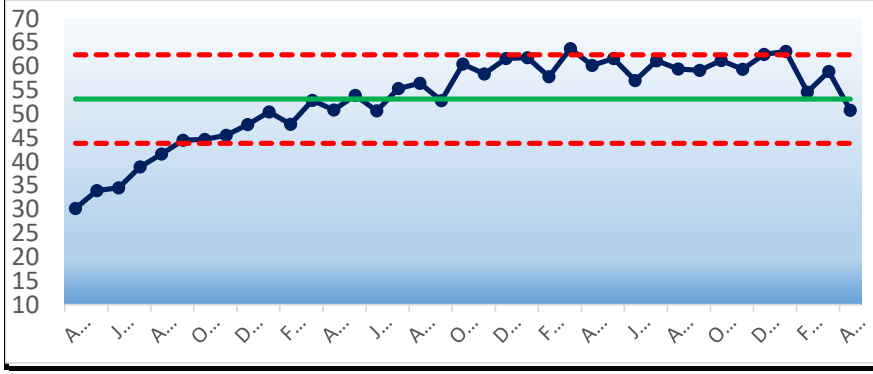
The number of long stay patients (> 21 days) was 49 in April, a continued reduction on recent months.

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

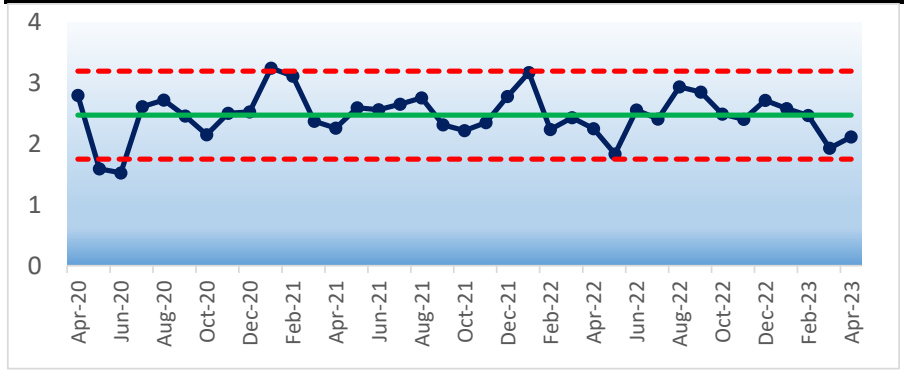
Occupied bed days per 1,000 population were at 50.8 in April, a reduction on recent months. In the 2 years prior to the pandemic, occupied bed days per 1,000 population averaged 57.8, above the current level.

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

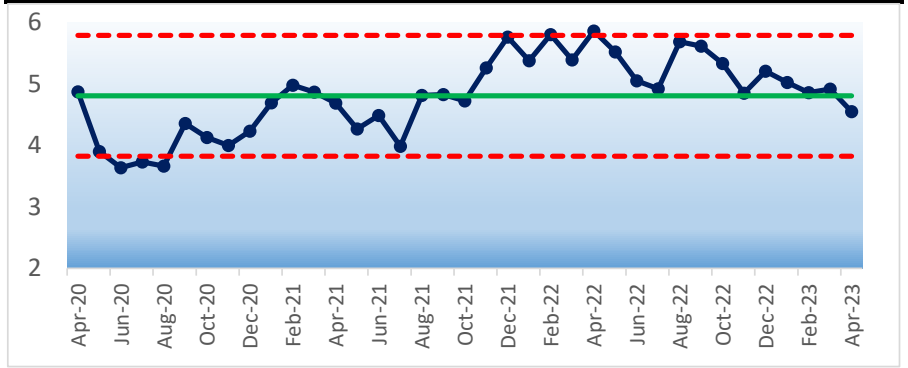
Elective length of stay increased in April but remains below our local stretch target of 2.5 days.

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

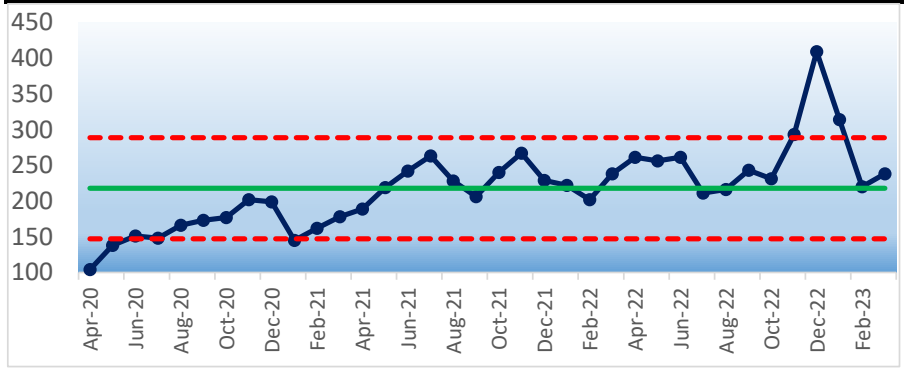
Non-Elective length of stay was 4.6 days in April, a reduction but remaining above our local stretch target. There is a combination of factors affecting patient flow as described in indicators 6.5.1 - 6.7.1. Primarily driven by high numbers of patients remaining with no criteria to reside and patient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

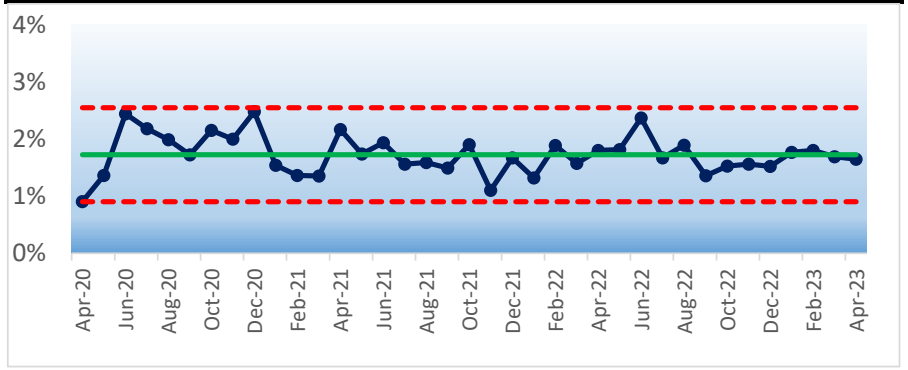
Theatre utilisation was at 81.2% in April, remaining below the local intermediate target of 90%. There is ongoing work across the board but focussed initial work with ophthalmology colleagues to understand how we achieve GIRFT productivity within HDFT. There remains an impact from Covid-19 causing late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

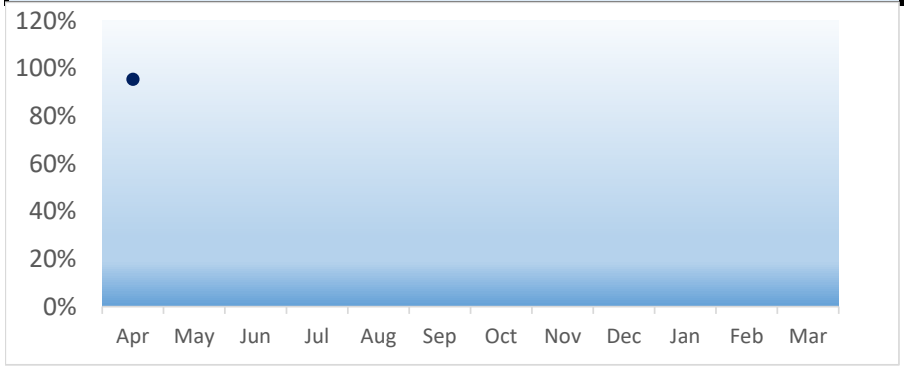
Domain 7 - Activity

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

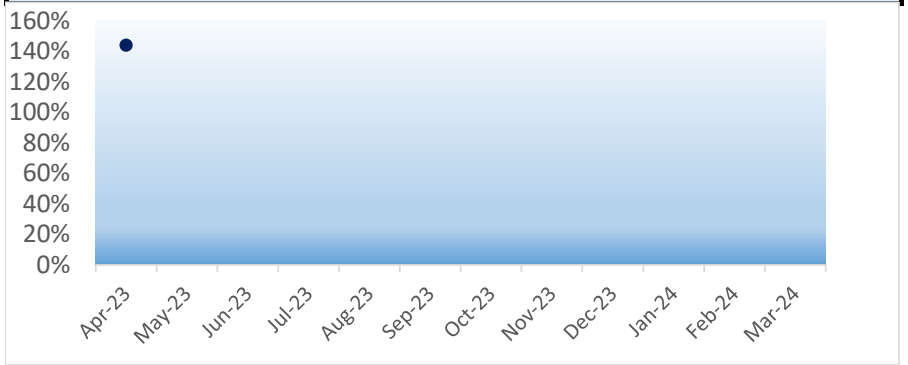
In March, GP referrals were 71% above level of the equivalent month in 2019/20 - the significant difference is due to the comparison with March 2020 which was at the start of the first wave of the pandemic. On a year to date basis, GP referrals are 11% above 2019/20.

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

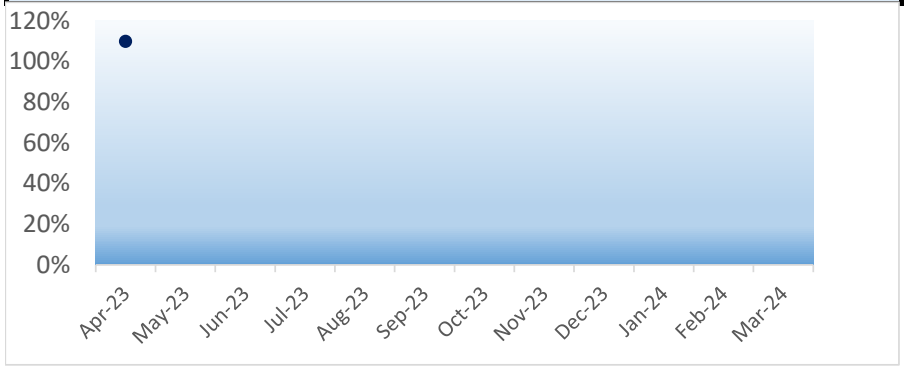
Outpatient activity was 17% above plan in March. New outpatient attendances were 11% above plan and follow up attendances were 20% above plan.

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%

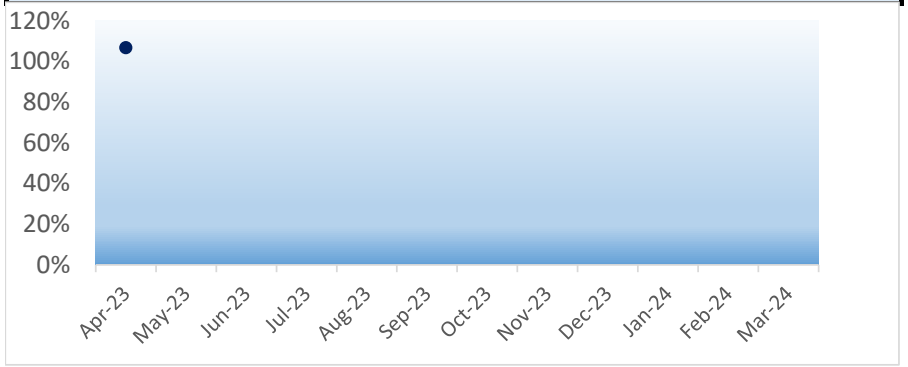
Indicator description

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%

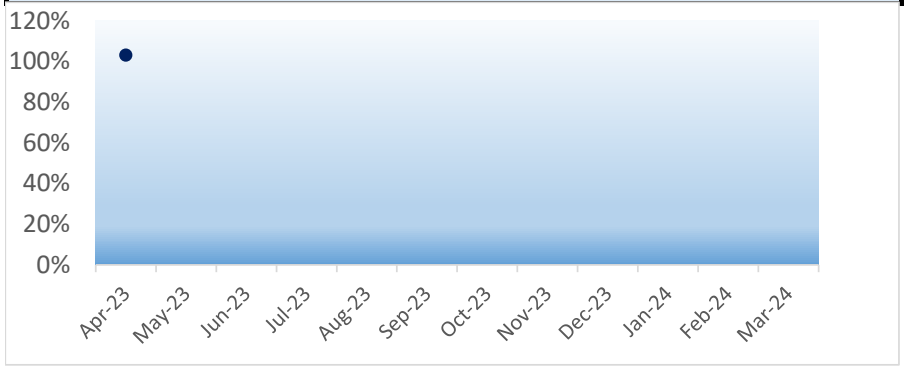
Indicator description

Emergency Department attendances against plan.

Narrative

Emergency Department attendances were 1% above plan in March.

Trend chart



Council of Governors' Meeting (held in Public)

6 June 2023

Title:	Election Update: Governor Elections – Terms of Office Extensions
Responsible Director:	Kate Southgate Associate Director of Quality and Corporate Affairs
Author:	Sue Grahamslaw Assistant Company Secretary

Purpose of the report and summary of key issues:	Owing to a slight delay in governor elections, the terms of office of specific governors require further extensions in order that their positions in post remain valid whilst elections are held or the data verified.	
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	
	Digital transformation to integrate care and improve patient, child and staff experience	
	Healthcare innovation to improve quality	
Corporate Risks	None	
Report History:	At the Remuneration, Nomination and Conduct Committee (RNCC) on 2 December 2022, it had been agreed to extend specific Governors' Terms of Office owing to the change in the Trust's constitution resulting in a delay in governor elections.	
Recommendation:	The Council of Governors is requested to agree the further extensions to specific Governors' Terms of Office to allow for the full and proper election process to take place recognising that data needs to be as accurate as possible.	

8

COUNCIL OF GOVERNORS' MEETING

Election Update and Extension of Governor Terms of Office

Prepared for Council of Governors' Meeting, 6 June 2023

1.0 INTRODUCTION

In March 2022, the Council of Governors commenced a review into the constituencies that form the Trust's membership and therefore Council seats. The Council delegated the initial review to the Remuneration, Nomination and Conduct Committee.

At the RNCC meeting on 1 December 2022, extensions to tenure were agreed to 30 June 2023 for any governors whose term was due to expire on 31 December 2022. This extension was required owing to the need to update the Trust's Constitution.

2.0 CURRENT SITUATION

The review of constituencies previously agreed, together with a change in staffing within the Corporate Affairs Team have resulted in the following situation with regard to expected election dates:

2.1 Public Constituencies (14 seats – elected)

The election process for public governors has begun and nominations are currently being sought in three constituencies. However, the timeline for elections mean that the result will be declared on Friday 14 July 2023.

- Harrogate and surrounding villages (total of five seats)
  - One seat to be elected
  - Incumbent governor had term extended to 30 June 2023
  - **Requirement will be to extend the term for an additional 2 weeks until the declaration of results on 14 July 2023**.

- Ripon and West District (total of two seats)
  - One seat to be elected
  - Incumbent governor had term extended to 30 June 2023
  - **Requirement will be to extend the term for an additional 2 weeks until the declaration of results on 14 July 2023.**

- Wetherby & Harewood, Alwoodley, Adel & Wharfedale and Otley & Yeadon (total of two seats)
  - One seat to be elected
  - Incumbent governor had term extended to 30 June 2023
  - **Requirement will be to extend the term for an additional 2 weeks until the declaration of results on 14 July 2023.**
  - Council had previously been advised that another Governor's term concluded on 31 August 2023. However, on further review, that Governor's tenure commenced on 1 September 2021 for a three year term, meaning their tenure will actually conclude on 31 August 2024, not 2023.

- Knaresborough and East District (total of two seats)
  - No elections required at this time

- Rest of North Yorkshire and York (total of one seats)
  - No elections required at this time

- Rest of England (total of two seats)
  - No elections at this time
  - This constituency has been divided into Rest of England – North and Rest of England – South as part of the constitution amendments
  - Both seats are vacant
  - Work is currently ongoing to remap the existing membership data to these two constituencies; the Council of Governors will be kept informed of progress being made.

2.2 Staff Constituency (six seats - elected)

Following the constitution amendments, there will be one seat in each of the following staff classes:

- Medical Practitioners' Staff
- Nursing, Midwifery & Allied Health Professionals (AHP)
- 0-19 Services Staff
- Community Services Staff
- Other Clinical Staff
- Non-Clinical Staff

Owing to the requirement to update the staff membership database, elections in the staff constituency have not yet progressed.

However, the incumbent staff governor in the Nursing, Midwifery & AHP staff class had their term extended to 30 June 2023. **There is therefore a requirement to extend this staff governor's term until 1 October 2023 by which it is anticipated that staff governor elections will have taken place.**

2.3 Stakeholder Constituencies (six seats - appointed)

Following the constitution amendments, there will be one seat in each of the following staff classes:

- Harrogate Integrated Facilities (one seat)
- Local Authority (two seats)
- Further Education (one seat)
- Voluntary Sector (one seat) – category under review
- Patient Experience Sector (one seat)

3.0 PROPOSAL

With election processes underway in the local public constituencies and a timetable agreed, it is proposed that the extensions to the three elected public governor and one staff governor terms are granted. It should however be noted that one public governor, if re-elected for an additional three year term, would therefore have a tenure of more than 9 years.

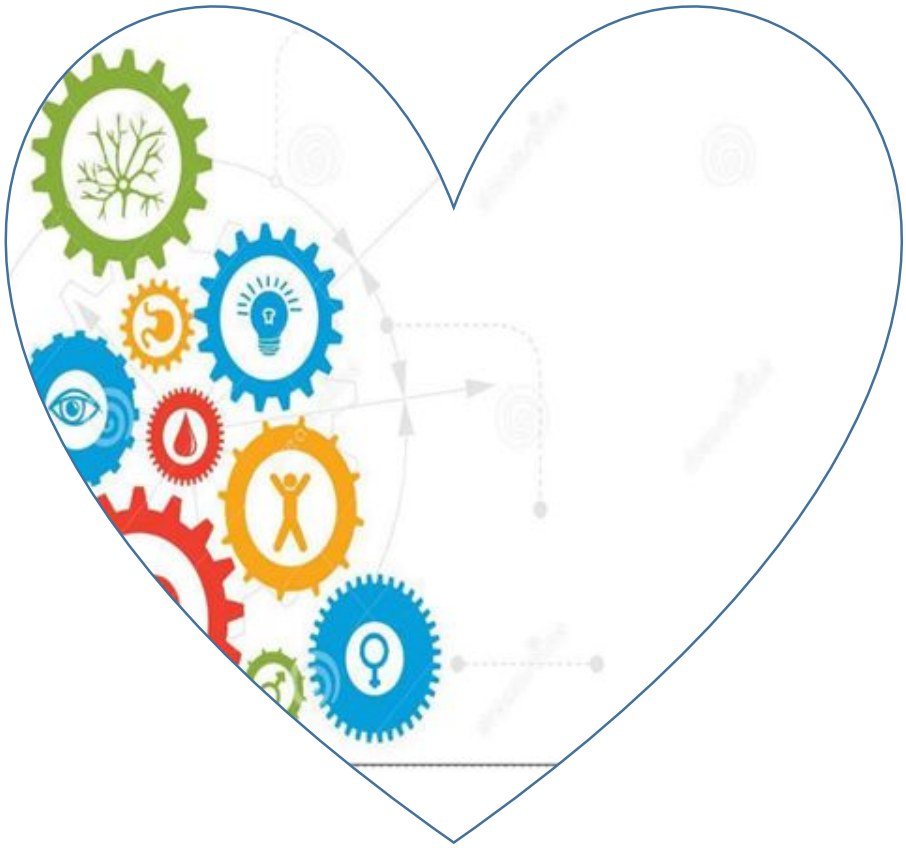
The elections for the Rest of England North, Rest of England South and the staff constituency will take place after the elections that are currently underway for public governors, noting that consideration will need to be given to timing so as to try to avoid the summer holiday period.

4.0 RECOMMENDATIONS

The Council of Governors are recommended to review the proposal and approve the extensions to the public and staff governor terms of office as outlined.

Kate Southgate
Associate Director of Quality and Corporate Affairs
6 June 2023

NHS
Harrogate and District
NHS Foundation Trust



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Harrogate and District NHS Foundation Trust

Quality Account 2022-2023

teamHDFT
At our best

Contents

PART 1

The Quality Account is an annual report, which reviews our performance and progress against the quality of services we provided In 2022 – 2023 and sets out our key quality and safety improvement priorities for 2023 - 2024. It demonstrates our commitment to continue improving our services and provide high quality, safe and effective care to our patients, their carers and their families. This means that it is essential that we focus on the right quality and safety priorities for

Introducing our Quality Accounts

Welcome to the 2022-23 HDFT Quality Accounts.

Thank you for your interest in reading our 2022-23 Quality Accounts.

At HDFT we have worked incredibly hard during 2022-23 to review, renew and reinvigorate the work we do with regards to Quality and Safety.

In this report, we set out what we have achieved in 2022-23 with regards to the priorities we set. These priorities were identified via the Trust's learning systems to identify areas of our work where we could improve the quality and safety of the care we provide, the effectiveness of our services or the experience people have whilst working with us or accessing our services.

We also set out the quality and safety improvement priorities for 2023-24.

Comments from our stakeholders on the content of the Quality Account are included in full in the Annex of this report.

We welcome involvement and engagement from all colleagues and stakeholders because their comments help us acknowledge our achievements and identify further improvements to be made.

I can confirm that the Board of Directors has reviewed the 2022-23 Quality Account and can confirm that to the best of my knowledge, the information contained within this report is an accurate and fair account of our performance.

We hope that you enjoy reading this year's Quality Account.

With best wishes

Jonathan Coulter

Chief Executive

What is a Quality Account?

The Quality Account is an annual report published for the public from providers of NHS healthcare about the quality of the services it provides. The report provides details on progress and achievements against the Trust's quality and safety priorities for the previous year and what the Trust will focus on in the next year.

What should a Quality Account look like?
Some parts of the Quality Account are mandatory and are set out in regulations (NHS Quality Account Regulations 2010 and Department of Health – Quality Accounts Toolkit).

The Quality Account must include:

Part 1: Introduction
A statement from the Board of the organisation summarising the quality of NHS Services provided.

Part 2: Looking Back
Looking back at the previous year's performance.
A series of statements from the Board for which the format and information required is prescribed and set out in the regulations and toolkit.

Part 3: Looking Forward
A review of the quality of services in the organisation for the coming financial year. This is presented under three domains: Patient Safety, Clinical Effectiveness and Patient Experience.

What does it mean for Harrogate and District NHS Foundation Trust (HDFT)?
The Quality Account allows NHS healthcare organisations to demonstrate its commitment to continuous, evidence-based quality improvement and to explain its progress against agreed quality and safety priorities, how the organisation performed in other quality areas eg service delivery and to inform the public of its future quality plans and priorities.

What does it mean for patients, members of the public and stakeholders?
By putting information about the quality of services into the public domain, NHS Healthcare Organisations are offering their approach to quality for scrutiny, debate and reflection. The Quality Account should assure the Trust's patients, members of the public and its stakeholders that as an NHS organisation, it is scrutinising each and every one of its services, providing particular focus on those areas that require the most attention.

How will the Quality Account be published?
The Quality Accounts are published electronically on the NHS Choices website and we will also make them available on our own website: www.hdft.nhs.uk

About Us

Our Services

Acute and Community Services for Harrogate and District and wider North Yorkshire:

- Harrogate District Hospital which includes an Emergency Department, comprehensive medical and surgical specialities, an oncology centre, maternity services and extensive outpatient facilities
- Community Services which includes podiatry, district and community nursing, therapy services and community dental services

Children's Public Health (0-25) Services

- 9 local authorities in North East and Yorkshire
- Looking after over 500,000 children
- The largest provider of 0 – 19 services in England

HDFT in Numbers

3 INTEGRATED CARE SYSTEMS	OVER **5,000** COLLEAGUES	**21,000** VIRTUAL OUTPATIENT ATTENDANCES
118,000 HOME VISITS	HOSPITAL CATCHMENT AREA **c200,000**	**£300M** TURNOVER
LOOKING AFTER OVER **500,000** CHILDREN	COMMUNITY SERVICES POPULATION **c620,000**	LARGEST **EMPLOYER** IN HARROGATE AND DISTRICT
55,000 EMERGENCY DEPARTMENT ATTENDANCES		OVER **2,000** CANCER TREATMENTS

Part 2: Priorities for Improvement 2022-23 and Statements of Assurance from the Board

The information presented in this Quality Account represents information which has been monitored over the last 12 months by the Trust Board, Council of Governors, Quality Committee and the Executive led Quality Governance Management Committee.

The majority of the Account represents information from all of our Directorates presented as total figures for the Trust. The indicators, to be presented and monitored, were selected following discussions with the Trust Board. They were agreed by the Executive Team and have been developed over the last 12 months following guidance from senior clinical staff.

The Trust has consulted widely with members of the public and local committees to ensure that the indicators presented in this document are what the public expect to be reported.

2022-2023 has been an exciting time for quality and safety at HDFT with significant work to transition towards a new approach to the quality agenda. Key activities during the year have been:

- The development of a new Trust Strategy which puts quality and safety at the heart of everything we do
- The development of a revised Board Assurance Framework that complements the Trust Strategy
- A full scale review and implementation of a revised Quality Framework which includes a new structure in our Quality Team to ensure it is fit for purpose and future proofed, as well as full scale revision to our governance structures.
- Ensuring we have processes, structures and frameworks in place to transition from the Serious Incident Framework to the new Patient Safety Incident Response Framework
- Clear and dedicated improvement projects for our quality priorities which are monitored and reviewed continuously through our revised governance structures.
- A full scale review of quality improvement and decision to implement a revised continuous improvement model.

We approach 2023-2024 with a strong grounding in our quality framework, which will enable us to move forward proactively with the challenges and opportunities that the next 12 months will bring, to ensure that HDFT can implement the necessary changes for key initiatives such as:

- The Patient Safety Incident Reponses Framework
- The NHS Complaints Standard Framework
- The Care Quality Commission revised inspection Framework
- Three Year delivery plan for maternity and neonatal safety
- NHS delivery and continuous improvement review

We hope that our Quality Account provides you with an overview of the work that we have undertaken during 2022-2023 as well as highlighting where we will go next in our continuous improvement journey.

Emma Nunez
Executive Director Of Nursing, Midwifery And AHPs / Deputy Chief Executive

Jackie Andrews
Executive Medical Director

Our Quality System

We have reviewed our local system to understand the people who are involved in patient safety activities across HDFT, as well as the systems and mechanisms that support them.

Our commitment is that each patient is treated with equality, respect and dignity and, most importantly of all, as a person. HDFT is a complex system with many interrelated components that are crucial to ensuring that everything works. Our core internal system is made up of:

3 **CLINICAL DIRECTORATES**	**LTUC** **LONG TERM AND UNPLANNED CARE**	**PSC** **Planned and Surgical Care**
CC **CHILDREN**	**1** **CORPORATE DIRECTORATE**	**HIF** **HARROGATE INTEGRATED FACILITIES (SUBSIDURY COMPANY)**

The corporate Quality Team consists of the Patient Experience Team, the Patient Safety Team and the Compliance Team under the leadership of the Associate Director of Quality and Corporate Affairs, reporting in to the Executive Director of Nursing, Midwifery and Allied Health Professionals with support from the Executive Medical Director.

Over the past 18 months, the Quality Team in HDFT has been in a transitional period during which time a complete review of the functions and structure of the team has taken place. The new structure is now almost complete and operates under new leadership.

Core quality activities undertaken at HDFT includes;

- Risk Management
- NHS Patient Safety Strategy
- Central Alerts system
- Incident Management
- Legal SLA / Budget
- Learning from Events, Claims and Complaints
- Serious Incidents
- Patient Safety Framework
- LFPSE [Formally NRLS]
- Claims Management
- Coroners Management
- Oversight of Datix system
- Clinical Effectiveness
- NICE
- Management of CQC Regulations and all CQC related activity
- Policy Management
- Friends and Family

- Complaints & PALs
- Patient engagement activities

Other activities within the Trust that provide insights to patient safety include Structured Judgement Reviews, Learning from Deaths and Quality Improvement projects, as well as our day to day activities such as safety huddles, hot de-briefs and governance meetings.

Our colleagues within each of the directorates predominantly own the operational 'work-as-done' for these patient safety activities. Largely the respective directorate Triumvirate Leads, Clinical Leads and Quality Assurance Leads, who are in turn supported by the central Quality Team who provide a strategic overview.

The emergent Quality Team has been built to fit and respond to both the hospital and also the extensive size of our community footprint and the nuances of the teams, services and structures we work in. The HDFT Quality Team will be integral in facilitating our patient safety journey and patient safety culture on our road to implementing PSIRF.

In 2022-2023 we have also embarked on an ambitions continuous improvement journey:

- HDFT has been using a lean, quality improvement approach for over 10 years – we know this approach works and we've seen the improvements it can bring.
- Now we want to take our approach to improvement to the next level – to embed improvement at the centre of our culture and operating model.
- We're partnering with Catalysis and KPMG, international leaders in improving healthcare with extensive experience supporting NHS trusts.
- Over the next 18 months they will support us to develop our own improvement operating model, to train and coach our teams, and to build our capacity and capability to sustain our improvement journey.
- It will be **our** team HDFT approach, based on tried and tested principles, but tailored to our strategy, our culture, our needs.
- The first stage is to understand our readiness for this journey by examining our processes and systems, meeting colleagues throughout the Trust and observing how we work at every level from frontline to the Board

Performance Against Priorities 2022-2023

In 2022-2023 at HDFT we revised our Trust Strategy. Within it one of our Key Ambitions is: Best Quality, Safest Care.

Our ambition is to provide the best quality, safest care, where quality is defined by safety, effectiveness and patient experience.

Ever Safer Care

Through continuous learning and improvement we will make our processes and systems ever safe – we will never stop seeking improvement. Our quality programmes for 2022-2023 within this are:

- Emergency Department
- Theatres Safety
- Inpatient Falls
- Pressure Ulcers

Excellent Outcomes

We want excellent outcomes for our patients and the children and young people we support which improve their health, wellbeing and quality of life – we will do this by providing effective care based on best practice standards. Our quality programmes for 2023-2023 within this are:

- Acting on Missed Results
- Medication Errors – with a focus on Insulin

A Positive Experience

We want every patient, child and young person to have a positive experience of care – we will do this by listening and acting on their feedback to continuously improve. Our quality programmes for 2022 – 2023 within this are:

- A focus on the NHS Patient Experience Framework

SAFE: Best Quality, Safest Care: Ever Safer Care through Continuous Learning and Improvement

Quality Programme: Emergency Department

Why The Emergency Department?

Following a number of incidents in our Emergency Departments in 2021-2022 a review of process was undertaken that identified there were areas for improvement. We therefore selected this as a quality priority for 2022-2023.

What were we aiming to achieve?

As part of the project we aimed to:

- Improve our streaming model to improve patient experience, flow through the department and improve performance
- Reconfigure the department including a “fit to sit” area
- Improve flow with further development of the acute medicine model
- Improve the Urgent Care Response
- Increase our Virtual Ward capacity

What did we achieve?

Significant work has been undertaken to ensure the success of this improvement priority. Key areas have included:

- Streaming model developed and in place. Recruitment completed to ensure sustainable staffing model.
- Acute referral triage pathway developed
- Reconfiguration of the department has included the introduction of a fit to sit area and a major refurbishment of the majors area of the department
- Acute medicines model in progress with an acute medicine staffing review being complement, new colleagues in post and revised training plan implemented.
- The Urgent Care Response pathway was approved and key colleagues recruited to.
- The capacity of virtual wards has been completed with an increase in elderly medicine consultant capacity in place.

SAFE: Best Quality, Safest Care: Ever Safer Care through Continuous Learning and Improvement

Quality Programme: Theatres Safety

Why Theatres?

Following a number of incidents in our Theatres in 2021-2022 a review of process was undertaken that identified there were areas for improvement. We therefore selected this as a quality priority for 2022-2023.

During 2022 - 2023 much work was done to identify areas requiring improvement, investment and review within both Main theatres and the Day Surgery Unit. 5 specific areas were focused on:

- Patient experience and safety
- Reduction in agency
- Recruitment
- Staff retention
- Theatre utilisation

What were we aiming to achieve?

As part of the project we aimed to:

- Devise patient feedback bespoke to theatres to capture patient experience within our service.
- Remove outsourced agency with permanent staff, maintaining safety and competence to deliver best care.
- Review the safe staffing levels as defined nationally by the AFPP (the Association of Perioperative Practice).
- Form an education team to support all staff with training, development and progression to retain skills and knowledge within the departments.
- Explore the capacity for surgery in the current theatres, focusing on utilisation and flow.

What did we achieve?

Patient experience and safety

During the year we launched a project called ‘Keeping the patients voice in the room’. This included designing a patient feedback questionnaire, bespoke to the theatre pathway, from arriving in the suite, to anaesthetic room, theatre and recovery room. Capturing rich information of patient perception of how we deliver our service.

Using the PDSA (Plan, Do, Study, Act) model, the team then reviewed results, shared and enhanced the questionnaires to aid the ability to get the pertinent information to help us improve further.

Two children’s versions were created, 2-9 years and 10-16 years, again designed with paediatric input and asking questions that will help improve the service going forward.

In addition, parents are now asked to complete the adult version as to their experience as the parent/carer.

Other key workstreams have included:

- Accountable Items Policy – this is a document that includes information on counting of all procedural items such as surgical swabs, instruments and sharps. The Policy has been adapted and updated to create standardised practice, this has removed variation in practice and reduced the risk of mistakes – this in now fully embedded.

- Tendable audits – audits have been created that are bespoke to theatre, covering all safety metrics for assurance
- Stop Before You Block Policy – this is a policy that details the process to follow prior to administering an anaesthetic block. This policy has been implemented along side a new prep stop block process. A multi disciplinary team (MDT) approach has been introduced to reduce variations in practice and allow opportunity to check before performing any invasive procedure.
- Daily documented de-briefs – as part of compliance with 5 steps to safer surgery, the 5th step is to record a narrative of what went well and things to learn or escalate. This has been updated and enhanced in the year.
- Lessons learned board, never events and datix feedback – shared with all the team on platforms, boards, and digital TV email and team meetings to ensure staff are aware of areas needing improvements or concern
- Hot topic board, highlighting areas to focus on for a month. Discussed at huddles and team meetings to raise awareness. Datix used to aid a topic.
- Project to transfer instrument trays into tins, to reduce risk of holes and de-sterilisation has commenced and is ongoing.

Reduction in agency

Reduction of outsourced agency to one team in February and total removal by 31st March 2023 due to recruitment drive.

Recruitment and retention

Establishment reviewed performed, aligning to AFPP safe staffing levels was completed and approved. This included:

- Uplift of 18 Band 5 to Band 6 to align leadership and clinical experience
- Formation of Education team – including an additional 2 Band 6 nurses
- 3 ATP (assistant theatre practitioner (B3) introduced
- Increased resource for the administrative team
- 1 Deputy Matron introduced

Further opportunities available to staff to develop and progress with the introduction of:

- Surgical first assistants
- Anaesthetic nurse training
- Surgical Care Practitioner
- ODP apprenticeships
- Band 2-3 progression ATP training

In addition the following workstreams have been undertaken:

- Roles & responsibilities shared – ie. Safeguarding, IPC and Tissue viability lead
- Leadership training, NHS Leadership Academy, almost 30 staff completed Edward Jenner Programme. In house first line leaders training
- Cultural workshops – discover barriers and opportunities to be our best
- Incident / Safety Event handling training
- Core team skills – using clinical leadership within specialities to create a core set of expertise that new staff can rotate through
- Personal developed plans with the support of the Education team
- Speciality workshops in surgery and anaesthetics
- 3 day Induction workshop for every new starter regardless of experience to ensure expectations are clear, shared objectives and support networks in place

Theatre Utilisation

- Prompt start trials – elective procedures, ophthalmology, obstetrics and Trauma – new ways of working discussed and some major changes in Trauma and Obstetrics, ongoing work in other areas to achieve better start times.
- Saturday working – in orthopaedic
- Evening sessions, aim to return to pre-pandemic. Working with anaesthetics to create a model that is sustainable within workforce
- Flow within theatres, to and from wards, better communication and support to aid transfer of patients where wards may be understaffed and struggling

SAFE: Best Quality, Safest Care: Ever Safer Care through Continuous Learning and Improvement

Quality Programme: Inpatient Falls

Why Falls?

Nationally, falls and fall-related injuries are a common and serious problem for older people. People aged 65 and older have the highest risk of falling, with 1 in 3 people older than 65, and 1 in 2 of people older than 80 falling at least once a year. The human cost of falling includes distress, pain, injury, loss of confidence, loss of independence and mortality.

Work is ongoing around our own demographic of 65 years and older, with a specific focus on personalised risk assessment and implementation of the national quality standards for Falls. However, we are aware that around 77% of falls within the Trust currently, are with someone who has a confirmed diagnosis of Dementia, and that this can influence not only their physical but also their mental wellbeing. Similarly, this has a significant impact on the family members and carers of people who fall.

Harrogate is known to have a greater than average number of elderly population, and this is set to increase by 2025 for the number of residents present aged 65 and over.

Therefore as a Trust, we are aware that falls can have a significant impact on quality of life, health and healthcare costs and have made the prevention of falls a Trust priority for 2022 - 2023. There is a direct focus on staff education, the introduction of safety huddles, the employment of specialist nurses, regular completion of risk assessments with interventions, and learning from previous incidents.

What were we aiming to achieve?

We were aiming to achieve a reduction in falls causing moderate to severe harm. Our plan to achieve this was by:

- The implementation of safety huddles on the wards.
- Increased education for falls prevention and the importance of keeping patients moving when in hospital.
- Improved awareness around the requirement for timely medication reviews when patients are at risk of falling.
- Launching the national Yellow Sock Scheme and improving awareness around safe footwear.
- Ensuring all patients had a personalised toilet plan for continence.
- Developing new, up to date falls and bedrail guidance.
- Increased awareness around the new falls and bedrails guidance.
- Education around the importance lying and standing blood pressures, and improving overall compliance in completing these.
- Introduce a new lying and standing blood pressure teaching session with competency sign off.
- Identifying that the process and documentation for reporting and reviewing falls required a different approach to ensure that learning was being shared within the directorates.
- Identify any learning following the falls investigation process and implements actions accordingly. This is to then feed into the different forums such as Fundamentals of Care, Patient Safety Forum and the Quality Summit.
- The development and completion of a monthly audit, to monitor the above and implement specific actions accordingly.

What did we achieve?

A Trust wide Falls Action Plan consisted of nine different domains. Initially, the falls specialist service chose to focus on three key areas for 2022 – 2023. These were; the completion of lying and standing blood pressures on all of the patients over 65 within 48 hours of admission, ensuring all patients were assessed for a walking aid within 24 hours of admission in order to assist with mobility and reduce deconditioning. Finally, checking that all patients had a falls risk assessment completed on admission, transfer to a different ward and updated every seven days. This would include individualised actions to increase mobility and reduce the risk of a fall.

- There has been a significant improvement on the monthly falls audit, showing an increase in the completion of Multifactorial Falls Risk Assessments (MFRA's), lying and standing Blood Pressure (BP) and assessments for walking aids for those aged 65 and over.
- Achieved funding for the Trust to work alongside the Improvement Academy around falls.
- A quality improvement project has been successfully launched known as the Yellow sock scheme. This has had good feedback from staff and patients and has increased awareness around the risk of falls.
- A new electronic learning module was created, specifically targeting falls prevention, and is mandatory for staff to complete every three years currently.
- A new process has been developed for falls learning tools, and will allow more individualised learning actions to be developed following incidents.
- Key performance indicators have been developed for falls. This will allow senior management to review compliance levels regularly and allow for learning to be developed for each ward.

The falls data is captured via our Tendable app (real time audit), and is viewed in graph form showing each departments compliance rates. This is available for all senior management teams to view and is shared as part of the Integrated Care Board report, at Matron and Ward Manager meetings, via the Fundamentals of Care meeting and Patient Safety Forum. This is then fed up to the Quality Summit. This ensures rapid learning across the whole of the Trust.

The ward managers and matrons set 'days without falls targets' for their departments which consisted of targets to achieve bronze, silver, gold and platinum awards. These awards have proved popular with colleagues, and allow the trust to showcase the departments that have worked hard to achieve their falls prevention targets.

SAFE: Best Quality, Safest Care: Ever Safer Care through Continuous Learning and Improvement

Quality Programme: Pressure Ulcers

Why Pressure Ulcers?

Pressure ulcers are caused when an area of skin and the tissues below are damaged as a result of being placed under pressure sufficient to impair the blood supply. They cause pain and distress, can lead to longer stays in hospital, increased care in the community and cost the NHS a significant amount of money. They are categorised by severity according to a classification by the European Pressure Ulcer Advisory Panel from category one (least severe) to category four (most severe). They are more likely to occur in people who are ill, have a neurological condition, poor mobility, impaired nutrition, poor posture, or a medical device.

Pressure ulcers are usually preventable with good assessment of individual risk and effective application of preventative measures such as the use of effective equipment to reduce pressure, regular position change, good nutrition and hydration, and good skin care. Pressure ulcers can have a significant impact on patients and as such, the prevention of pressure ulcers has been a specific part of our quality improvement work at HDFT since 2012/13 and this focus has continued during 2022 - 2023 through:

- Education and support
- Risk assessment and documentation
- Learning from incidents

What were we aiming to achieve?

The Trust currently has a Quality Review Panel which meets bi-monthly. The objectives of this group being to drive continual improvement of pressure ulcer prevention and to ensure that if omissions in care are identified for pressure ulcers acquired by patients receiving either HDFT hospital or community provided care, there are timely and appropriate action plans in place to prevent recurrence and provide assurance of the learning process.

Pressure ulcers are defined to have no omissions in care if all reasonable care and treatment has been provided to prevent or minimise damage to skin through pressure. Our aims have been to:

- Reduce the incidence of category two, three, four, unstageable and deep tissue injury pressure ulcers acquired by people whilst in HDFT care
- Promote best practice in prevention and management of pressure ulcers
- Understand if there have been any identifiable omissions in care or not when a pressure ulcer is investigated, and to learn from investigations into the root cause of pressure ulcers
- Continue with our programme of pressure ulcer training and education for staff
- Continue to support a “zero tolerance” approach to pressure ulcer development in people who are receiving HDFT care, which will be supported by our pressure ulcer prevention strategies including training and investigation processes.

What have we done?

Education has been a key focus for the Tissue Viability team throughout 2022-2023, both in community and across our inpatient acute services. Challenges with releasing time for colleagues to access education have been overcome by the Tissue Viability Nurse (TVN) team attending clinical areas to

undertake ad hoc education at the patients bedside. This has ensured a connection between classroom learning and practical patient care and has been well received.
The Tissue Viability Nurses work closely with the Trust Clinical Skills Educators to ensure all workforce groups have tailored, role specific education on skin care and pressure ulcer recognition and prevention. This training is also delivered to preceptorship groups as part of the trusts 2-year support programme for newly registered nurses and as part of the induction for healthcare support workers.

Mandatory training “Preventing Pressure Ulcers” is delivered every month, using a hybrid method of face to face and virtual training and covers all aspects of pressure ulcer development, management, and strategies to prevent occurrence or deterioration of existing pressure ulcers. The training offers colleagues hands on, interactive and engaging sessions which highlight the significant impact pressure ulcers have on patients, carers and the workforce. Feedback is consistently positive and any recommendations for amendments considered.

We continue to work closely with our specialist podiatry team which has been invaluable to ensuring appropriate treatment is provided to patients in HDFT care. Podiatry and TVN once again joined forces on International Stop the Pressure Day in November 2022 to facilitate a full day drop in training event open to all clinical colleagues.

Pressure ulcer incidence data is displayed on the Trust’s dashboards and shared through reports to our senior management teams and as part of the Integrated Board Report. Data is displayed on quality boards in both acute and community services and monthly audit via a real time audit application (Tendable) provides assurance and highlights areas for improvement.

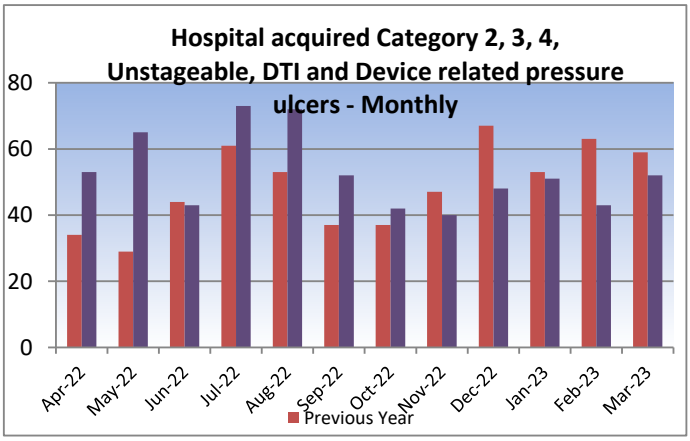
We continue to use and monitor an evidence-based pressure ulcer risk assessment tool (Purpose T) and associated management plan within our community areas and inpatient areas, and this has been extended to our paediatric patients. The pressure ulcer risk assessment tool and pressure ulcer management plan are now completed on electronic patient records across all HDFT clinical areas.

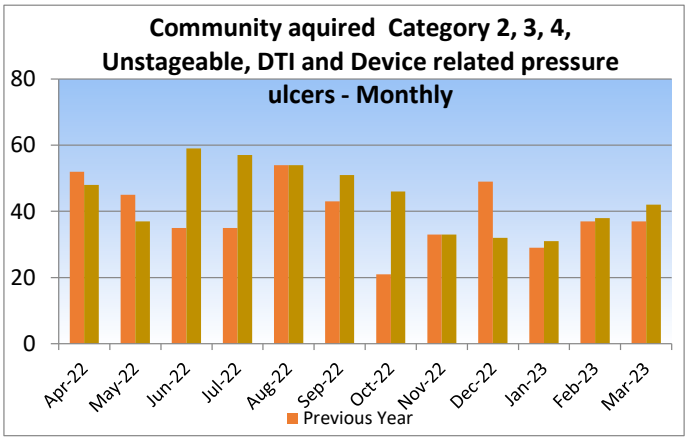
A monthly newsletter “Tissue Viability News” focusing on a different topic each month has been well received by colleagues and highlights areas for improvement identified through the pressure ulcer investigation process. A TVN colleague of the month award has proved popular, showcasing colleagues who go the extra mile to prevent pressure ulcers.

What are the results?

The data from 2022-2023 shows an increase in pressure ulcers across acute and community services at HDFT. Whilst this increase is disappointing, it must be noted that there has been recognised, increased reporting due to the additional training, earlier recognition of pressure ulcers and an increase in TVN presence across the organisation ensuring increased vigilance. The number of pressure ulcers with omissions in care, identified through the root cause analysis process, have decreased with only one community acquired pressure ulcer showing omissions in care, a notable improvement from 12 recorded in 2021 - 2022.

The pressure ulcer data presented below is reported through the HDFT event reporting system.





OUTCOMES: Best Quality, Safest Care: Excellent outcomes through effective, best practice

Quality Programme: Missed Results

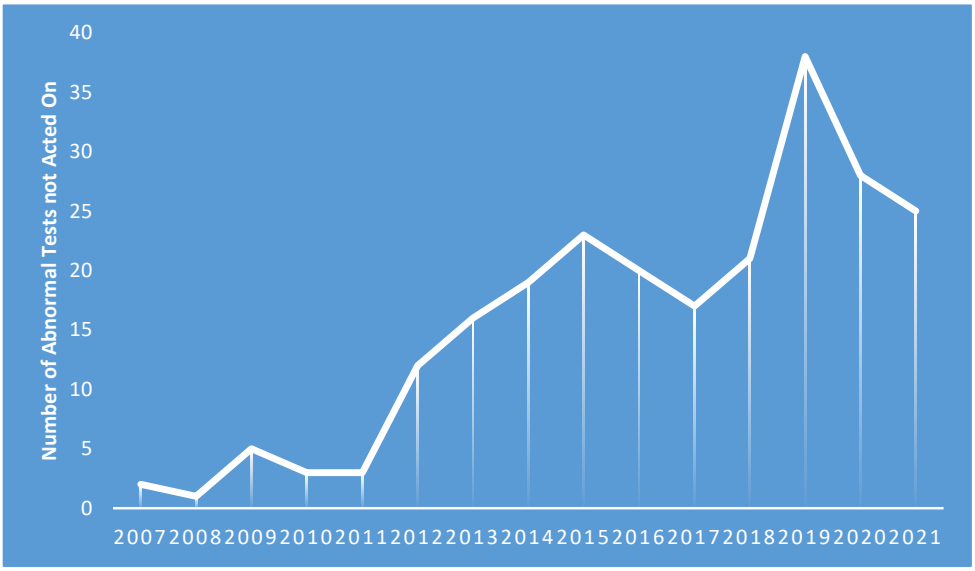
HDFT performs many thousands of investigations every year, and the number continues to increase. These tests include blood tests, x-rays, scans and other specialist investigations such as specific tests of the heart and lungs. Each investigation is always performed for a specific purpose – sometimes to diagnose or exclude a medical condition, to monitor its progress and in response to treatment or part of overall health surveillance.

It is important that every test performed has its result acted on appropriately. Although this happens correctly for the overwhelming number of tests, unfortunately sometimes an investigation result is missed and the correct action therefore not taken. Although this often results in low or no harm occurring, it can occasionally have significant consequences and therefore it is important that we try to eliminate such occurrences.

Why Missed Results?

In 2021, we undertook 2 investigations to see how many tests are missed, what impact they had and were there any common themes we could learn from to prevent such errors happening again.

The graph below shows how the number of cases where abnormal test results were not acted on and how this has increased over the last 15 years. Part of this rise will be due to the improved reporting of errors over this period, together with the increased number of tests being performed. However we felt it important to ensure our systems and process were as robust as possible:



What were we aiming to achieve?

We wish to ensure that all results are seen promptly and appropriately actioned. In doing so, we will expect to reduce the number of cases where patients have come to harm due to avoidable delays in their treatment or investigation.

What have we done?

We looked back at all the cases since 2007 where a missed result had led to patient harm. Many of these had been investigated as Serious Incidents, and action plans implemented to prevent a similar recurrence. The specific causes in each case were often unique, but 2 themes were identified:

1) Occasions where the correct test had been performed but the requesting health professional did not see the result or failed to identify some concerning features in a long report (such as following a scan)
2) Correct procedures were followed by the requesting health professional, but further actions did not occur (when being referred on to specialist team meetings)

In the summer of 2022, a 3 day rapid improvement workshop (RPIW) was held, facilitated by our Quality Improvement team. This brought together individuals from a variety of clinical teams and departments, together with secretarial team members, IT experts, consultants, junior doctors and other allied healthcare professionals. Following the workshop, 25 potential actions were identified.

Over the rest of 2022-2023, each of these actions was either implemented or further explored as to whether they could be introduced. Overall, specific actions implemented during that year included:

1) Enabling results to be visible immediately in the Emergency Department on screens and on hand-held devices
2) Refining which results are telephoned from the laboratory when they are abnormal
3) Empowering appropriate members of the team to action or file results, which enables more senior members to focus on abnormal results
4) Sharing practices across teams to embed daily result reviewing as part of normal practice
5) Introduction of new tracking software – the Cancer multi-disciplinary teams now use a new software solution to ensure agreed actions are followed up
6) Certain teams have increased their allotted time for administrative duties

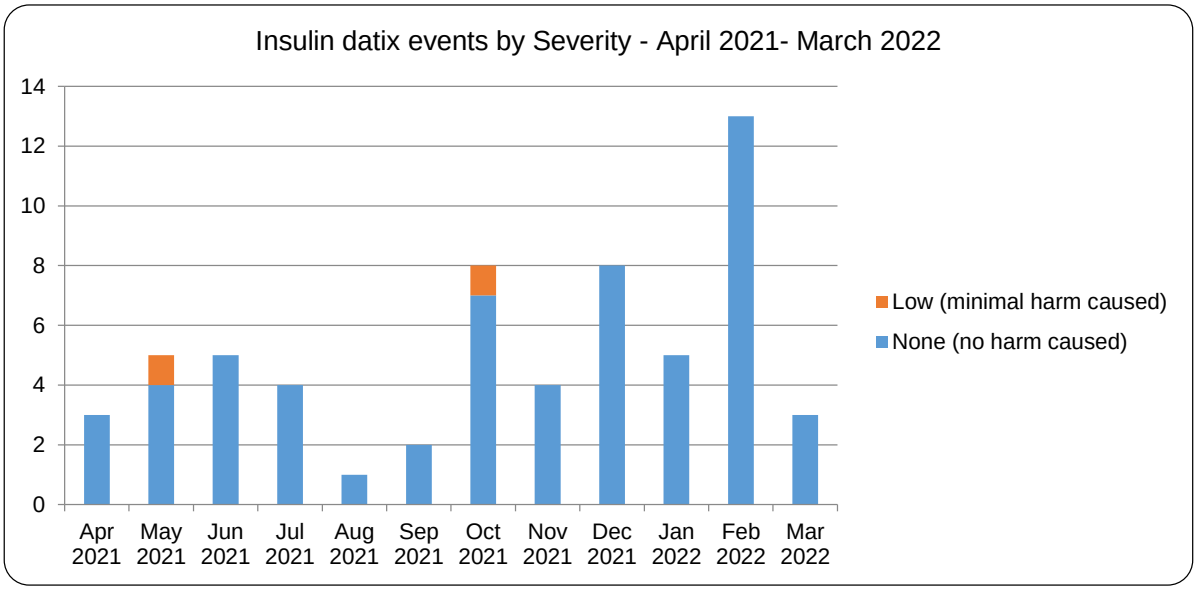
OUTCOMES: Best Quality, Safest Care: Excellent outcomes through effective, best practice

Quality Programme: Medication Errors – A Focus on Insulin

Why Insulin Medication Errors?

Insulin is a high-risk medicine. High-risk medicines are defined as medicines that have a high risk of causing injury or harm if they are misused or used in error. The Medicines Quality and Safety Group regularly reviews trends in reported medication incidents and noted high reported number of insulin medication incidents in October 2021, this led to the formation of the Insulin Safety Group in December 2021. This group explored the types of incident that were happening and what interventions they could implement to reduce the number of insulin medication incidents and reduce patient harm. As reported insulin medication incidents remained high at the end of 2021 - 2022, the Trust chose to adopt this as one of the Quality Priorities for 2022 - 2023.

What were we aiming to achieve?



The overall aim of this Quality Priority was to reduce the number of reported insulin medication errors and reduce harm to patients. To do this, there was a more in-depth piece of work to understand the trends in reported insulin medication incidents to help target interventions to improve patient safety.

Data from 2021 - 2022 showed that the most common reasons for insulin medication incidents were prescribing and administration errors, with the incorrect insulin medicine or dose being the most common prescribing incident.

What have we done?

The Insulin Safety Group sought feedback from staff to understand what improvement ideas they had for reducing insulin medication incidents. The following ideas were implemented:

- Insulin safety e-learning for all medical, nursing and pharmacy staff

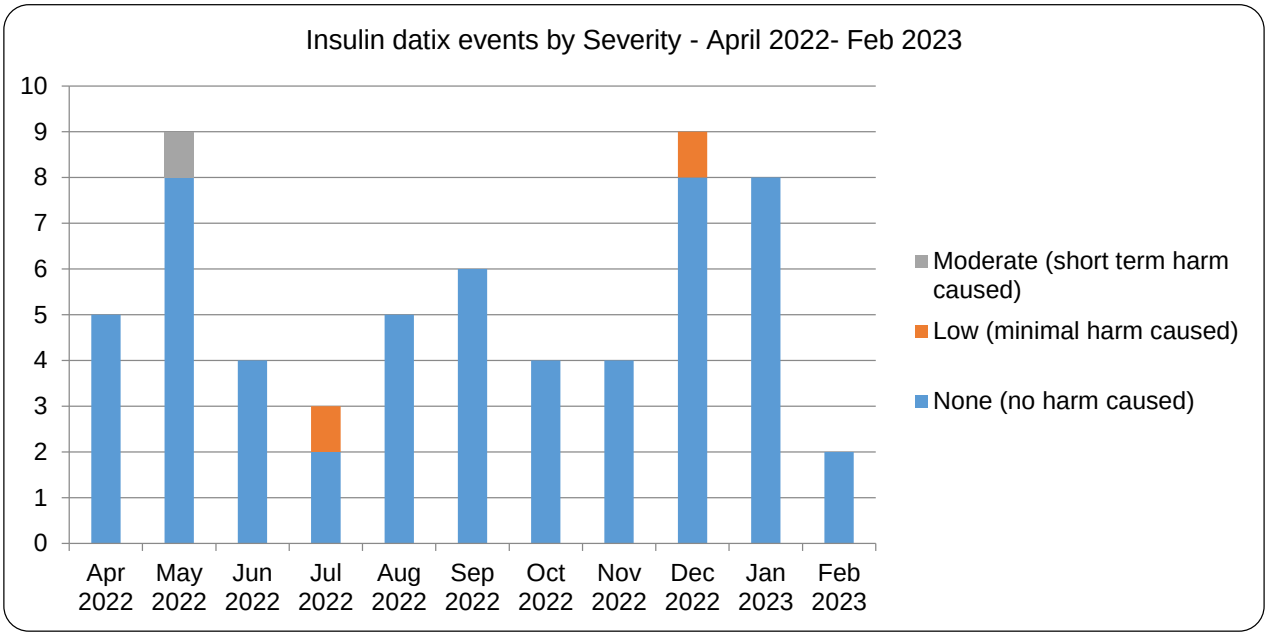
- Electronic Prescribing Medicines Administration (EPMA) insulin protocols updated to reduce the risk of selection of the incorrect insulin when prescribing
- Insulin teaching sessions to medical, nursing and pharmacy staff

What are the results?

The data below shows that these interventions were successful in achieving an improvement in the short-term; however, an increase in reported insulin medication incidents was seen again in December and January 2023. The reasons for this were explored in more detail and the Insulin Safety Group identified a specific trend relating to management of Diabetic Ketoacidosis on acute admission. This will form the focus on a new quality improvement initiative in 2023-2024.

April 2022 – February 2023

No Harm Events reported: 56
Low Harm Events reported: 2
Moderate Harm Events reported: 1



9

EXPERIENCE: Best Quality, Safest Care: A positive experience for every patient by listening and acting on feedback

Quality Programme: A focus on patient experience

HDFT Patient Experience and Engagement - At a Glance

172 COMPLAINTS	**1134** CONCERNS AND QUERIES	**338** COMPLIMENTS AND THANK YOU'S RECEIVED CENTALLY
75% OF COMPLAINTS ON AVERAGE RESPONDED TO WITHIN 25 DAY TIMEFRAME (AGAINST A KPI of 95% - increased from 56% in 2021-2022)	**35-40** TOTAL OPEN CONCERNS ON AVERAGE, REDUCED FROM **150**	**12** COMPLAINTS REFERRED TO PARLIMAENTARY HEALTH SERVICE OMBUDSMAN
55, 724 FRIENDS AND FAMILY TEST RESPONSES	**92%** OF PATIENTS OVERALL THINK THEIR EXPERIENCE OF CARE AT HDFT WAS VERY GOOD OR GOOD OVERALL	**1** PHSO COMPLAINT TO INVESTIGATION

FRIENDS AND FAMILY TEST (FFT)

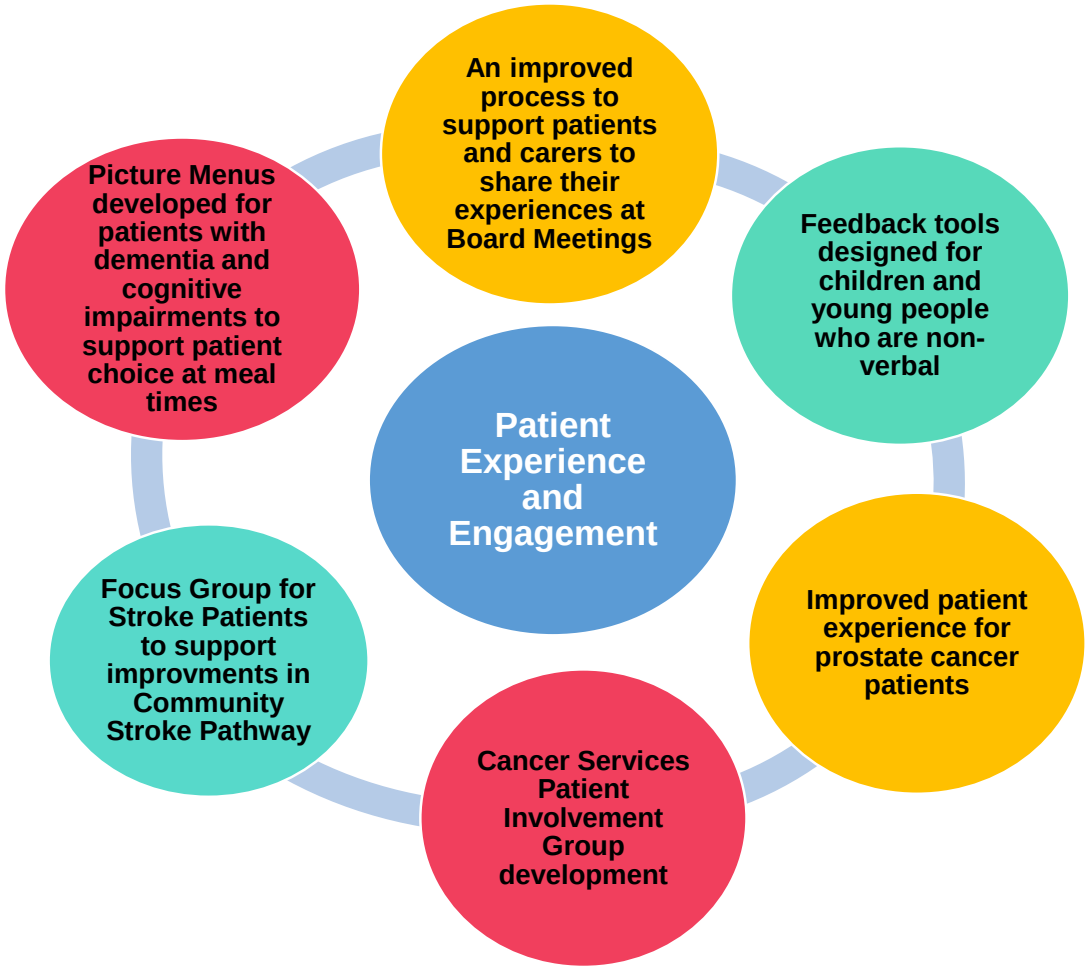
The Friends and Family Test was created by NHS England and is a quick, anonymous way for patients, carers, families, children and young people to give feedback about their experience after receiving NHS care or treatment.

It provides a valuable insight into how people feel about our services and is integral to our desire to ensure continuous learning and improvement from patient experience, based on real-time feedback.

Patients, carers, families, children and young people should have the opportunity to give regular feedback about their experience of care from all HDFT Services, and the Patient Experience Team have introduced new collection methods to ensure accessible access to feedback;

- Updated easy-read feedback forms, with a children and young person's version designed with help from Specialist Children's Services
- A new online FFT, available in standard and easy-read versions. Accessible via QR (Quick Read) codes displayed on posters through HDFT departments. The URL can also be shared via email, text message or shared in virtual consultation chats and is also found on the HDFT website.

KEY PROJECTS 2022 – 2023



We have selected two projects to provide further information on in greater depth:

FEEDBACK TOOLS DEVELOPED FOR NON-VERBAL CHILDREN & YOUNG PEOPLE

Specialist Children's Services (SCS) identified a gap in making sure children and young people with complex communication needs are able to give feedback about their experience of care at HDFT. With commissioning support from the Integrated Care Board (ICB), Specialist Children's Services co-produced three feedback tools, working with children and young people, parents, carers, staff and teachers to develop and evaluate each feedback method.

The three methods are;

1). An online survey for children and young people who have the capacity to read and answer questions using a touch pad, supported by the use of pictures and emojis to help them give feedback. Including free

text options for Children and Young People to type comments and specific questions asking how they felt during their appointment, e.g. happy, scared, fun, boring.

2). A talking survey using a touch pad and symbols/emojis that allow Children and Young People to point and indicate how their appointment has felt, what was good and what could be improved.

3). Method 3 has been designed as an observational feedback tool for parents and carers of Children and Young Peole with profound and/or multiple learning disabilities. This asks parents and carers to feedback by observing their child's verbal cues, mannerisms and body language during the appointment to help staff understand what works well and what they can do differently to ensure these appointments are supportive and meeting the children's needs.

These feedback tools are now being implemented in SCS, with support from the Patient Experience Team to assess feedback and the take up of each tool to monitor initial success.

SCS have also been one of the first HDFT services to implement the new Children and Young People's Friends and Family Test, which includes a new character named Jif, who was created by Children and Young People from SCS teams. Jif is a passionate NHS champion and is now a firm feature on our feedback forms, helping children to recognise feedback for HDFT services!

IMPROVED EXPERIENCE FOR PROSTATE CANCER PATIENTS

The Macmillan Urology Nurse Team noticed that some patients were being asked to attend multiple appointments and blood tests, increasing their attendance to hospital, often unnecessarily.

Not only was this not a good use of nursing time having to perform multiple tests, prescribing and dispensing medications, it also meant that patients were attending hospital more often than they needed, to collect medication that rarely had an impact on their health outcomes.

Jess, one of the Macmillan Urology Nurse, was keen to streamline their pathway, reduce their appointments, interactions and prescribing, and improve overall patient experience.

By implementing her Quality Improvement training, Jess created a new clinic run by Macmillan Urology Specialist Nurses. With greater knowledge and experience of metastatic prostate cancer, these clinics provide a more specialist service to patients, and hopefully help to relieve some of their anxiety during treatment.

Early patient feedback has been really positive. Patients feel that this way of care delivery is less intrusive in their day to day lives, due to the reduced hospital visits and blood tests. They are also grateful for the specialist knowledge the nursing team are able to provide in regard to PSA (a prostate specific antigen) trends and red flag symptoms that they did not have before.

The Patient Experience Team are working with the nursing team to develop a patient survey to more formally evaluate the new clinics and ensure patient feedback continues to help shape and develop the clinics.

PATIENT AND CARER SURVEYS

23

PATIENT SURVEYS SET UP IN 2022-2023

16

ONGOING PATIENT & CARER SURVEYS

Services Include

End of Life Care, Radiology, Theatres, Specialist Children's Services, Woodlands and SCBU

IN FOCUS

Theatres and Day Surgery

Feedback opportunities are available to all patients who are looked after in Theatres and Day Surgery Unit (DSU), including a specific survey for children and young people aged 2-10. Theatres and DSU understand how vital patient feedback and focus is, and employ the ethos "Keeping the patient voice in the room", particularly as they care for people often at their most vulnerable.

There is a "You Said, We Did" board present in both Theatres and DSU, displaying feedback, comments and ideas for improvements from patients and staff.

Feedback from the patient surveys is also disseminated to the teams during Safety Huddles each week.

Woodlands and Special Care Baby Unit

Woodlands ward and the Special Care Baby Unit (SCBU) have ongoing patient surveys, to gather feedback to ensure continuous improvement and learning and quality care.

There are paper versions of the survey available in all rooms and bays, along with QR (Quick Read) codes displayed on posters around the wards to encourage those who can to leave feedback via the online version of the survey.

Feedback from the survey is largely positive;

- "Our time is hospital was absolutely amazing. Every single person we saw were friendly professional and went above and beyond which is so important especially when it comes to children/babies that may be unwell. I found the whole experience comforting and I felt my child received the best care possible and he was in very safe hands. Thank you to each and every one of you. You're all incredible."
- "The staff were just so lovely, caring and clearly experienced. It inspire confidence that your child is well looked after"
- "Very efficient and supportive staff. Very thorough with examinations and explanations"
- "Thorough and listened to mothers' instinct which is so important."

Where feedback is identified that can be used to inform learning and improvements, these are shared with the ward staff and wider team via email.

Some examples of actions for improvement in 2022 – 2023 have included;

Improvement point	Action
Poor communication with families around what procedures and tests are taking place.	Please can we makes sure that families are kept up to date with their children's care. Please ensure that we are sharing information such as what tests/procedures will be done, why and how long this may take.
Patient felt that staff needed to ask more frequently about their pain score.	Current system is under review. New routine to be implemented shortly.
Curtains broken or not fitting.	Inspected curtains, and found the curtains were not hung up correctly, in bed 8, 14 and 15. Curtains have been rehung and replace where necessary today.
Staff did not introduce themselves.	Please remember to introduce yourself to families first thing on a shift whilst you are completing your safety checks.

Performance Against Other Quality and Safety Indicators

This section of the Quality Account provides an update on:

- Seven day services within the NHS
- Patient Safety Incidents
- Serious Incidents and Never Events
- Duty of Candour
- Patient Safety Alert Compliance
- NHS Staff Survey Results
- Whistleblowing
- Freedom to Speak Up
- Guardian of Safe Working

Seven Day Services Within the NHS

What do we mean by seven day services?

Seven-day services in the NHS is ensuring all patients who are admitted to hospital as an emergency, receive high quality and consistent care no matter what day or time of the week they enter a hospital. . The seven-day services programme is designed to improve hospital care with the introduction of seven-day consultant-led services that are delivered consistently over the coming years.

Ten clinical standards for seven-day services in hospitals were developed in 2013 through the Seven Day Services Forum, chaired by Sir Bruce Keogh and involving a range of clinicians and patients. The standards were founded on published evidence and on the position of the Academy of Medical Royal Colleges (AoMRC) on consultant-delivered acute care. These standards define what seven-day services should achieve, no matter when or where patients are admitted.

Monitoring of the Clinical Standards at HDFT

Whilst formal monitoring of the seven day service was suspended nationally due to Covid-19, HDFT have continued to make strides in ensuring our services are fit for purpose. During 2022-2023 HDFT has undertaken stakeholder engagement to create our new Clinical Services Strategy which is due to be launched in Quarter 2 of 2023-2024. This strategy will have a key focus on the growth of the HDFT@Home Integrated Care Services and increased networked acute service to ensure resilience of our seven day services. Below is a summary of key activities for 2022-2023:

Urgent 2 Hour Response

This service was established in 2022-2023, as part of Harrogate and Rural Alliance (HARA), to provide a response within 2 hours from referral in the Community to anyone over 18 and suffering a crisis (mental health crisis is excluded).

There are 9 pathways included and the primary purpose of the service is to prevent avoidable admissions and readmissions into the hospital, treating people within their own home. The service operates from 8am to 8pm seven days a week, accepting referrals from GPs, YAS, Care Homes and other community providers.

Where appropriate, patients may then be referred into the Hospital at Home consultant to avoid admission to Hospital whilst ‘stepping up’ acuity of care. The UCR team also work closely with the Trust’s Palliative team.

7 Day Community Discharge Hub

Responding to national guidance, we created a Community Discharge Hub that operates 7 days a week. The Hub is an integrated service within the HARA alliance, with both HDFT and North Yorkshire County Council colleagues meeting daily to organise timely supported discharge and ensure smooth transfer of care. This work has built on the existing Discharge Planning Team, Adult Community team and the North Yorkshire County Council Social workers and transfer of care coordinators who work together to ensure early identification of patients who will require support on discharge and ensure they are discharged to the most appropriate pathway as soon as they no longer require treatment that can only be provided in hospital.

ARCH (Acute Response and Rehabilitation - Community and Hospital)

This team brings together: the Supported Discharge Service; Acute and Frailty inpatient therapy services; Community therapy and Intermediate Care bed based rehabilitation.

The service operates seven days a week delivering 35 ‘virtual beds’ of capacity to support patients leaving hospital sooner with additional short-term support in their home environment.

Over the last few months the service has expanded its offer to include a ‘Hospital at Home’ ward that allows 10 of these virtual beds to be occupied by a higher acuity of patients under the care of a dedicated Geriatrician.

The Hospital at Home service does not yet have consultant cover 7 days a week, however there is a dedicated Night Nursing team across the 7 days to support the admission of higher acuity patients onto the Hospital at Home (HaH) ward. We have applied for further funding to hire further medical staff into the HaH team, including more nurses and ACPs, so that cover can be brought up to 7 days a week.

The Trust is working closely with the ICB to expand the capacity of ARCH to manage 43 ‘virtual beds’ in the Community, of which: 25 will be intermediate care/ Community rehab/ reablement beds, 10 UCR beds and 10 higher acuity ‘Hospital at Home’ beds under the care of Geriatricians (18 trajectory by December 2023 has been submitted but yet to be confirmed - subject to funding).

The model is based on a ‘pull’ approach from both the wards and Community, with the team actively finding and tracking suitable cases from ED, the Acute Frailty Unit and Frailty Wards. It also takes referrals from therapy and clinical teams on other inpatient wards.

The ARCH model works across the following three discharge pathways. These should make up 50% of the discharges from the hospital for patients aged 65+ years, with the other 50% of patients leaving on Pathway.

- Pathway 1 - Patients that go back to their own home some short term reablement or other personalised community-based support to help with their recovery and care. Pathway 1 is also for people who have a home care package that is being restarted at the same level as that delivered prior to admission to hospital after lapsing during their hospital stay.
- Pathway 2 - Patients that require short term rehabilitation and potentially reablement in a community bedded facility or care home with therapeutic and nursing support to help with their recovery. The intention must still be to get the person back to their home (or usual place of residence) following the period of rehabilitation.
- Pathway 3 - Patients who require bed-based 24-hour care following discharge from hospital, which will include people discharged to a care home for the first time.

Patient Safety Events

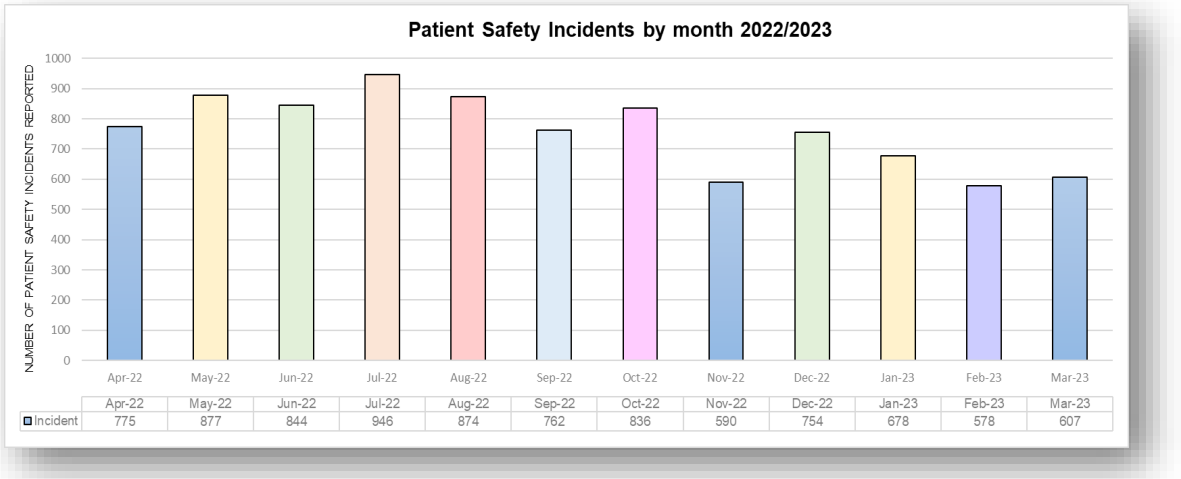
What is a patient safety event?

Patient safety events are any unintended or unexpected events which could have, or did, lead to harm for one or more patients receiving healthcare. HDFT encourages events to be reported and believes that a strong reporting culture (i.e. a high level of events reported), is a sign of a good patient safety culture and provides an opportunity to learn, prevent recurrence and improve patient safety.

What has 2022-2023 looked like for patient safety events at HDFT?

The Quality Team coordinates patient safety review and reporting at HDFT and this year the team has undergone significant changes which have included the appointment of the Associate Director of Quality and Corporate Affairs, and further specialised roles to help strengthen and change processes in relation to patient safety, event reporting, and encouraging a positive learning culture.

The number of Patient Safety Events reported at the Trust, per month, during the year is noted below. The Trust has a robust policy and process to ensure that all events are identified, managed, reported and investigated in accordance with national guidance.



	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Incident	775	877	844	946	874	762	836	590	754	678	578	607

Learning from events is shared following investigations at the Serious Incident Committee, Directorate Quality and Safety Governance Meetings and The Quality and Learning Summit. Learning is also embedded throughout our monthly learning newsletter, “Quality Street News” and any immediate patient safety learning is shared through our own internal patient safety alert process. The Quality and Learning Summit has dedicated time to ensure cross directorate learning is identified, discussed and then shared effectively across the organisation. This learning is identified from all safety events, including no and low harm, as well as moderate and above.

Action plans from investigations are actively monitored for compliance and to ensure appropriate evidence of completion is gained.

This year, the Datix Cloud (DCIQ) project commenced to provide the Trust with an updated safety and risk management system that has the capability to record and report on information required to meet mandatory requirements. Introduction of brand-new modules to support additional mandated external reporting requirements, ensuring HDFT is compliant with regulations as well as increasing staff satisfaction and engagement creating an open and just culture.

Serious Incidents and Never Events

What is serious incident (event) and a Never Event?

A Serious Incident (SI) is an incident or accident involving a patient, a member of NHS staff (including those working in the community), or member of the public who face either the risk of, or experience actual, serious injury, major permanent harm or unexpected death in hospital, other health service premises or other premises where health care is provided. It may also include incidents where the actions of health service staff are likely to cause significant public concern. These are all events that the Trust believes to be worthy of investigation by an Independent Panel and/or fall into the category of an incident that must be reported to the local Commissioning agencies.

Some Serious Incidents are called Never Events (NE). Never Events are serious incidents that are entirely preventable because guidance or safety recommendations providing strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.

What has 2022-2023 looked like for serious incidents (events) and Never Events at HDFT?

HDFT is committed to identifying, reporting and investigating serious events, and ensuring that learning is shared across the organisations, and actions are taken and embedded to reduce the risk of recurrence. Our serious events were used to help inform our quality priorities and their associated improvement plans.

The Trust has declared a total of 30 compressive serious events this year, this includes two external investigations completed by HSIB, and 3 Never Events. This is in comparison to 21 in 2021-2022. The Never Events that occurred have been a key focus on the improvement work that has been undertaken in our theatres environment. Further detail on this can be found in the Theatres Improvement section of this report.

The process of how serious events are investigated was reviewed following the restructure of the Quality Team, and included the introduction of a new governance structure. As part of this review, an internal audit was undertaken which provided significant assurance of changes embedded.

HDFT''s Serious Incidents in Numbers:

25	2	3
Serious Events	HSIB Investigations	Never Events

Duty of Candour

What is Duty of Candour?

The Care Quality Commission (CQC) introduced the Duty of Candour regulation in November 2015. Duty of Candour sets out specific requirements that providers must follow when things go wrong with a patient's care and treatment. Requirements include informing people about the incident, providing a truthful apology and providing feedback to patients following the investigation of the incident.

What has 2022-2023 looked like for Duty of Candour at HDFT?

HDFT is committed to promoting an open and honest culture and staff are encouraged to report patient safety events that have occurred. New monitoring processes have been implemented to ensure statutory duty of candour is carried out effectively and timely.

The number of events triggering statutory duty of candour is 180. In 150 of these cases, the duty was followed, in 19 cases the decision was made not to apply the duty of candour – the reasons for this have been documented and reviewed, all of which were appropriate. Six cases are in the process of being completed.

Patient Safety Alerts Compliance

What is a Patient Safety Alert?

Patient safety alerts are used to inform the healthcare system of recognised safety risks and offer appropriate guidance for the prevention of incidents that may result in severe harm or death to patients.

These alerts are issued by NHS England / Improvement through the Central Alerting System (CAS) which is a web-based cascade tool utilised for issuing alerts, public health messages and useful safety information to the NHS and other healthcare organisations. Patient safety alerts are developed with input, advice and guidance from the National Patient Safety Response Advisory Panel, which assembles frontline healthcare staff, patients and their families, safety experts, royal colleges and other professional and national bodies. The panel discuss and advise on approaches to respond to patient safety issues through the publication of alerts which are identified through the clinical review of incidents reported to the NRLS and Strategic Executive Information System by NHS Trust and other health care providers and also from concerns raised by members of the public.

Alerts can also be issued where there is a common problem occurring throughout the NHS and can be an important part of a wider programme of work. Systems and equipment are commonly subject to patient safety alerts where there are recognised errors or faults and would therefore require action to be taken to reduce the risk to patient safety.

What has 2022-2023 looked like for Patient Safety Alerts at HDFT?

Coordination of patient safety alerts is carried out by the Patient Safety Team (part of the Quality Team) who work with various Trust departments and Directorates to facilitate compliance, and monitor on-going work or action plans used to address the issues raised.

The Trust has implemented a new streamlined process relating to Patient Safety Alerts. All alerts are now captured and monitored through our Datix Reporting System.

The Trust received two NatPSAs within 22/23.

- NatPSA/2023/001/NHSPS – Use of Oxygen cylinders where patients do not have access to medical gas pipeline systems
- NatPSA_2022_003_NHSPS - Inadvertent oral administration of potassium permanganate

These alerts were assessed and both deemed applicable to HDFT. Actions were completed within the required timescale, and appropriately overseen by the relevant governance groups.

NHS Staff Survey Results

What is the NHS Staff Survey?

The NHS Staff Survey is one of the largest workforce surveys and has been conducted every year since 2003. All staff working in the NHS are invited to take part in the NHS Staff Survey. The survey offers a snapshot in time of how people experience their working lives and information is gathered at the same time each year. The survey captures a national picture alongside local detail, enabling organisations to understand what it is like for staff across different parts of the NHS and to support further improvements.

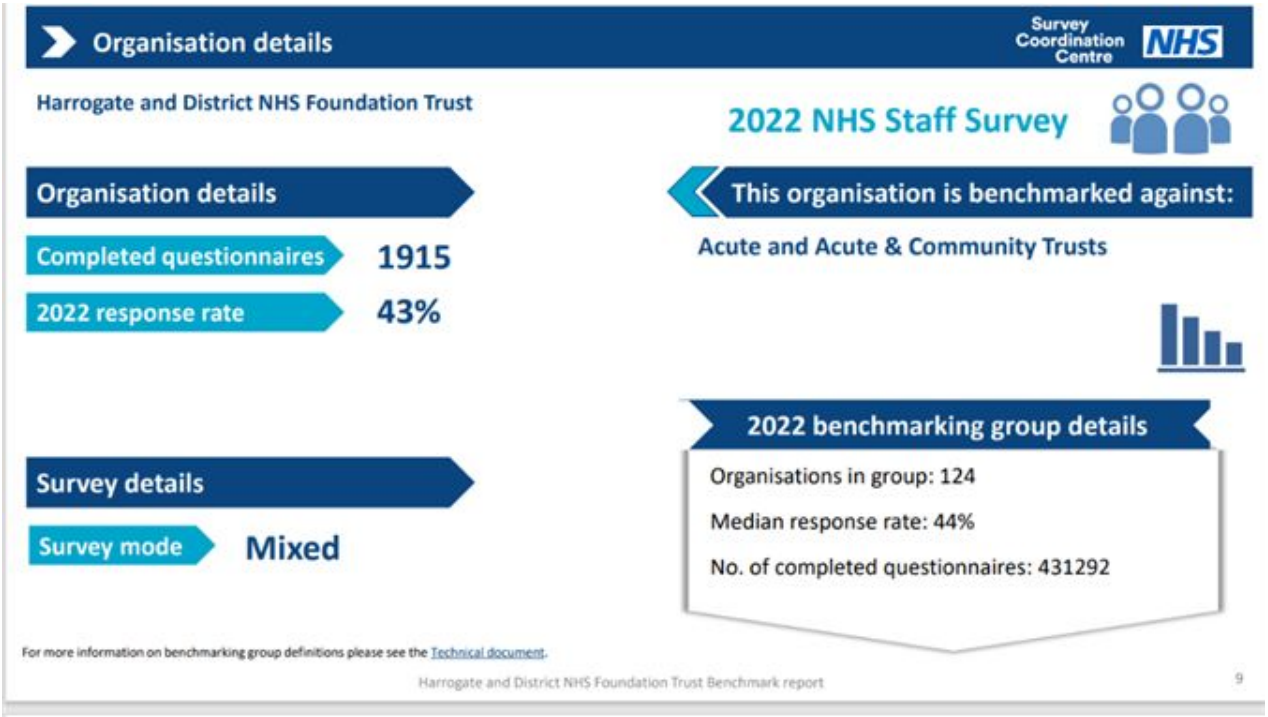
What has 2022-2023 looked like for the NHS Staff Survey at HDFT?

In September 2022, all NHS trusts in England were required to participate in the National NHS Staff Survey. The survey was designed to collect the views of staff about their work and the healthcare organisation they work for.

The aim of the survey is to gather information that will help improve the working lives of NHS Staff and enable them in turn to provide better care for patients. Obtaining feedback from staff and taking account of their views and priorities is vital for driving service improvements in the NHS.

At HDFT; survey invites were distributed to staff by email as well as through the post (using a mixed mode approach i.e. web and paper based).

A total of 1915 staff completed the survey questionnaires. Based on the 4495 staff invited to participate this provides a response rate of 43%, representing a significant increase since the start of the pandemic. In 2021 the Trust achieved a response rate of 39%.



Themes

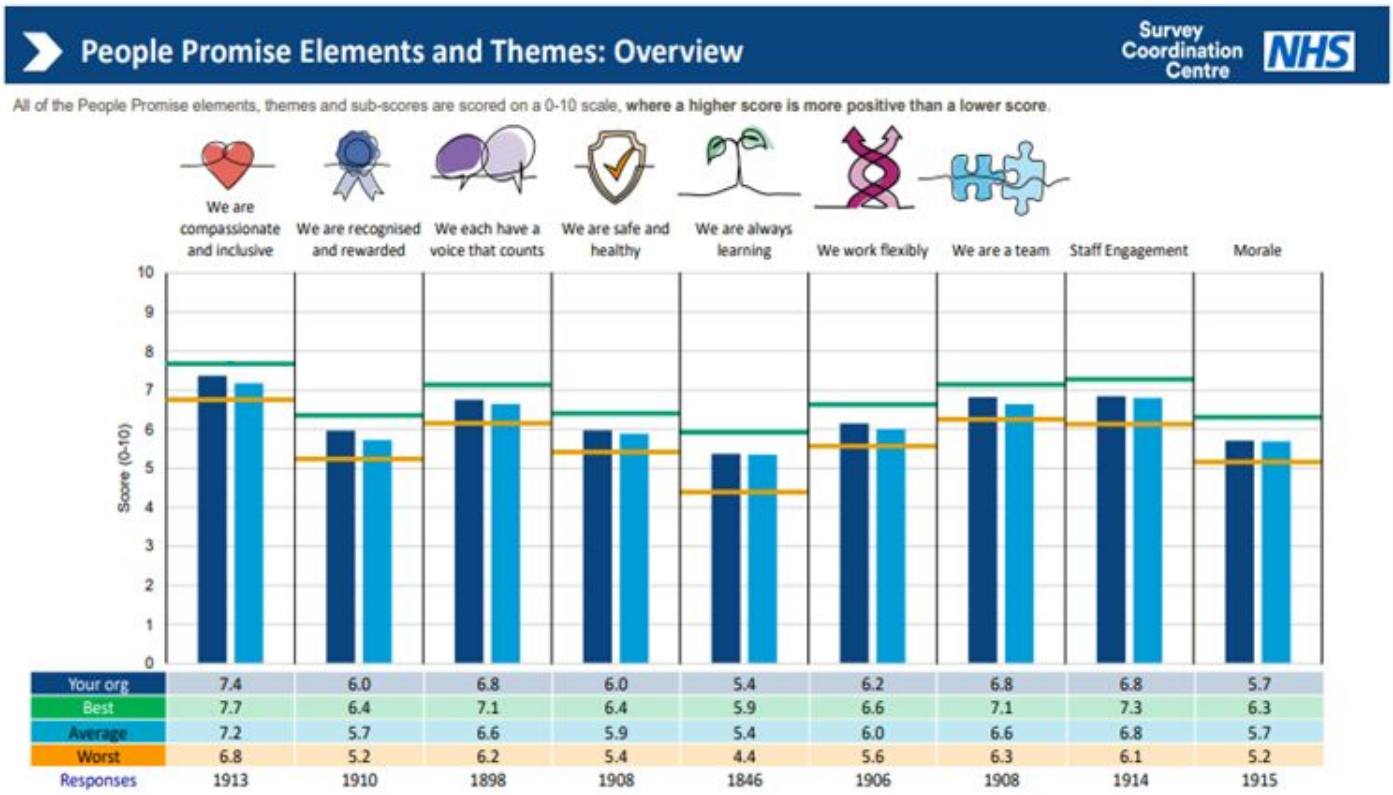
From 2021 onwards, the questions in the NHS Staff Survey are aligned to the People Promise. This sets out, in the words of NHS staff, the things that would most improve their working experience and is made up of seven elements:

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).

Results

The People Promise Elements and Theme results overview is shown below. This table compares our scores to the best, the average and the worst scores within our comparator group. HDFT is above average for our benchmarking group in 6/7 elements, and meets the average in one element (We are always learning) and the two themes (Staff Engagement, and Morale).



Compared to last year's results, our scores have increased in all nine of the People Promise elements and themes.

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.

Areas to Focus On

- 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. However this is well below the benchmarking group average of 42.9% in 2022.
- The number of staff saying that they have worked additional unpaid hours is significantly higher than the average for comparable organisations (65.1% compared with the average of 56.3%). This is also notable when viewed against the number of staff saying that they work additional paid hours. The HDFT figures are significantly lower than the comparable average (25.8% compared with the average of 40.4%).

Whistleblowing

What is Whistleblowing?

Whistleblowing occurs 'when a worker raises a concern about dangerous or illegal activity that they are aware of through their work' (Public Concern at Work). A 'protected disclosure' is one where a worker must have a reasonable belief and in good faith believes that their disclosure is in the public interest.

What has 2022-2023 looked like for Whistleblowing at HDFT?

HDFT is committed to achieving the highest possible standards of quality, honesty, openness and accountability in all of our practices. An important aspect of accountability and openness is a mechanism to enable employees, workers and volunteers to voice their concerns in a responsible and effective manner and for them to feel valued for doing so.

Confidentiality is a fundamental term of every contract of employment, however, where an individual discovers information which they believe shows serious malpractice or wrongdoing within the Trust, this information should be disclosed without fear of reprisal. To qualify for the protection (a 'qualified disclosure') afforded by The Public Interest Disclosure Act 1998, staff must have a reasonable belief that one or more of the following matters is either happening, has taken place or is likely to happen in the future:

- A criminal offence
- The breach of a legal obligation
- A miscarriage of justice
- A danger to the health and safety of any individual
- Damage to the environment
- Deliberate attempt to conceal any of the above

In addition to the legal framework, in 2010 the NHS Staff Council agreed that 'Employees in the NHS have a contractual right and duty to raise genuine concerns they have with their employer about malpractice, patient safety, financial impropriety or any other serious risk they consider to be in the public interest'. This change has been incorporated into the Terms and Conditions of Service Handbook for staff employees.

The Francis Report 'Freedom to Speak Up – A review of whistleblowing in the NHS' published in February 2015, clearly indicated that NHS staff did not feel safe raising their concerns about patient care that was being delivered. A key theme of the report was the requirement for openness, transparency and candour about matters of concern; the need for a 'just culture' as opposed to a 'no blame culture'. Sir Francis also recommended the introduction of a 'Freedom to Speak Up Guardian' post as an additional person staff can raise concerns with and at HDFT Joanna Cann, currently fulfils this role.

At HDFT we have a wide range of avenues for colleagues to raise their concerns:

- DATIX (Incident Reporting tool)
- Line Manager
- Lead Clinician
- Matron
- Staff Side Representative
- Human Resources
- Occupational Health
- Chaplains

- Freedom to Speak Up Guardian
- Guardian of Safe Working
- Associate Director of Quality and Corporate Affairs
- Safeguarding Team

Concerns may also be raised to the next level of management; for example:

- A member of a Directorate Triumvirate
- A Deputy/Assistant Director
- A Divisional General Manager/Divisional Nurse/Clinical Director
- Heads of Service
- An Executive Director
- The Chief Executive
- A Non-Executive Director (NED) – the Senior Independent Director (Laura Robson) in particular has a role to support staff who need to utilise the whistleblowing process.

If colleagues feel unable to report at any of these levels for any reason, or feels their concerns have not been addressed adequately at an earlier level, they may choose to report their concerns externally. Concerns may be raised with an external regulatory body (which includes prescribed bodies or persons).

HDFT would urge staff to allow the Trust the opportunity to investigate and resolve the concerns prior to reporting externally if at all possible. If the investigation finds the allegation is unsubstantiated and all internal procedures have been exhausted, but the member of staff is not satisfied with the outcome, the Trust recognises the lawful rights of employees to make disclosures to prescribed persons. In order to maintain the protection afforded by the Act, disclosure other than to the Trust must be made to prescribed bodies or persons and the Trust encourages staff to notify the Chief Executive of their intention to disclose their concerns externally. The Trust also encourages staff considering this course of action to seek advice from the Trust's Freedom to Speak up Guardian.

Freedom to Speak Up

What is Freedom to Speak Up (FTSU)?

The National Guardian's Office and the role of the Freedom to Speak Up (FTSU) 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 effect the cultural change that ensures speaking up becomes business as usual. Workplace culture is the character and personality of our organisation. It is made up of our organisation's leadership, values, traditions and beliefs, and the behaviours and attitudes of the people in 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).

What has 2022-2023 looked like for Freedom to Speak Up at HDFT?

At HDFT, our Freedom to Speak Up Guardian works alongside existing systems and processes for staff to raise concerns e.g. directly with managers, lead clinicians or tutors, to other departments e.g. Human Resources, Quality Team, or to other staff e.g. staff governors, chaplains, Trade Union representatives, executive or non-executive Directors. The Freedom to Speak Up Team provide advice and support to staff who raise concerns, work to support a culture of speaking up, providing challenge where required.

What were we aiming to achieve?

At HDFT we aim to make it as easy as possible for every colleague to speak up safely when they want to raise a concern that they do not feel they can do through the usual methods of speaking to their line manager. We aim for speaking up to be business as usual at HDFT and to have Fairness Champions in each clinical and non-clinical area to support with signposting and championing speaking up. We aim for colleagues and ex-colleagues, whether employed directly or as contractors, students or volunteers to be able to speak up about anything that gets in the way of doing a good job.

What have we done?

We have continued to embed the Freedom to Speak Up values of courage, impartiality, empathy and learning into our shared understanding of the key elements of a fair, just and safe culture, which are:

1. Fairness, compassion and psychological safety: ensuring each individual knows they will be treated fairly and compassionately by the group if things go wrong or they speak up to stop problems occurring.

2. Diversity, inclusivity, trust and respect: ensuring people are treated fairly regardless of ethnicity, gender, disability or other characteristics;

3. Speaking up and listening: ensuring speaking up about concerns, events, errors or poor behaviour is welcomed, and seen not just as safe, but the right thing to do;

4. Leadership and teamwork: ensuring supportive, effective and ideally multidisciplinary teamwork alongside compassionate and collective leadership to reinforce a sense of care and belonging, a culture of honesty, authenticity and safe conflict;

5. Trust Values and behaviours: ensuring we promote and expect positive behaviours that improve patient safety and colleague experience, and that behaviour which is at odds with our values is called out and challenged;

6. Open to learning and improvement: ensuring that when things go wrong there is focus on no blame, a just culture, an understanding of human factors, supporting staff, and learning.

Over the last 2 years we have trained 22 additional Fairness Champions across the organisation and have confirmed ongoing commitment from the existing champions. We are rolling out the inclusion of the National Guardian Office's training "Speak Up" for all colleagues employed by the organisation, "Listen Up" for all leaders and Fairness Champions and "Follow Up" for all senior management. Mobile App developments are under consideration to improve access remotely for colleagues to Speak Up as well as to support with data collection which is reported quarterly to the NGO.

What are the results?

Currently, the Freedom to Speak Up Team includes:

- 1 x Freedom to Speak Up Guardian
- 1 x Freedom to Speak Up Associate Guardian
- 42 x Fairness Champions across the organisation.

Since October 2022 there have been 16 formal contacts made and recorded with the FTSU Guardian. Out of these 16, they are broken down by the following staff groups:

- Medical: 1 contact
- Registered Nurses, Midwives and AHPs: 11 contacts
- Administration, Clerical, Maintenance and Ancillary: 3 contacts
- Non-registered clinical support staff: 1 contact

Themes are analysed and reported to the National Guardian Office quarterly.

Summary

A culture that inhibits speaking up because of recrimination and blame acts as a significant barrier to staff wellbeing and patient safety. The work to promote a fair, just and safe culture is focused on ensuring our leaders and managers create positive, supportive environments for all colleagues, knowing that they will then create caring, supportive environments and deliver high quality care for patients. We must promote and expect positive behaviours that improve patient safety and staff experience, constructively challenging behaviour that is at odds with our values to enable people to learn about the impact of their words or actions. All colleagues need to be confident that they will be treated fairly and compassionately, and that speaking up about concerns, events, errors or poor behaviour is welcomed, the right thing to do and an opportunity to learn. We must continue to train colleagues to be positive and compassionate leaders and effective members of teams, where they can reinforce a culture of honesty, authenticity and safe conflict. We continue on a journey towards ensuring all of our staff work in positive and supportive environments that enable them to deliver the highest quality of care for our patients.

Guardian of Safe Working

What is a Guardian of Safe Working Hours (GSW)?

The safety of patients is a paramount concern for the NHS. Significant staff fatigue is a hazard both to patients and to the staff themselves. The safeguards around working hours of doctors and dentists in training are outlined in the terms and conditions of service (TCS) and are designed to ensure that this risk is effectively mitigated and that this mitigation is assured.

The guardian is a senior person, independent of the management structure within the organisation, for whom the doctor in training is working and/or the organisation by whom the doctor in training is employed. The guardian is responsible for protecting the safeguards outlined in the 2016 TCS for doctors and dentists in training. The guardian will ensure that issues of compliance with safe working hours are addressed, as they arise, with the doctor and /or employer, as appropriate; and will provide assurance to the trust board or equivalent body that doctors' working hours are safe.

What has 2022-2023 looked like the Guardian of Safe Working Hours at HDFT?

At Harrogate, as for the wider NHS, safe, patient focused care is at the centre of everything we strive to achieve. Sadly staff fatigue is a hazard to patients and the staff themselves. The Junior Doctors Contract introduced in 2016; enshrined safeguards around doctors' working hours to ensure that this risk is effectively mitigated.

As a part of the new contract, the trust has appointed Dr Matthew Milsom, Director of Undergraduate Education, as Guardian of Safe working, a role independent of the management structure of the trust with these primary responsibilities:

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.

As Guardian of Safe Working Hours Dr Milsom monitors exception reports from junior doctors of breaches in agreed work schedules, whether this is working over hours, covering more than one bleep, or missing educational opportunities. These exception reports serve as a barometer of junior doctor sentiment towards working conditions and provide valuable information enabling me to look for repeating patterns and solutions.

Dr Milsom is able to liaise with supervisors to agree time off in lieu or additional payment for the extra time worked. He can levy fines against the Trust if there are major breaches and is tasked with using these funds to improve conditions for the junior doctors. Dr Milsom works with HR, medical education, and with doctors in training through a Junior Doctors Forum, used to highlight any concerns.

Dr Milsom states "*I see the role as much more than a statutory safeguard, and rather as one part of the jigsaw of patient safety that links quality of training for doctors with the safety and well-being of our patients*".

As Guardian, Dr Milsom provides the Board of Directors with a Guardian of Safe Working Report each quarter. Its purpose is to convey the state of safe working of doctors in training ('junior doctors') and ensure that any issues of compliance with hours or rota patterns are addressed by the doctor and the trust as appropriate. All rota patterns, in all specialties at Harrogate are compliant. Dr Milsom is also a member of the HDFT People and Culture Sub-Committee of the Board.

The 2022-2023 year has seen an increase in the number of exception reports submitted, predominantly around workload pressures and the need to work beyond scheduled hours to maintain safe patient care.

Ten fines for significant breaches of contract have been issued in 2022-2023. Following each fine, a focused investigation and analysis is conducted by the Guardian of Safe Working and the directorate leadership to understand what happened and more importantly what learning can be taken from the event to prevent further breaches from occurring. Recognition of excessive workload within medicine led to the recruitment of 6 fellows to bolster the workforce. This is a fantastically positive outcome and highlights the importance of the exception reporting process and the beneficial actions they can lead to.

Statements of Assurance from the Board

This section of the Quality Account provides an update on:

- A Review of Services
- Participation in Clinical Audits
- Participation in Clinical Research
- Goals agreed with our Commissioners
- What others say about the Trust: CQC
- Secondary Uses Service
- Information Governance
- Payment by Results Clinical Coding Audit
- Learning from Deaths Update
- Reporting Against Core Indicators

Review of Services

During 2022/23 HDFT provided and/or sub-contracted 61 relevant health services.

HDFT has reviewed all the data available to them on the quality of care in all of these relevant health services.

The income generated by the relevant health services reviewed in 2022/23 represents 99% of the total income generated from the provision of relevant health services by HDFT for 2022/23.

Clinical Audit

What is Clinical Audit?

A clinical audit is a way to find out if healthcare is being provided in line with standards. This informs care providers and patients where services are doing well and where improvements could be made. The aim is to allow quality improvement to take place where it will be most effective and improve outcomes for patients. Clinical audits can look at care both nationwide via national audits; and locally where healthcare is provided via local audits.

What has 2022-2023 looked like for Clinical Audit at HDFT?

National Audits

During 2022/23, 39 national clinical audits and 2 national confidential enquiries and clinical outcome review programmes (6 individual topics) covered relevant health services that HDFT provides.

During that period, HDFT participated in 97% of national clinical audit programmes and 100% of national confidential enquiries which were open and it was eligible to participate in.

To provide further context, there were 42 mandatory audit programmes on the National Clinical Audit and Patient Outcome Programme (NCAPOP), 36 of which were relevant to HDFT. The trust participated in all 36 (100 %) of the open NCAPOP programmes which it was eligible to participate in.

There were also 30 non-NCAPOP audits listed, 18 of which were relevant to HDFT: The trust participated in 15 (83%) of open non-NCAPOP programmes which it was eligible to do so.

The national clinical audits and national confidential enquiries that HDFT participated in, and for which data collection was completed during 2022/23 are listed in the Annex, alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

The reports of 30 of the national clinical audits and studies and 2 NCEPOD reports were reviewed by HDFT during 2022/23. This included national audits for which data was collected in earlier years with the resultant report being published in 2022/23. In response to the findings, quality improvement actions have been identified, monitored and completed to improve the safety and quality of healthcare provide by HDFT.

Local Audits

During 2022-2023 a joint audit programme between the Clinical Effectiveness Department and Internal Audit was in place. As per previous years, this focused on the high priority areas for HDFT in order to provide assurance through the governance structure. This ensured there was no duplication of work and that resources were used more efficiently. Joint audit planning has been undertaken again in preparation for 2023-2024.

The reports of 40 local projects (clinical audits, service evaluations and patient surveys) were completed and reviewed by relevant audit or governance groups at HDFT during 2022-2023 and HDFT intends to take the relevant actions to improve the quality of healthcare provided.

Examples of Quality Improvement as a result of local clinical effectiveness projects

Local Audit 1: It's all in the timing – a service evaluation

In 2019 there were up to 5 different clocks or pieces of medical equipment displaying time in anaesthetics rooms, operating theatres and the recovery room in Harrogate District Hospital. Staff noticed that most were telling different times and almost none were accurate. The aim of this project was to ensure that we avoided any possible issues that could affect patient or staff safety due to faulty time-keeping.

Locating the Problem

An initial audit was carried out to check and compare against GMT all clocks and time displaying equipment in each of the five anaesthetic rooms and theatres, the recovery area and the storage room. This clearly demonstrated inaccuracy and inconsistency in the time displayed.

Understanding the Impact

A survey was carried out to assess if staff felt there had been situations where the display of inaccurate time had caused any problems or had affected them or their patients. 49 members of staff responded: 50% said they had been in a situation where this had almost caused a problem; 10% felt it had caused delays in list flow; 8% felt patient safety had been affected; 16% felt it affected staff in terms of breaks and wellbeing. 50% said they used their own phone or watch as they did not trust the clocks. Comments from staff included that incorrect times were documented in patient records, there was confusion over how long procedures had actually taken, one staff member considered a change of surgical technique and there was agitation among staff as they felt it was later than it actually was. The survey showed there was a negative impact on staff wellbeing and potentially patient safety in time-critical procedures as a result of inaccurate time-keeping.

What next…

A clear plan for improvement was developed:

- All unnecessary clocks were removed
- Each of the existing clocks were corrected and the Department Equipment Officer regularly checked for possible errors
- Staff were advised always to check the time on the main computer which was wired to the network and is self-maintained.

In the longer term, it was recommended the Department Equipment Officer should work with supplies to ensure network powered digital wall clocks are installed in all main theatres, DSU and the labour ward

Re-audit

Following the improvements recommended in the initial audit, a re-audit was completed and these results showed:

- 93% of the clocks audited were showing the correct time (all but one are network powered digital clocks)
- I clock (7%) was analogue and was 3 minutes late
- 3 anaesthetic rooms did not have a wall mounted clock

Further actions are planned to replace the remaining two analogue clocks and to install more network powered clocks in the three anaesthetics rooms that do not yet have them.

Local Audit 2: Audit on patient records for IV sedation against standards of the commissioning guidance in conscious sedation

The 2017 Guidance 'Commissioning Dental Services: Service Standards for conscious sedation in a primary care setting' clarifies guidance issued by the Royal College of Surgeons. It is to support commissioners with the implementation and monitoring of contemporaneous standards in conscious sedation practice and outline NHS England commissioning intentions.

Locating the Problem

An initial audit was carried out in April 2020 to ensure HDFT Community Dental Service was meeting standards in safety and excellent patient care whilst undergoing IV sedation.

The audit looked at patient assessment, information and consent, sedation delivery and patient recovery and discharge. In total there 29 criteria against which the service was measured.

Understanding the Impact

In 58% of those criteria, the service achieved 80% or above compliance, with 17% achieving 100% compliance. Compliance of less than 80% occurred in 13 areas, of which 24% was less than 50%.

What next…

The results were presented and discussed at a peer review meeting and, whilst the service was either meeting or close to meeting the 100% target in many areas, other criteria were likely being met, but were not being correctly recorded. A number of recommendations for improvement were identified and an action plan was developed.

Specific changes highlighted included redesigning the paperwork to ensure criteria were correctly recorded; ensuring the same paperwork was used across all sedation clinics; ensuring notes were computerised/scanned on to the SOEL dental software system prior to being sent to archive and educating staff on the importance of correct documentation. The results and action plan were discussed with dentists who perform IV sedation at the Peer Review audit meeting.

Re-audit

A re-audit took place in April 2022 which demonstrated significant improvement in record keeping compliance with the commissioning guidance and local standards.

Clinical Research

What is Clinical Research?

Clinical research is an arm of medical science that establishes the safety and effectiveness of Medication, Diagnostics products, Medical devices and Treatment regimes' which may be used for prevention, treatment, diagnosis or relieving symptoms of a disease.

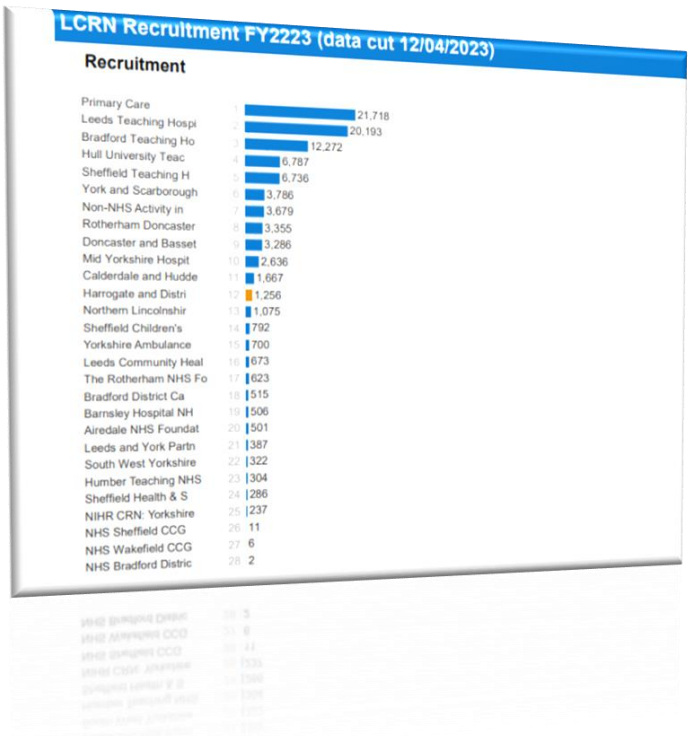
What has 2022-2023 looked like for Clinical Research at HDFT?

This section highlights our research activity across HDFT, providing information on our performance, the safety and quality assurance processes in place and some of the wider projects the department is aiming to achieve.

It is well recognised that NHS organisations partaking in research deliver better care and outcomes for their patients and access to research attracts and retains highly qualified and competent staff. HDFT is fully committed to making sure that everyone has the chance to take part in research and continues to drive a culture where an offer to participate in research is considered part of everyday standard care.

Between April 2022 and March 2023, the Trust had **95 clinical trials** or studies open or in follow up across **21 clinical and non-clinical areas** inviting suitable participants to take part. This included 5 commercial studies and 90 non-commercial trials with 2% of patients involved in commercial trials and 98% in non-commercial trials. **41** clinicians supported by **31** research delivery and administrative staff led these studies.

The number of patients receiving relevant health services by HDFT in 2022-2023, who were recruited to participate into high quality National Institute for Health and Care Research (NIHR) portfolio research studies was 1238. HDFT recruited the highest number of patients to a national trial known as SAFA . This trial repurposed the drug spironolactone for the treatment of adult acne and the results will inform NICE guidelines . Utilising spironolactone as a treatment for acne will reduce the prescribing of antibiotics for this condition.



HDFT is an active member of the Yorkshire and Humber Clinical Research Network and contributed to the overall recruitment for the regional network as the 12th most active trust of the partner organisations. Compared with 27 other trusts and health organisations in the Yorkshire and Humber region (See graph)

Research Governance and Good Clinical Practice

The research department continues to ensure that all research conducted at HDFT fully complies with Good Clinical Practice (GCP), the UK Policy Framework for Health and Social Care Research standards and the Health Research Authority approval conditions. To achieve this, the research department has established systems for quality assurance and internal monitoring for safety, data completion and compliance. The research department has reviewed its systems for quality assurance during 2021-2022 and an internal audit was conducted. Suggested areas for improvement included additional storage space for archived research materials and additional dedicated space to deliver and grow research. Both these aspects have been addressed in 2022-2023.

All research staff continue to achieve competence in research through experience, competency framework standards, Good Clinical Practice (GCP) courses and a doctor's induction and nurse preceptorship programme. The Research and Innovation Manager and Research Matron surveyed all nurses and AHPs in 2022 to establish the training needs of these professional groups in relation to research. They are currently looking at how the department can support a trust wide approach of continuous learning and is hoping to introduce a research internship programme in 2023-2024 for nurses and AHPs . In her capacity as Research Matron she continues to participate in a national group project to look at a how research can be better represented and included in the matrons handbook.

Patient and Public Involvement

The National Institute for Health Research (NIHR) sets targets for HDFT to complete a number of surveys of research participants. This year the Trust actively engaged with the Participant In Research Experience Survey (PRES) and not only exceeded the set target but demonstrated a high level of patient satisfaction with trust research services.

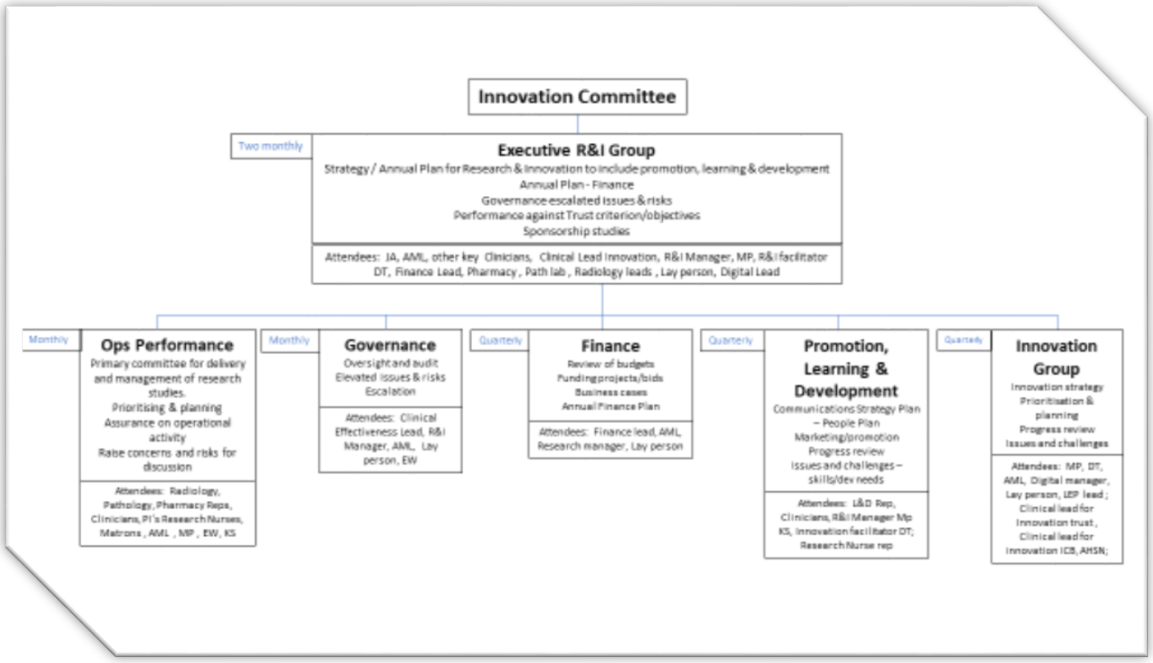
HDFT research has a dedicated presence on social media platforms such as Facebook and Twitter to ensure research continues to be connected to patients across our communities. The community of users (HDFT and public) is growing and the use of these mediums is proving to be an excellent method of result dissemination, recruitment to studies and increasing knowledge of the research activity of the Trust.

Research Performance and Safety

All research studies undertaken at the Trust are performance managed against set targets. These performance metrics are regularly presented to our main funder, the Yorkshire and Humber Clinical Research Network (YHCRN).

The Research and Innovation (R&I) Group chaired by the Executive Medical Director, review safety monitoring and financial performance. Research publications to which HDFT has contributed are also presented to the R&I Group and distributed to the Trust community via the Communications Team. The group embraces a multidisciplinary team and includes several lay representatives to ensure independent and diverse views are reflected in reviews of performance.

The newly formed Sub-Committee of the Trust Board, the Innovation Committee has been implemented and new governance structures enacted ensuring robust reporting. Issues can be escalated and reported from this Committee the Trust Board. (See diagram). The R&I team also engage with the clinical effectiveness forum to support safety and governance issues for research and looks at emerging issues



across all three quality assurance areas.

9

Our research aims to feed into and align with the Department of Health and Social Care themes, such as greater community based service research, collaboration with social care partners and co-morbidity self-directed care programmes.

The research teams at HDFT have forged and continue with successful working relationships with our primary care providers (GPs, GP confederations, Clinical Commissioning Groups, Integrated Care Boards and third parties), to increase the opportunities for communities to be involved in health research and to grow research in our community and forge more partnership and collaborations with our social care and public health providers. Funding secured from the Y&H CRN allowed for the appointment of new staff which has led to a number of novel initiatives. As a consequence, allied health professionals working in the trust have become more involved in leading research and we are able to offer more research to potential participants accessing our 0-19 service, care homes, schools, community dentists and other social care settings. For example we have successfully opened and run a community dentistry study this year looking at whether patients would accept weight management and dietary advice from dentists and a podiatry study testing the effectiveness of Orthotics and exercise for the treatment of Symptomatic Flat Feet in Children. One of our community physiotherapy practitioners has also been supported and sponsored by the trust to open his own study looking at patient perceptions and outcomes of utilising community physios on site in GP practices.

We have extensive links with local academic partners enabling research activity across our Trust services portfolio. These include the University of Leeds (acute and dental services), the Bradford Institute of Health Research (patient safety and hospital experience), the University of York (reproductive,

dermatology, immunology and infection, health sciences, health visitor, podiatry, and evidence-based studies), University of Sheffield (dermatology and diabetes), University of Southampton and Drug Safety Research Unit and University of Newcastle (0-19 services). A newly developed Skin Research Centre in York has provided significant opportunity to align with research strengths within the University of York including opportunities for Science Discovery, Mental health and skin cancer.

HDFT is an active member of the YHCRN, Yorkshire and Humber Academic Health Sciences Network. HDFT is also an active member of Medipex ensuring that all intellectual property (research originated or not) generated by the Trust is appropriately protected, developed, and exploited.

The executive have supported opportunities to engage with innovation and have committed to developing an Innovation HUB led by the R&I team in Harrogate on behalf of the region. Accommodation for the HUB has been secured and an Innovation facilitator has been appointed and a Clinical Lead for innovation is about to be appointed. These positions will support Harrogate becoming a lead trust for innovation in healthcare and a test bed for novel approaches.

Summary

In summary, HDFT research department has managed to offer a wide range of research to patients in many clinical areas in a safe and effective manner. The department has re-established itself as an important part of the care pathway within the trust and provided many benefits to patients and staff. The department this year has implemented robust key quality and safety assurance measures to continue research safety. Newly established staff training and development programmes ensure anyone working in the trust involved in research will understand, comply with, and lead research effectively.

The department has ambitions to grow more commercial research and to drive the innovation agenda over the next year towards supporting a process of self-funding through the development of further commercial research and collaborations with local providers. The research strategy aligns with the novel trust clinical strategy. These ambitions will increase opportunities for participation in research and provide additional access to novel treatments whilst also expanding opportunities for staff within the trust to engage in research.

Goals Agreed with Commissioners (CQUINS)

What is CQUIN?

The Commissioning for Quality and Innovation (CQUIN) framework is about improving the quality of healthcare. Commissioners reward excellence by linking a proportion of income to the achievement of locally set and agreed improvement goals. These goals are embedded into contracts and are essential for the implementation of National Institute for Health and Care Excellence (NICE) Quality Standards, resulting in improved patient care, experience and improvements against outcomes.

What will CQUINS look like in 2023-2024 at HDFT?

NHS England have identified a small number of clinical priority areas, where improvement is expected across 2023-2024. Many of these are short-term clinical improvements that have been selected due to their ongoing importance in the context of COVID-19 recovery. The selected priorities are:

CQUIN01: Staff flu vaccinations	
Applicability: Acute, Specialised Acute, Community, Mental Health, Specialised Mental Health, Ambulance **CQUIN goal:** 75% to 80% **Supporting ref**: NICE NG1031	Staff flu vaccinations are critical in reducing the spread of flu during winter months; protecting those in clinical risk groups and reducing the risk of contracting both flu and COVID-19 at the same time and the associated worse outcomes, and reducing staff absence and the risk for the overall safe running of NHS services. The proportion of patient-facing NHS staff accessing seasonal flu vaccinations declined dramatically in the 2021/22 flu season and it is important that we do all we can to reverse this to protect staff and patients. Section 1.7 of NICE guideline NG103 makes recommendations for increasing the uptake of vaccination amongst healthcare staff. The green book is clear that this should include non-clinical staff who have contact with patients.
Rationale for HDFT National and local reduction in uptake in 2022-2023 - additional support to recover levels to 2021-2022 and beyond being worked up	

CQUIN03: Prompt switching of intravenous (IV) antimicrobial treatment to the oral route of administration as soon as patients meet switch criteria	
Applicability: Acute CQUIN goal: 60% to 40% (NB lower % = more compliant) Supporting ref: NICE NG153	There are significant benefits to IVOS interventions demonstrated in research literature including: increasing hospital bed capacity to support recovery from the COVID-19 pandemic; reducing exposure to broadspectrum antibiotics; increasing nursing workforce capacity; reducing drug expenditure; reducing carbon footprint of medicines; and reducing healthcare-associated bloodstream infections. This CQUIN aligns with a commitment in NHS England's 2022-23 Priorities and Operational Planning Guidance to support reduced lengths of hospital stays by ensuring that intravenous antibiotics are only used for as long as clinically necessary.
Rationale for HDFT Identified as a potential CIP and quality improvement programme by our IPCC	

CQUIN04: Compliance with timed diagnostic pathways for cancer services	
Applicability: Acute CQUIN goal: 35% to 55% Supporting ref: Rapid cancer diagnostic and assessment pathways4	Faster diagnosis is proven to improve clinical outcomes: patients are more likely to receive successful treatment when diagnosed earlier. This indicator sets out key elements of the timed pathways for colorectal, lung, oesophago-gastric, prostate, head & neck and gynaecological cancers, which have been identified by a clinical expert group as crucial to achieving faster diagnosis targets. There is currently a lack of focus on the pathways. In many cases the required diagnostic tests and actions are happening, but not within the required timeframes and in some cases possibly not in the right order, making achievement of faster diagnosis standards less likely.
Rationale for HDFT Slippage in performance due to pandemic - new community diagnostic centres and other pathway changes being brought on line	

CQUIN05: Identification and response to frailty in emergency departments	
Applicability: Acute CQUIN goal: 10% to 30% Supporting ref: SDEC guide to frailty5	There are well-evidenced links between frailty and adverse health outcomes including deconditioning, malnutrition and irreversible cognitive decline which may all lead to increased health and care requirements. Early identification of frailty can mitigate some of these risks. Under the NHS Long Term Plan, every acute hospital with a Type 1 Emergency Department (ED) was asked to provide acute frailty services for at least 70 hours a week. Patients with grades of frailty CFS 6 or above should be assessed for frailty associated syndromes via a comprehensive geriatric assessment and/or be referred to the acute frailty service.
Rationale for HDFT Due to HDFT district demographic this is a priority focus for us- new acute frailty unit recently opened	

CQUIN12: Assessment and documentation of pressure ulcer risk	
Applicability: Acute; Community hospital inpatients CQUIN goal: 70% to 85% Supporting ref: NICE CG17916 NICE QS8917	NICE clinical guideline CG179 sets out clear best practice for assessing the risk of pressure ulcer development and acting upon any risks identified. It is fully aligned with the recently republished NPIAP (National pressure injury advisory panel) international clinical practice guidelines. This indicator has been expanded for 2022/23 to include inpatients in acute settings as well as community hospitals. This is expected to contribute to reducing the number of pressure ulcers nationally, improving standards of care for patients in both settings.
Rationale for HDFT Ongoing HDFT local Quality Priority	

What Others Say About the Trust: CQC

What is the CQC?

The Care Quality Commission (CQC) regulates and inspects health and social care services in England. They check that services meet the Health and Social Care Act 2008 ('the Act') and the CQC Fundamental Standards. If they feel that an organisation provides good, safe care the CQC registers it without conditions. The CQC provides assurance to the public and commissioners about the quality of care through a continuous monitoring of a Trust's performance across a whole range of core services.

What did the CQC note in 2022-2023 for HDFT?

HDFT is required to register with the Care Quality Commission and our current registration status is: "***Registered without Conditions***".

The Care Quality Commission has not taken enforcement action against HDFT during 2022-2023.

HDFT have not received a full inspection of services since 2016 – 2018, however in 2022-2023 our Maternity Services were inspected in the Safe (Requires Improvement) and Well-Led (Good) Domains.

HDFT have not taken part in any special reviews or investigations during 2022-2023.

The current overall ratings for HDFT are **GOOD.**

Secondary Service Users

What is a Secondary Users Service?

The Secondary Uses Service is designed to provide anonymous patient-based data for purposes other than direct clinical care such as healthcare planning, commissioning, public health, clinical audit and governance, benchmarking, performance improvement, medical research and national policy development.

What has Secondary Users Service looked like in 2022-2023 for HDFT?

The Trust submitted records during 2022/23 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data:
Which included the patient's valid NHS number was:

- **99.9%** for admitted patient care;
- **100.0%** for outpatient care;
- **99.3%** for emergency care.

Which included the patient's valid General Practitioner Registration Code was:

- **100.0%** for admitted patient care;
- **100.0%** for outpatient care;
- **100.0%** for emergency care.

Information Governance

What is Information Governance?

The legal framework governing the use of personal confidential data in a health care setting is complex and includes the NHS Act 2006, the Health and Social Care Act 2012, the Data Protection Act 2018, and the Human Rights Act. The law allows personal data to be shared between those offering cares directly to patients, but it protects patients' confidentiality when data about them are used for other purposes.

What has Information Governance looked like in 2022-2023 for HDFT?

The Data Security and Protection Toolkit (DPST) is an online self-assessment tool that allows organisations to measure their performance against the National Data Guardian's 10 Data Security Standards.

The assessment year runs from 1st July 2021 to the 30th June 2022. The levels of assurance are:

- Standards Met
- Standards Exceeded

The results of this years submission was: **Standards Met**

During the year Internal Audit audited 13 of the 33 mandatory standards. The levels of assurance were:

- Unsatisfactory
- Limited
- Moderate
- Substantial

The overall assurance level across all 10 NDG Standards was rated as **Substantial,** this was an improvement from the previous year where the level of assurance was Moderate.

Payment by Results Clinical Coding Audit

What is Clinical Coding?

Clinical coding is the process whereby information from medical records for each patient is expressed as a code. This may include the operation, treatment provided, a diagnosis, any complications and comorbidities. These codes are processed to result in one of a number of possible health resource group codes, each of which has a specific payment tariff that the hospital then receives.

What has Clinical Coding looked like in 2022-2023 for HDFT?

The Trust was subject to the Payment by Results clinical coding audit during 2022/23 by the Audit Commission.

The Trust commissioned an external Payment by Results clinical coding audit by D&A Consultancy during 2022-2023 and the accuracy rates reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) were:

- Primary Diagnosis = **97%**
- Secondary Diagnosis = **93%**
- Primary Procedure = **95%**
- Secondary Procedure = **94%**

Results should not be extrapolated further than the actual sample audited. Specialties audited were General Surgery, Breast Surgery and Elderly Medicine.

The Trust will be taking the following actions to improve data quality:

- Continue to engage with clinical colleagues to ensure high-quality coded clinical data which is reliable, fit for purpose and effective for statistical analysis.
- Continue to deliver a programme of clinical coding standards and standards refresher training for all staff involved in the clinical coding process, and provide an assessment framework which supports coders to gain Accredited Clinical Coder (ACC) status by passing the National Clinical Coding Qualification (UK).

Learning from Deaths

What is Learning from Deaths?

CQC published its report Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England in December 2016, making recommendations about how the approach to learning from deaths could be standardised across the NHS. The Secretary of State accepted all these recommendations and a framework was developed for the NHS on identifying, reporting, investigating and learning from deaths in care.

What has Learning from Deaths looked like in 2022-2023 for HDFT?

During 2022- 2023, **837** of the Trust inpatients died compared to **715** in 2021 - 2022. This comprised the following number of deaths which occurred in each quarter of that reporting period:

- **191** in the first quarter;
- **179 i**n the second quarter;
- **225** in the third quarter;
- **242** in the fourth quarter.

By 01/04/2023, 75 case record reviews had been carried out in relation to these deaths.

The number of deaths in each quarter for which a case record review was carried out was:

- **19** in the first quarter;
- **18 i**n the second quarter;
- **17** in the third quarter;
- **21** in the fourth quarter.

4 cases out of the 75 were assessed to have received suboptimal care. Learning was identified and shared where appropriate.

These cases were analysed using the Structured Judgement Review (SJR) tool, as described in the National Mortality Case Record Review Programme by the Royal College of Physicians.

In 2022 - 2023, no cases were identified by the SJR tool that required formal investigation, providing assurance that incident reporting and the Medical Examiner scrutiny both provide early identification of cases warranting such inquiry. (The case triggering a Serious Incident investigation had been highlighted prior to the SJR).

Cases chosen for SJR during this year were selected from the following groups:

- Highlighted by the Medical Examiner as possible poor care
- The patient had a learning disability or autism
- The cause of death was linked to aspiration pneumonia
- Patient who were admitted with injuries to scalp or limbs (indicating they had a fall at home)
- The cause of death was due to a stroke
- Deaths where modelling suggested the chance of death was low

Summary of learning points identified

These case reviews have highlighted that in the majority of cases, the standard of clinical care delivered is of good or excellent quality, with frequent consultant reviews of the majority of our inpatients. Areas for improvement include note-keeping and early senior input in complex cases.

Actions taken

The following actions have been taken as a result of the learning identified to date:

- Cases with deficiencies in care have been discussed in detail at departmental Quality of Care meetings
- We have trained more staff to perform SJRs so that a higher number of cases can be scrutinised
- We have purchased a new IT system which will enable better analysis of trends in care quality
- We have continued to emphasise the need for senior involvement in complex or difficult cases
- We have set up a new governance group to coordinate between Palliative Care, the Medical Examiner, bereavement care and organ and tissue donation teams.
- Cases are presented at the Mortality Review Group which is a virtual meeting open to all trust employees.

The impact has been:

- A greater number of cases are now being examined by the SJR processes
- We have the ability to triangulate SJR findings with other sources such as complaints, incident reports and claims

These numbers have been estimated using the validated National Mortality Case Record Review methodology available from National Mortality Case Record Review (NMCRR) programme resources | RCP London.

Reporting Against Core Indicators: NHS Digital

What is NHS Digital?

NHS digital support NHS staff at work through design, developing and operating the national Information Technology (IT) and data services that support clinicians and NHS staff at work, help patients get the best care, and use data to improve health and care.

What have the Core Indicators like in 2022-2023 for HDFT?

Since 2012/13 HDFT has been required to report on performance against a core set of indicators using data made available by NHS Digital. The core set of indicators are prescribed in the NHS Outcomes Framework (NHS OF) developed by the Department of Health and Social Care to monitor the health outcomes of adults and children in England. The framework provides an overview of how NHS Trusts are performing and uses comparative data against the national average and other NHS organisations with the lowest and highest scores.

Set out in the tables below are the quality indicators that HDFT are required to report in their Quality Accounts this year. The data given in this section, unless otherwise stated, has been taken from the data made available to the Trust by NHS Digital.

Preventing people from dying prematurely and enhancing quality of life for people with long-term conditions

Summary Hospital Mortality Index (SHMI)

This measure looks at deaths in hospital or within 30 days of discharge and is standardised to allow for variations in the patient mix in different hospitals. NHS England publish a value for each Trust every quarter. The national score is set at 1.000 – a Trust score significantly above 1.000 indicates higher than expected death rates, whereas a score significantly below 1.000 indicates lower than expected death rates.

SHMI (Summary Hospital Level Mortality Indicator)

	Data period	
	Dec 20 - Nov 21	**Dec 21 - Nov 22**
HDFT value	1.037	1.013
HDFT banding	2 (as expected)	2 (as expected)
National average	1.000	1.000
Highest value for any acute Trust	1.195	1.222
Lowest value for any acute Trust	0.716	0.717

Jan 22 to Dec 22 data due to be published 11/05/23

Note - highest and lowest trust scores include all providers with data published by NHS England

Data source:
https://digital.nhs.uk/data-and-information/publications/ci-hub/summary-hospital-level-mortality-indicator-shmi

HDFT considers that this data is as described for the following reasons:

- Independent clinical coding audits are carried out on an annual basis by accredited clinical coding auditors to provide assurance of the accuracy of coded data;
- The SHMI data is reviewed and signed off by the Medical Director.

HDFT has taken the following actions to improve this rate, and so the quality of its services, by:

- Actively using the Healthcare Evaluation Data tool that enables the Trust to clinically review and analyse mortality data in detail on an on-going basis. This has been rolled out across the organisation;
- Implementing the learning from deaths processes within the Trust and contributing to the national database using Datix mortality review tool. This methodology has been rolled out nationally across England and Scotland. It is an accepted methodology for case note review and in line with recommendations in National Guidance on Learning from Deaths (National Quality Board March 2017). In addition to specialty specific case note reviews, focused reviews of situation specific deaths are undertaken as required;
- Individual specialty alerts are investigated as deemed appropriate, either through the mortality review process, coding anomalies or discharge processes or a combination of these. The overall Trust SHMI remains below expected levels.

Palliative care coding

The data shows the percentage of patient deaths in hospital with specialist palliative care coded at either diagnosis or specialty level. This denotes that the patient had clinical input from a specialist palliative care team during the hospital admission that ended in their death. In some mortality measures, this is taken into account in the standardisation, making the assumption that a patient who has had specialist palliative care input should not be classified as an unexpected death. A proportion of people who die in hospital will receive specialist palliative care input but the recording of this varies widely between hospitals.

Palliative care coding - % patient deaths with palliative care coded at either diagnosis or specialty level

	Data period	
	Dec 20 - Nov 21	**Dec 21 - Nov 22**
HDFT value	39	39
National average	39	40
Highest value for any acute Trust	64	66
Lowest value for any acute Trust	11	13

Note - highest and lowest trust scores include all providers with data published by NHS England
Note - figures now only published to 0 decimal places
Data source:

https://digital.nhs.uk/data-and-information/publications/ci-hub/summary-hospital-level-mortality-indicator-shmi
HDFT considers that this data is as described for the following reasons:

- Independent clinical coding audits are carried out on an annual basis by accredited clinical coding auditors to provide assurance of the accuracy of coded data;
- The data is reviewed and signed off on a quarterly basis by the Medical Director;
- This data originates from the clinical coding of specialist palliative care input by the Palliative Care Team (PCT) and is based on evidence documented in patient records;
- The PCT record all face-to-face and telephone contacts on an electronic patient system called SystmOne, whilst the clinical coders base their coding on information in the paper medical record. If there is telephone contact only, documentation in patients' paper medical records will be by the ward team, but may not always be recorded clearly as PCT input and therefore may be difficult for clinical coders to identify. Previously the Information Services team also extracted activity data from SystmOne for accurate submission of mortality data, but due to reduced capacity in the Information Services team, this did not happen for some months. This was resumed in May 2019;
- The use of the HDFT Care Plan for Last Days and Hours of Life is well established on adult wards. This supports ward staff to care for dying patients and in theory means that fewer patients require referral to the PCT.

HDFT has taken the following actions to improve this rate, and so the quality of its services, by:

- Continued PCT attendance at multi-disciplinary team (MDT) meetings

Helping people to recover from episodes of ill health or following injury

PROMs – Patient Reported Outcome Measures

PROMs calculate the health gain after elective surgical treatment using pre- and post-operative patient surveys. Four common elective surgical procedures were included in the survey: groin hernias, hip replacements, knee replacements and varicose vein operations. However the mandatory varicose vein surgery and groin-hernia surgery national PROM collections ended on 1 October 2017. A high health gain score is good.

Data for PROMS has not be collected or submitted at a national level since 2020-2021.

Emergency readmissions within 30 days

This data looks at the percentage of all patients who are readmitted to hospital as an emergency within 30 days of being discharged. A low percentage score is good.

	2020/21	2021/22	2022/23
Total number of emergency readmissions within 30 days	3328	4218	4243
As a percentage of all emergency admissions	16.98%	18.76%	18.34%
Number of emergency readmissions within 30 days (Payment by Results exclusions applied)	2445	2861	2887

As a percentage of all emergency admissions	12.48%	12.72%	12.48%

Data source – local data collection

HDFT considers that this data is as described for the following reasons:

- Data presented is locally derived non-standardised readmission rates as the standardised readmission rates are no longer published by NHS England.
- Data is recorded onto the Trust's main patient administrative system (PCS) and collected via reliable information technology (IT) systems.

HDFT has taken the following actions to improve this rate and so the quality of its services, by:

- Routinely presenting emergency readmissions information to the Trust Board each month;
- Continuing to periodically carry out a number of clinical audits to understand this further;
- Using national benchmark data to review how HDFT performs compared to local trusts and a benchmark group of similar trusts.

Ensuring that people have a positive experience of care

Inpatient survey – responsiveness to patients' personal needs

This measure is the average weighted score of five questions from the national inpatient survey relating to responsiveness to inpatients' personal needs. The scores are an average weighted score of five questions relating to responsiveness to inpatients' personal needs, presented out of 100 with a high score indicating good performance.

Inpatient survey - responsiveness to inpatients' personal needs

	Data period			
	2018/19	**2019/20**	**2020/21**	**2021-2022**
HDFT value	71.4	68.7	77.1	-
National average	67.2	67.1	74.5	-
Highest value for any acute Trust	85	84.2	85.4	-
Lowest value for any acute Trust	58.9	59.5	67.3	-

Results for 2021-2022 and for 2022-2023 are yet to be published nationally

Data source:

https://digital.nhs.uk/data-and-information/publications/statistical/nhs-outcomes-framework/february-2021/domain-4-ensuring-that-people-have-a-positive-experience-of-care-nof/4.2-responsiveness-to-inpatients-personal-needs

Treating and caring for people in a safe environment and protecting them from avoidable harm

Venous thromboembolism (VTE) risk assessment

The National Institute for Clinical Excellence (NICE) recommends that all patients in hospital should be assessed for their risk of developing VTE (blood clots). This measure shows the percentage of eligible inpatients who were risk assessed. A high percentage score is good.

VTE (venous thromboembolism) risk assessment - % eligible admitted patients risk assessed for VTE

	Data period							
	Q1 2021/22	Q2 2021/22	Q3 2021/22	Q4 2021/22	Q1 2022/23	Q2 2022/23	Q3 2022/23	Q4 2022/23
HDFT value	96.62	96.27	96.73	96.04	96.02	95.80	95.49	93.91
National average	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Highest value for any acute Trust	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Lowest value for any acute Trust	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a

Data source – local data collection

HDFT considers that this data is as described for the following reasons:

- There is a well-established protocol for VTE risk assessment on admission;
- Data is recorded onto the Trust's main patient administrative system (PCS) and collected via reliable information technology (IT) systems;
- Education on VTE risk assessment is part of the Trust's essential training so staff understand the importance of it.

HDFT intends to take the following actions to improve this and so the quality of its services, by:

- Continuing to identify wards with poorer performance and examining whether there are issues with completion of the risk assessment or inputting of information onto PCS.

Clostridium difficile rates

The table shows the number of Trust apportioned cases of *C. difficile* infection (CDI) per 100,000 bed days reported from hospital inpatients aged two years or over.

	Data period		
	2019/20	2020/21	2021/22
HDFT value	22.84	25.73	26.74
National average	13.60	15.39	16.24
Highest value for any acute Trust	51.01	80.65	53.62
Lowest value for any acute Trust	0.00	0.00	0.00

Data source:
https://www.gov.uk/government/statistics/clostridium-difficile-infection-annual-data

HDFT considers that this data is as described for the following reasons:

- We actively encourage the testing for *C.difficile* in all patients with loose stool unless they is a very clear clinical reason not to sample (an example of this would be not sampling a patient who has been given an enema or laxative for the management of acute constipation).
- We continue to conduct twice-weekly antimicrobial stewardship rounds in particular to detect and restrict prescribing of high risk antibiotics.
- Post infection reviews are conducted for all healthcare acquired cases of *C.difficile* in order to determine lapses in care and extract learning which can be used to prevent future cases.

HDFT intends to take the following actions to improve this rate, and so the quality of its services, by:

- Continuing to review the prescribing of antimicrobials. Overall, the use of antimicrobials at HDFT and in the local community is below both the regional and national average;
- Continuing to review our cleaning and decontamination strategy as the evidence for the role of the environment in the transmission of healthcare associated infection including CDI is now overwhelming;
- Continue to undertake post infection review's and effectively communicate the lessons learnt from these investigations with all Trust Directorates.

Patient safety incidents

The data looks at two measures related to patient safety incidents reported to the National Reporting and Learning System (NRLS) compared to all acute non-specialist trusts:

- The rate of incidents reported per 1,000 bed days. A high rate is good; however incident reporting rates may vary between trusts and this will impact on the ability to draw a fair comparison between organisations;
- The number and percentage of those reported incidents that resulted in severe harm or the death of a patient. A low score is good.

HDFT's latest published scores are below:

	2020/21		
	Rate of incidents reported (per 1,000 bed days)	Incidents that resulted in severe harm or death	
		Number	Rate (per 1,000 bed days)
HDFT value	100.70	34	0.460
National position (all acute trusts)	57.33	6828	0.252
Highest value for any acute Trust	118.74	261	1.083
Lowest value for any acute Trust	27.18	4	0.033

	2021/22		
	Rate of incidents reported (per 1,000 bed days)	Incidents that resulted in severe harm or death	
		Number	Rate (per 1,000 bed days)
HDFT value	95.20	32	0.329
National position (all acute trusts)	54.88	7116	0.221
Highest value for any acute Trust	205.52	216	0.846
Lowest value for any acute Trust	23.67	3	0.016

Data source:

NHS England » Organisation patient safety incident reports

HDFT considers that this data is as described for the following reasons:

- The data relating to patient safety incidents is reported by front line staff;
- There is a robust policy and process within the Trust to ensure that all incidents are identified, managed, reported and investigated in accordance with national guidance;
- The Trust ensures that there are appropriate measures in place to prevent recurrence and also promotes organisational learning;
- Since 1 April 2019 the Trust has reported all 'present on admission' pressure ulcers to the NRLS in line with national guidance.
- All of the severe harm and death incidents reported were robustly investigated in line with the Trust's policy and processes and actions to address the findings have been put in place.

HDFT has taken the following actions to improve this score and so the quality of its services, by:

- Continuing to promote patient safety as a key objective across the organisation and implementing a number of mechanisms to ensure compliance with, and delivery of national frameworks;
- Commencing development of a continuous learning and improvement programme whereby output from events and complaints is disseminated to targeted staff groups in a manner which maximises learning;
- Ensuring there is a continued focus on quality at an organisational, directorate and front line level through a variety of structures, for example quality of care teams, quality governance groups at corporate and directorate level, patient safety visits, quarterly monitoring reports, case conferences and learning events;
- Undertaking a restructure of the Trust's quality governance framework including development of a Patient Safety Forum supporting implementation of the National Patient Safety Strategy, which aims to continuously improve patient safety.
- Purchasing Datix IQ which will be implemented and rolled out across the Trust over the next financial year to assist in the robust reporting and monitoring of incidents.

Performance against indicators in the Single Oversight Framework

The following table demonstrates HDFT's performance against the national standards included in the Operational Performance Metrics section of NHS Improvement's Single Oversight Framework for each quarter in 2022/23

April 2022 – March 2023

Performance Indicator Description	Q1	Q2	Q3	Q4	YTD
RTT - incomplete - % in 18 weeks	68.2%	64.6%	61.9%	63.2%	63.2%
Diagnostic waiting times - maximum wait of 6 weeks	68.7%	50.4%	62.7%	60.8%	60.8%
Trust total - Total time in A&E - % within 4 hours	68.7%	67.2%	65.8%	78.7%	70.1%
All Cancers: 14 Days Target	83.2%	54.6%	58.7%	63.0%	64.4%
All Cancers: 14 Days Target All Breast Referrals	85.6%	24.0%	8.4%	25.3%	35.3%
All Cancers: 31 Day Target - 1st Treatment	97.6%	98.0%	99.3%	99.6%	98.6%
All Cancers: 31 Day Target - Subsequent Treatment - Surgery	95.6%	96.0%	91.8%	100.0%	95.9%
All Cancers: 31 Day Target - Subsequent Treatment - Drug treatment	100.0%	99.2%	99.2%	99.1%	99.4%
All Cancers: 62 Day Target	82.0%	76.8%	80.3%	79.8%	79.8%
All Cancers: 62 Day Target Screening	58.3%	47.7%	44.4%	50.0%	51.2%
All Cancers: 62 Day Target Cons Upgrade	86.6%	83.2%	85.9%	69.6%	83.1%
Incidence of hospital acquired C-Difficile (Cumulative)	11	16	21	23	23
Incidence of hospital acquired C-Difficile (Cumulative cases due to a lapse in care)	0	0	2	2	2

Key performance to note:

- Overall in 2022/23, 63.2% of patients were waiting less than 18 weeks for consultant led treatment. The overall RTT waiting list increased in March to 25,500. The increase was largely due to operational pressures within the Trust, including the number of Covid inpatients during the month and the first wave of industrial action, impacting our ability to deliver elective activity. However the focus on clearing the 78+ week waiters continues with the number of 78+ week waiters and the number of 52+ week waits both reducing throughout the year. The Trust has reported zero 104+ week waits since July 2022;
- The Trust did not achieve the diagnostic waiting times standard in 2022/23 with on average, 61% of patients being seen within 6 weeks. Whilst the standard is not being achieved, mainly driven by a Covid-19 driven DEXA waiting list, progress in reducing long waiting patients has been made across all diagnostic modalities;
- Performance against the A&E 4-hour standard remains below the 95% standard but has seen a sustained significant improvement during Quarter 4 2022/23. Performance reflects the continuing significant pressures with high bed occupancy relating to discharge challenges and staff absenses, coupled with the current building works which is impacting ED capacity;
- There were 290 ambulance handover delays of over 60 minutes reported in 2022/23 (45 in the previous year) and 465 handover delays of over 30 minutes (212 in the previous year). Prevention of ambulance handover delays continues to be a focus with the Trust operational processes being

shared across the region by NHS England. Despite the high bed occupancy, acuity and activity, the lost hours to handover in Harrogate remains very low and in the top quartile nationally;

- 3 out of 7 cancer waiting time standards were achieved for the year overall with the exceptions being the 14 day standards for suspected cancer and breast symptomatic referrals, the 62 day treatment standard and the 62 day screening standard;
- The Trust reported 23 cases of hospital acquired C. difficile in 2022/23, compared to 36 in 2021/22. Root cause analysis has been completed on all cases and indicated that 21 of these were not due to lapses in care. 2 cases were deemed to be due to lapses in care. 2 cases of hospital acquired MRSA (methicillin-resistant staphylococcus aureus) were reported in 2022/23.

PART 3: Plans for the Future and Priorities for Improvement

This section of the Quality Account provides an update on:

- Consultation
- 2023-2024 Priorities
  - Best Quality, Safest Care: Ever safer care through continuous learning
  - Best Quality, Safest Care: Excellent outcomes through effective, best practice care
  - Best Quality, Safest Care: A positive experience for every patient by listening and acting on feedback
- Our plans for the Patient Safety Incident Response Framework (PSIRF)

Plans for the Future - Consultation

Our Commitment

At HDFT we are committed to ensure we focus on the areas of quality and safety that will make a real difference to the people we serve. Whilst improvement projects can sometimes make a big impact over a short period of time, we have committed to a three year development programme across our key quality priorities. 2023-2024 sees us enter our second year of this ambitious programme.

As such following consultation with colleagues across the Trust, the region and nationally as well as with our governors and a wide range of individuals and stakeholders who took part in the development of our Trust Strategy. We can confirm that our Quality Priorities will continue to focus on:

- Theatres Safety
- Inpatient Falls
- Pressure Ulcers
- Missed Results
- Medication Errors
- Patient Experience

This does not mean that we did not make the steps forward and progress we wished in 2022-2023, it means that we have achieved our goals across the majority of the priorities and we will now implement further step changes over the next 12 months to take these improvement projects to the next level.

SAFE: Best Quality, Safest Care: Ever Safer Care through Continuous Learning and Improvement

Quality Programme: Theatres Safety

Aims for 2023-2024

The aim for 2023-2024 is to continue to progress at pace with the improvement workstreams for theatres.

Objectives

The objectives for 2023-2024 include:

- Continuous improvement projects
- WHO Safety Checklist Review and digitisation of documentation
- Cataract one stop shop developed, reviewed and embedded
- Hand Hygiene campaign completed to include on the 5th May 2023 World hand hygiene day
- Development of a staff engagement group
- Designing career road map from Band 2 to Band 8a
- Wellbeing room – opened and to expand to other areas
- Ongoing training and education programmes, including orthopaedic and urology workshops
- Review theatre module – to include updating purpose T documentation
- Reduce high use of agency, exception being short notice sickness
- Green theatre project – more sustainability and waste reduction projects
- Procedure room in endoscopy suite, kit ordered, collaborative work
- TIF 1 – vanguard theatres utilised
- TIF1 Wharfedale – business case in development
- TIF2 – phased recruitment
- Review and align NATSSipS with anaesthetic colleagues
- ACSA review in November 2023, ongoing work ready for re-accreditation

Performance measures

- Number of Never Events
- Agency spend

SAFE: Best Quality, Safest Care: Ever Safer Care through Continuous Learning and Improvement

Quality Programme: Inpatient Falls

Aims for 2023-2024

National guidance from NAIF, suggests if specific interventions are implemented, such as a Multi-Factorial Risk Assessment (MFRA) for all those aged 65 and over, then the Trust should be able to reduce the number of inpatient falls by 20-30%. Therefore, as a Trust, we will look to ensure those suggestions are met, and do so by ensuring the suggested preventative measures are in put into place and then measured accordingly.

Evidence based interventions will be implemented via the multidisciplinary team, with an aim of preventing falls. Any learning from incidents will be robust and measurable, with actions that are meaningful and embedded across the organisation. Finally, falls will remain a trust quality priority.

Objectives

- A reduction in the number of inpatient falls, which resulted in moderate to severe harm, in comparison with 2022/23.
- Embed a new, directorate led, investigation process for falls resulting in moderate to severe harm.
- Improve compliance in ensuring all patients admitted with a fall, or who are 65 and older, receive an evidence based, MFRA within 6 hours of admission.
- Improve compliance rates of the number of patients 65 and older to receive a lying and standing blood pressure, within 48hours of admission.
- Develop new robust documentation for post falls and risk assessments.
- Work closely with multi-disciplinary teams to reduce the number of deconditioned patients within HDFT.
- Continue with evidence based staff education, around the prevention of falls.
- Continue to monitor data and implement meaningful and measurable actions that improves patient safety.

Performance measures

- A designated staff member with a specialist interest in falls, will complete a monthly Tendable audit on five random patients per ward, and then disseminate the findings via the Ward Manager and Matron meeting's and the monthly Fundamentals of Care meeting.
- A Team Lead for falls, will monitor Key Performance Indicators (KPI's) monthly, using data from the monthly falls audit, and the trust incident reporting system and then feed this in to the relevant forums such as Patient Safety Forum, Professional Practice Forum, and the Quality Committee.
- Matron's audits will also monitor the completion of MFRA'a and lying and standing blood pressures.

SAFE: Best Quality, Safest Care: Ever Safer Care through Continuous Learning and Improvement

Quality Programme: Pressure Ulcers

The prevention of pressure ulcers has been a specific part of our quality improvement work at HDFT since 2012/13 and as one of the Trusts Quality Priorities for 2023/24, this focus will sharpen and intensify.

Aims for 2023-2024

All colleagues at HDFT will be committed to ensuring all preventative measures are in place and monitored to reduce the incidence of pressure ulcers occurring, or deteriorating in HDFT care, across both acute and community settings. Learning from incidents will be robust, measurable, and meaningful and will be monitored to ensure actions are fully embedded across the organisation to improve the quality of care delivered.

Objectives

- Rule out pressure ulcers acquired or deteriorating in HDFT services which result from omissions in care.
- Zero tolerance for hospital acquired category 4 pressure ulcers.
- A reduction in the incidence of category 3 and medical device related pressure ulcers acquired in HDFT hospital care in comparison with 2022/23.
- Embed a new, directorate led, investigation process for any pressure ulcers resulting in moderate or severe harm.
- Achieve 100% compliance with pressure ulcer risk assessment and associated care planning.
- Focus on **preventing** pressure ulcers rather than **treating** them.
- Continue to guide and advise colleagues, patients and carers through high quality education and support.
- Make meaningful, and measurable changes based on data unique to HDFT which directly improves patient care.

Improvement work in progress or scheduled

- Development of new information leaflets for patients, carers, families, residential, nursing and home care services, explaining shared care in relation to pressure ulcer prevention and management.
- Increased education opportunities from TVN team – ad hoc and planned.
- Implementation of Statistical Process Control (SPC) data capture.
- Mock coroners court Summer 2023 and Spring 2024 to highlight and embed the importance of accurate and thorough documentation.
- TVN attendance at Theatre, ED, maternity and paediatric training and induction days

Performance measures

- TVN team have commenced monthly Tendable audits for assurance regarding PU risk assessment and care planning - results reported to fundamentals of care group and directorate QoC meetings.
- Tendable audits to monitor pressure ulcer risk assessments:
    - Weekly ward manager
    - Monthly Matrons
    - Implementation of revised PULT process to involve directorate Heads of Nursing, Matrons and quality assurance leads.

OUTCOMES: Best Quality, Safest Care: Excellent outcomes through effective, best practice

Quality Programme: Missed Results

Aims for 2023-2024

Fundamentally, we wish to reduce the number of results which are not acted upon appropriately. As previously noted, the numbers of cases reported as incidents is dependent on many other factors, making tracking of our progress difficult. We also record instances where a missed result has unfortunately led to harm, but these cases are fortunately low in number and sporadic, so a reduction in patient harm may take many years to demonstrate. Therefore we have chosen to monitor our progress by looking at how many investigation results have not been documented as actioned, or “filed”, on our ICE electronic results system. The act of “filing” indicates that a health professional has looked at the result and decided whether further action is needed or not. This acts as a final safety net to ensure that very result is viewed in a timely manner.

Objectives

To help achieve or aims we plan to introduce the following changes in the next year:

1) Each clinician will get a list of all results not filed on a weekly basis. This will also be shared with each Clinical Directorate, so that if individual clinicians or teams have a backlog it can be promptly addressed.
2) Each test which is suspicious of malignancy will trigger an email direct to the clinician in charge. This is in addition to visual alerts on the ICE system and automatic referral to the cancer team meetings.
3) We will continue to explore whether normal results can be filed automatically. This reduces the burden on individual clinicians and lessens the likelihood of an abnormal test being missed. Our current IT systems do not allow enough flexibility to do this currently, but we are investigating whether artificial intelligence (AI) processes could provide a solution.
4) We will ensure that as we work to introduce our new Electronic Patient Record, it includes processes which enable prompt filing with appropriate safety netting features.

Performance measures

Reviewing the number of investigation results that have not been documented as action, or “filed” on our ICE electronic results system.

OUTCOMES: Best Quality, Safest Care: Excellent outcomes through effective, best practice

Quality Programme: Medication Errors – A Focus on Insulin

Aims for 2023-2024

Medication incidents remain a priority for the organisation and are the fourth most common type of reported incident, and account for 8-12% of total reported incidents. The National Medicines Safety Improvement Programme (MedSIP) addresses the most important causes of severe harm associated with medicines. The overall ambitions of MedSIP align with the Medicines Quality and Safety Programme and the Quality Priority to reduce medication errors.

Objectives

The proposed ambitions for MedSIP at HDFT are:

- to reduce medicine administration errors in by 50% by March 2024
  - implementation of Omnicell automated cabinets will be an enabler
- to reduce harm from opioid medicines by reducing high dose prescribing (>120mg oral Morphine equivalent), for non-cancer pain by 50%, by March 2024
  - need to define specific programme to reduce harm from opioid medicines
- to reduce harm from insulin prescribing and administration errors by 50%, by March 2024
  - propose insulin safety group to oversee this workstream
- to reduce harm from infusion medicine prescribing and administration errors by 50%, by March 2024
  - propose EPMA infusions project

Performance Measures

A significant piece of learning from the 2022/23 Quality Priority for medication incidents was around how you use data effectively to demonstrate an improvement and the limitations of comparing trends in absolute reported incidents.

There will be a stronger focus on how we use Statistical Process Control tools as a means of understanding natural variation and help enable us to understand whether the changes we are making are resulting in improvement. This is very difficult to do with when comparing absolute data.

Insulin medication incidents will remain a priority due to the recent trends we have observed. Interventions will continue to optimise digital technology to reduce the human factors associated with medication incidents.

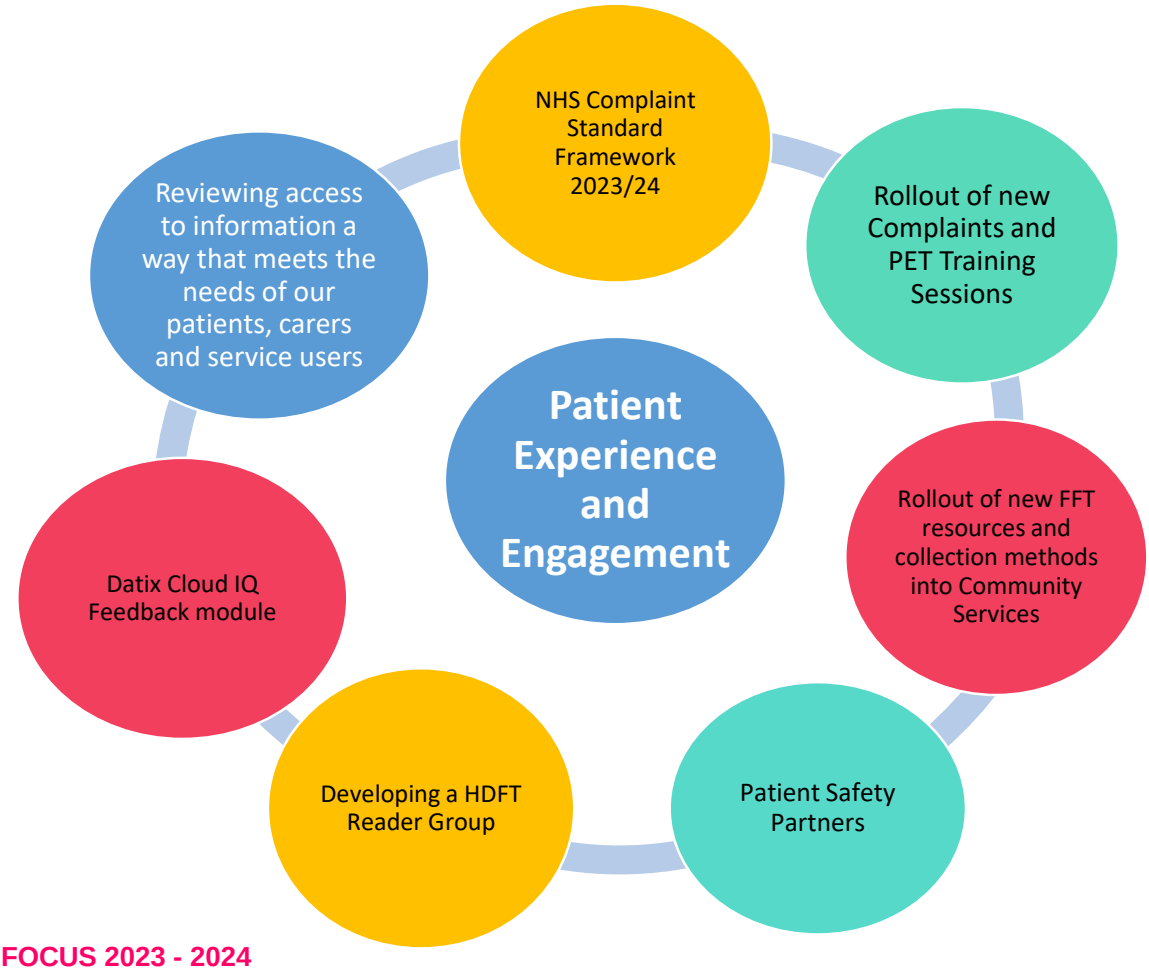
EXPERIENCE: Best Quality, Safest Care: A positive experience for every patient by listening and acting on feedback

Quality Programme: A focus on patient experience

Aims for 2023-2024

To continue to focus on the development of patient experience at HDFT.

KEY WORK FOR 2023-2024



IN FOCUS 2023 - 2024

HDFT Reader Group development

As part of a wider Patient Experience review, looking at how HDFT ensures the patient voice helps to tangibly influence and shape services and patient information, it has been identified that would be significant benefit to introduce a Patient and Carer Reader Group that would underpin all services in the Trust.

The purpose of the group would be to provide a patient/carer perspective on patient information and literature, such as posters, leaflets and webpages.

Currently, HDFT services can access reader groups through Healthwatch North Yorkshire and the Humber and North Yorkshire HCP.

It would allow us to increase our patient and public engagement however, if we were to develop our own group within the Trust.

The purpose of the group will be to help review and develop patient literature, to improve the quality of information and accessibility.

The Patient Experience Team are currently putting together a role descriptor and guidance to support the development of a HDFT Reader Group, and this will be one of our priorities over the next 12 months.

Datix Cloud IQ System

2023 will see the introduction of the new Datix Cloud IQ system to include a new feedback module that has been configured and developed in partnership between the Patient Experience Team, Quality Team and Datix.

The purpose of this new system is to allow for a more joined up, robust approach in capturing patient feedback and as well as formal complaints and concerns, the Patient Experience Team will be capturing compliments and thanks you's, general enquiries and signposting enquiries through the new system.

The outcome of this work will ensure all feedback is recorded, triaged and shared using a consistent approach through the PET, allowing staff and services easier access to feedback to support continuous quality improvement, learning, listening to patients, carers and families about what matters most and support staff development by having access to feedback to support appraisals, THIRVE conversations and revalidation where appropriate.

This work will support our commitment to Involvement, Learning and Governance as by implementing this new system module, we expect to have access to more robust data, themes, trends and insights around the patient experience at the Trust that will allow us to understand what we get right and also where improvements can be made.

PSIRF: A focus on the next 12 months

What is PSIRF?

The NHS Patient Safety Strategy 2019 describes the Patient Safety Incident Response Framework (PSIRF) as “a foundation for change” and as such, it challenges us to think and respond differently when a patient safety event occurs.

Unlike previous frameworks, PSIRF is not a tweak or adaptation of what came before. PSIRF is a whole system change to how we think and respond when an event happens to reduce the risk of recurrence.

Previous frameworks have described when and how to investigate a serious incident, PSIRF focuses on learning and continuous improvement. With PSIRF we are responsible for the entire process, including what to investigate and how. We will work collaboratively with our commissioners and regulators during this process. There are no set timescales or organisations to approve what we do. There are a set of principles that we should work to but besides that it is up to us to determine how we want to investigate and learning. This makes it exciting, innovative but can also make us feel some level of trepidation.

Over the past 18 months HDFT has focused on improving our approach to patient safety events, with many examples of learning and involvement. Essential to this is about promoting a *just culture* in which people feel safe to talk. Having conversations with people relating to a patient safety event can be difficult and we will continue to explore how we can equip and support our colleagues to best hear the voice of those involved. In doing so, we will also support our core ambition of working in partnership with patients to improve safety.

The challenge for us is to develop an approach to investigations that facilitates thematic insights to inform ongoing improvement. Our approach must acknowledge the importance of organisational culture and what it feels like to be involved in a patient safety event. Along with our HR colleagues we must look to further develop and foster a restorative just culture in which people feel psychologically safe. We recognise that changing culture is complex and we are passionate about being an organisation that lives and breathes a safety culture in which people feel safe to speak.

What will PSIRF looks like in 2023 - 2024 for HDFT?

At Harrogate and District Hospital NHS Foundation Trust (HDFT) we are fully committed to ensuring the development, implementation and success of the Patient Safety Investigation Response Framework (PSIRF). As a Trust Board we have welcomed the changes from the Serious Incident Framework to PSIRF. This gives us the opportunity to focus our efforts on learning and continuous improvement. The organisation has spent the last 12 months ensuring that we are prepared both with our systems and processes as well as our culture to ensure that we can fully immerse ourselves in the new framework. As a Trust Board, we now make a pledge to fully support the implementation of the PSIRF Plan for HDFT.

Emma Nunez

Executive Director of Nursing, Midwifery and AHPs / Deputy Chief Executive

Sarah Armstrong

Chair of HDFT

ANNEXES

This section of the Quality Account provides an update on:

Annex 1:
- Statements from Key Stakeholders
- Trust response to stakeholders

Annex 2:
- Statement of directors responsibilities

Annex 3:
- Abbreviations and definitions
- Clinical Audit
- How to provide feedback
- Other formats

ANNEX 1: Statements from Key Stakeholders

ANNEX 2: Statement of Directors Responsibilities

The directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended by the National Health Service (Quality Accounts) Amendment Regulations 2011).

In preparing the Quality Account, directors are required to take steps to satisfy themselves that:

- The Quality Accounts presents a balanced picture of the trust's performance over the period covered;
- The performance information reported in the Quality Account is reliable and accurate;
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;
- The data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review; and
- The Quality Account has been prepared in accordance with Department of Health guidance

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Account.

By order of the Board

Chair of HDFT: Sarah Armstrong

Signature:

Date:

Chief Executive of HDFT: Jonathan Coulter

Signature:

Date:

ANNEX 3: Abbreviations and Definitions

Abbreviation / Name	Definition
ACP	Advanced Care Practitioner
Audit	An audit is a way to find out if healthcare is being provided in line with standards and lets care providers and patients know where their service is doing well, and where there could be improvements.
AMU	Acute Medical Unit
BAME	Black and minority ethnic
BSL	British sign language
CAT	Clinical Assessment Team – changed to Combined Assessment Team (December 2018)
CATT	Clinical Assessment, Triage and Treatment
CAS	The Central Alerting System (CAS) is a web-based cascading system for issuing patient safety alerts, important public health messages and other safety critical information and guidance to the NHS and others, including independent providers of health and social care.
CCG	Clinical Commissioning Group Clinical Commissioning Groups (CCGs) commission a majority of the hospital and community NHS services in the local areas for which they are responsible. Commissioning involves deciding what services are needed for diverse local populations and ensuring that they are provided.
CEM	Royal College of Emergency Medicine
CHC	Continuing Healthcare
Clinical Audit	This is a quality improvement process that looks at improving patient care and outcomes through a review of care against a set of criteria. This helps to ensure that what should be done in a Trust is being done.
Clinical Outcome	A clinical outcome is the “change in the health of an individual, group of people or population which is attributable to an intervention or series of interventions.
Clinical Research	Clinical research is a branch of medical science that determines the safety and effectiveness of medication, diagnostic products, devices and treatment regimes. These may be used for prevention, treatment, diagnosis or relieving symptoms of a disease.
CNS	Clinical Nurse Specialist
COPD	Chronic obstructive pulmonary disease
Covid-19	A highly contagious respiratory disease caused by the SARS-CoV-2 virus.
CQC	Care Quality Commission Care Quality Commission (CQC) regulates and monitors the Trust’s standards of quality and Safety.
CQUIN	Commissioning for Quality and Innovation A payment framework which enables commissioners to reward excellence, by linking a proportion of payments to the achievement of targets
CTG	Cardiotocography
CVI	Certificate of visual impairment
Dashboard	Data visualisation tool that displays the current status of metrics and key performance indicators
Data Quality	Ensuring that the data used by the organisation is accurate, timely and informative.
Datix	DATIX is the Trust wide incident reporting system
ED	Emergency Department The Emergency Department (ED) assesses and treats people with serious injuries and those in need of emergency treatment. Its open 24 hours a day,

	365 days of the year.
EoL	End of life
EPaCCS	Electronic palliative care co-ordination system
ePMA	Electronic prescribing and medicines administration system
FFT	Friends and Family Test The Friends and Family Test (FFT) is a single question survey which asks patients whether they would recommend the NHS service they have received to friends and family who need similar treatment or care.
GP	General practitioner
HaRD	Harrogate and Rural District
HDFT	Harrogate and District NHS Foundation Trust
ICE	Requesting and reporting software
ICNARC	Intensive care national audit and research centre
Just Culture	A just culture considers wider systemic issues where things go wrong, enabling professionals and those operating the system to learn without fear of retribution.
LD	Learning disabilities
MAU	Medical Admissions Unit
MCA	Mental Capacity Act
MDT	Multidisciplinary team
NCAPOP	National Clinical Audit and Patient Outcome Programme
NCEPOD	National Confidential Enquiry into Patient Outcome and Death
Never Event	A Never Event is a type of serious incident (SI). These are defined as 'serious, largely preventable, patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers'
NEWS	National Early Warning Score (NEWS) is based on a simple scoring system in which a score is allocated to six physiological measurements already taken in hospitals – respiratory rate, oxygen saturations, temperature, systolic blood pressure, pulse rate Hull University Teaching Hospitals NHS Trust - Quality Accounts 21/22 Page 89 of 92 Abbreviation Definition and level of consciousness. NEWS2 is the latest version of the National Early Warning Score (NEWS), first produced in 2012 and updated in December 2017, which advocates a system to standardise the assessment and response to acute illness.
NICE	The National Institute for Health and Care Excellence The National Institute for Health and Care Excellence (NICE) provides national guidance and advice to health and social care organisations to ensure the service provided is safe, effective and efficient.
NPSA	National Patient Safety Agency Through analysis of reports of patient safety incidents, and safety information from other sources, the National Reporting and Learning Service (NRLS) develops advice for the NHS that can help to ensure the safety of patients. Advice is issued to the NHS as and when issues arise, via the Central Alerting System in England and directly to NHS organisations in Wales. Alerts cover a wide range of topics, from vaccines to patient identification. Types of alerts include Rapid Response Reports, Patient Safety Alerts, and Safer Practice Notices.
NIHR	National Institute for Health Research The National Institute for Health Research commissions and funds research in the NHS and in social care.
NMC	The Nursing and Midwifery Council (NMC) are the professional regulator for nurses and midwives in the UK, and nursing associates in England.

NRLS	National Reporting and Learning System National Reporting and Learning Service is a central database of patient safety incident reports. Since the NRLS was set up in 2003, over four million incident reports have been submitted.
PPE	Personal Protective Equipment is equipment that will protect the user against health or safety risks at work. It can include items such as safety helmets, gloves, eye protection, high-visibility clothing, safety footwear and safety harnesses. It also includes respiratory protective equipment.
PVG	Patient Voice Group
RCEM	The Royal College of Emergency Medicine (RCEM) is an independent professional association of emergency physicians in the United Kingdom which sets standards of training and administers examinations for emergency medicine in the United Kingdom and Ireland.
RTT	Referral to treatment
SI	Serious Incident An SI is an incident or accident involving a patient, a member of NHS staff (including those working in the community), or member of the public who face either the risk of, or experience actual, serious injury, major permanent harm or unexpected death in hospital, other health service premises or other premises where health care is provided. It may also include incidents where the actions of health service staff are likely to cause significant public concern.
SAU	Surgical Assessment Unit
SJR	Structured judgement review
SHMI	Standardised Hospital Mortality Indictor - is a hospital-level indicator which measures whether mortality associated with hospitalisation was in line with expectations.
SSNAP	Sentinel Stroke National Audit Programme
VTE	Venous thromboembolism
WDES	Workforce Disability Equality Standard
WRES	Workforce Race Equality Standard
WTE	Whole time equivalent

ANNEX 3: Clinical Audit

The national clinical audits and national confidential enquiries that HDFT was eligible to participate in during 2022-2023 are as follows:

1. Breast and Cosmetic Implant Registry
2. Case Mix Programme (CMP)
3. Child Health Clinical Outcome Review Programme
    - *Transition from child to adult health services*
    - *Testicular Torsion*
4. Chronic Kidney Disease Registry (previously listed under UK Renal Registry)
5. Elective Surgery (National PROMs Programme)
6. Emergency Medicine QIPs (*did not participate*)
    - *Pain in Children (care in Emergency Departments)*
    - *Assessing for cognitive impairment in older people*
    - *Mental health self harm*
7. Falls and Fragility Fracture Audit Programme (FFFAP)
    - FFFAP b. National Audit of Inpatient Falls
    - FFFAP c. National Hip Fracture Database
8. Inflammatory Bowel Disease (IBD) Audit
9. LeDeR - Learning Disabilities Mortality Review
10. Maternal, Newborn and Infant Clinical Outcome Review Programme
    - Perinatal confidential enquiries
    - Perinatal mortality surveillance
    - Maternal mortality surveillance and confidential enquiry
11. Medical and Surgical Clinical Outcome Review Programme
    - Crohns disease
    - Epilepsy study
    - Community Acquired Pneumonia
    - Endometriosis
12. Muscle Invasive Bladder Cancer Audit
13. National Adult Diabetes Audit (NDA)
    - National Diabetes Core Audit ,
    - National Pregnancy in Diabetes Audit
    - National Diabetes Foot care Audit
    - National Diabetes Inpatient Safety Audit
14. National Asthma and COPD Audit Programme (NACAP)
    - NACAP - Adult asthma secondary care
    - NACAP - Paediatric - Children and young people asthma secondary care
    - NACAP - Pulmonary Rehabilitation
    - NACAP - Chronic Obstructive Pulmonary Disease (COPD)
15. National Audit of Breast Cancer in Older People (NABCOP)
16. National Audit of Cardiac Rehabilitation
17. National Audit of Care at the End of Life (NACEL)
18. National Audit of Dementia (NAD)
    - NAD - Care in general hospitals
19. National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)
20. National Cardiac Arrest Audit (NCAA)
21. National Cardiac Audit Programme (NCAP)
    - NCAP - Myocardial Ischaemia National Audit Project (MINAP)
    - NCAP - National Audit of Cardiac Rhythm Management Devices and Ablation
    - NCAP - National Heart Failure Audit
22. National Child Mortality Database (NCMD)
23. National Comparative Audit of Blood Transfusion
    - Acute Upper GI Bleed (AUGIB)

24. National Early Inflammatory Arthritis Audit (NEIAA)
25. National Emergency Laparotomy Audit (NELA)
26. National Gastro-intestinal Cancer Audit Programme (GICAP)
    - National Oesophago-Gastric Cancer Audit (NOGCA)
    - National Bowel Cancer Audit (NBOCA)
27. National Joint Registry
28. National Lung Cancer Audit Programme
29. National Maternity and Perinatal Audit (NMPA)
30. National Neonatal Audit Programme (NNAP)
31. National Ophthalmology Database Audit
32. National Paediatric Diabetes Audit (NPDA)
33. National Perinatal Mortality Review Tool
34. National Prostate Cancer Audit (NPCA)
35. Perioperative Improvement Programme
36. Renal Audits
    - National Acute Kidney Injury Audit
37. Respiratory Audits
    - Adult Respiratory Support Audit
    - Smoking Cessation Audit – Maternity and Mental Health Services
38. Sentinel Stroke National Audit Programme (SSNAP)
39. Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme
40. Society for Acute Medicine Benchmarking Audit
41. Trauma Audit & Research Network
42. UK Parkinsons Audit

The national clinical audits and national confidential enquiries that HDFT participated in and for which data collection was completed during 2022/23 are as follows:

1. Breast and Cosmetic Implant Registry
2. Case Mix Programme (CMP)
3. Child Health Outcome Review Programme
4. Chronic Kidney Disease Registry (previously listed under UK Renal Registry)
5. Elective Surgery (National PROMs Programme)
6. Falls and Fragility Fracture Audit Programme (FFFAP)
7. Inflammatory Bowel Disease (IBD) Audit
8. LeDeR - Learning Disabilities Mortality Review
9. Maternal, Newborn and Infant Clinical Outcome Review Programme
10. Medical and Surgical Clinical Outcome Review Programme
11. Muscle Invasive Bladder Cancer Audit
12. National Adult Diabetes Audit (NDA)
13. National Asthma and COPD Audit Programme (NACAP)
14. National Audit of Breast Cancer in Older People (NABCOP)
15. National Audit of Cardiac Rehabilitation
16. National Audit of Care at the End of Life (NACEL)
17. National Audit of Dementia (NAD)
18. National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)
19. National Cardiac Arrest Audit (NCAA)
20. National Cardiac Audit Programme (NCAP)
21. National Child Mortality Database (NCMD)
22. National Comparative Audit of Blood Transfusion
23. National Early Inflammatory Arthritis Audit (NEIAA)
24. National Emergency Laparotomy Audit (NELA)
25. National Gastro-intestinal Cancer Audit Programme (GICAP)
26. National Joint Registry
27. National Lung Cancer Audit Programme
28. National Maternity and Perinatal Audit (NMPA)
29. National Neonatal Audit Programme (NNAP)
30. National Ophthalmology Database Audit
31. National Paediatric Diabetes Audit (NPDA)
32. National Perinatal Mortality Review Tool
33. National Prostate Cancer Audit (NPCA)
34. Perioperative Improvement Programme
35. Renal Audits
36. Respiratory Audits
37. Sentinel Stroke National Audit Programme (SSNAP)
38. Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme
39. Society for Acute Medicine Benchmarking Audit
40. Trauma Audit & Research Network
41. UK Parkinsons Audit

NATIONAL CLINICAL AUDITS 2022-2023

	Name of Audit/Clinical Outcome Review Programme	Part of NCAPOP?	Number of patients for which data submitted 2022/23	Data submitted as a percentage of the number of registered cases required for that audit
1	Breast and Cosmetic Implant Registry	No	28	100%
2	Case Mix Programme (CMP)	No	354	100%
3	Child Health Clinical Outcome Review Programme	Yes	TBC	TBC
4	Chronic Kidney Disease Registry (previously listed under UK Renal Registry)	No	638	100%
5	Elective Surgery (National PROMs Programme)	No		
5a	*Hip replacement*		Participated	Unable to ascertain
5b	*Knee replacement*		Participated	Unable to ascertain
6	Falls and Fragility Fracture Audit Programme (FFFAP)	Yes		
6a	*National Audit of Inpatient Falls*		6	100%
6b	*National Hip Fracture Database*		316	100%
7	Inflammatory Bowel Disease (IBD) Audit **Refers to all new patients on biologics Cumulative total = 168Check this*	No	783	100%
8	LeDeR - Learning Disabilities Mortality Review NB Continuous Data Collection	No	11	100%
9	Maternal, Newborn and Infant Clinical Outcome Review Programme NB Continuous Data Collection	Yes		
9a	Perinatal confidential enquiries		18	100%
9b	Perinatal mortality surveillance		18	100%
9c	Maternal mortality surveillance and confidential enquiry		1	100%

10	Medical and Surgical Clinical Outcome Review Programme	Yes		
10a	*Epilepsy Study*		5	100%
10b	*Crohns Study*		5	100%
11	Muscle Invasive Bladder Cancer Audit			
12	National Adult Diabetes Audit (NDA)	Yes		
12a	*National Diabetes Core Audit*		*1811*	100%
12b	*National Pregnancy in Diabetes Audit*		*12*	100%
12c	*National Diabetes Footcare Audit*		*445*	100%
12d	*National Inpatient Diabetes Audit including National Diabetes In-patient Audit – Harms*		7	100%
13	National Asthma and COPD Audit Programme (NACAP)	Yes		
13a	*NACAP - Adult asthma secondary care*		106	Unable to ascertain
13b	*NACAP - Paediatric - Children and young people asthma secondary care*		27	100%
13c	*NACAP - Pulmonary Rehabilitation*		11	Unable to ascertain
13d	*NACAP - Chronic Obstructive Pulmonary Disease (COPD)*		294	Unable to ascertain
14	National Audit of Breast Cancer in Older People (NABCOP) *(data submitted April 22- Sept 22)*	Yes	Participated	100%
15	National Audit of Cardiac Rehabilitation	No	199	100%
16	National Audit of Care at the End of Life (NACEL)	Yes	50	100%
17	National Audit of Dementia	Yes	TBC	TBC

18	National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)	Yes	12	85%
19	National Cardiac Arrest Audit (NCAA)	No	53	100%
20	National Cardiac Audit Programme (NCAP)	Yes		
20a	*NCAP-Myocardial Ischaemia National Audit Project (MINAP)*		259	96%
20b	*NCAP-National Audit of Cardiac Rhythm Management Devices and Ablation*		101	100%
20c	*NCAP-National Heart Failure Audit*		265	100%
21	National Child Mortality Database (NCMD)	Yes	Participated	Unable to ascertain
22	National Comparative Audit of Blood Transfusion	No		
22a	*Upper Acute GI bleed*		37	100%
23	National Early Inflammatory Arthritis Audit (NEIAA) **refers to patients recruited to the study in timeframe.*	Yes	15	Unable to ascertain
24	National Emergency Laparotomy Audit (NELA)	Yes	63	Unable to ascertain
25	National Gastro-intestinal Cancer Audit Programme (GICAP)	Yes		
25a	*National Oesophago-Gastric Cancer Audit (NOGCA)*		54	100%
25b	*National Bowel Cancer Audit (NBOCA)*		205	100%
26	National Joint Registry	No	605	Unable to ascertain
27	National Lung Cancer Audit Programme ** based on diagnoses in 2022/23*	Yes	119	100%
28	National Maternity and Perinatal Audit (NMPA)	Yes	1705	100%
29	National Neonatal Audit Programme (NNAP)	Yes	13	100%

30	National Ophthalmology Database Audit	No	TBC	TBC
31	National Paediatric Diabetes Audit (NPDA)	Yes	*1308*	100%
32	National Perinatal Mortality Review Tool	Yes	TBC	TBC
33	National Prostate Cancer Audit (NPCA) ** based on diagnoses in 2022/23*	Yes	208	100%
34	Perioperative Improvement Programme	No	TBC	TBC
35	Renal Audit	No		
35a	National Acute Kidney Injury Audit		TBC	TBC
36	Respiratory Audits	No		
36a	*Adult Respiratory Support Audit*		TBC	TBC
36b	*Smoking Cessation Audit – Maternity & Mental Health Services*		Audit delayed until further notice **	
37	Sentinel Stroke National Audit Programme (SSNAP)	Yes	272	90+%
38	Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	No	15	100%
39	Society for Acute Medicine Benchmarking Audit	No	30	100%
40	Trauma Audit & Research Network	No	243	100%
41	UK Parkinsons Audit	No	20	100%

Please note: data for all continuous projects continues to be reviewed and validated therefore final figures may change.

Please note: data for all continuous projects continues to be reviewed and validated therefore final figures may change.

For information, the Trust also participated in the following National audits and registries which were not listed on the 2022/23 Quality Accounts List:

For information, the Trust also participated in the following National audits and registries which were not listed on the 2022/23 Quality Accounts List:

Name of Audit	Part of NCAPOP?	Number of patients for which data submitted 2022/23	Data submitted as a percentage of the number of registered cases required for that audit
UK National Hand Registry	No	TBC	TBC
Bone and Joint Infection Registry (BAJIR)	No	TBC	TBC
Post Colonoscopy Colorectal Cancer (PCCRC) National Audit	No	TBC	TBC

The following 7 NCAPOP audits were not relevant to HDFT due to the Trust not providing the service:

1. Mental Health Clinical Outcome Review Programme
2. National Audit of Cardiovascular Disease Prevention in Primary care
3. National Clinical Audit of Psychosis
4. National Obesity Audit
5. Neurosurgical National Audit Programme
6. National Vascular Registry
7. Paediatric Intensive Care Audit Network (PICANet)

The following individual NCAPOP audits within relevant work streams were not relevant to HDFT due to the Trust not providing the service

- Falls & Fragility Fractures Audit Programme (FFFAP): Fracture Liaison Service Database
- Medical and Surgical Clinical Outcome Review Programme (NCEPOD): Physical Health in Mental Health Hospitals
- NCAP - National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)
- NCAP - National Adult Cardiac Surgery Audit
- NCAP - National Congenital Heart Disease Audit (NCHDA)

The following 6 non-NCAPOP audits were not relevant to HDFT due to the Trust not providing the service:

1. Cleft Registry and Audit Network (CRANE)
2. National Audit of Pulmonary Hypertension (NAPH)
3. Out-of-Hospital Cardiac Arrest Outcomes (OHCAO) Registry
4. Prescribing Observatory for Mental Health
5. UK Cystic Fibrosis Registry
6. Urology Audits
7. National Bariatric Surgery Registry

** Please note that the *Smoking Cessation Audit – Maternity & Mental Health Services* which was included in the NHS England Quality Accounts List 2022/23 has been delayed until further notice by the British Thoracic Society. Hence there was no data collection for 2022/2023

ANNEX 3: How to Provide Feedback and Other Formats

If you require this document in an alternative language or format (such as Braille, audiotape or large print), please contact our Patient Experience Team: hdft.patientexperience@nhs.net or 01423 555499.

Electronic copies of the Quality Account can be obtained from our website (www.hdft.nhs.uk). If you have any feedback or suggestions on how we could improve our Quality Account, please do let us know by emailing hdft.hello@nhs.net.

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Council of Governors' Meeting (held in Public)

6 June 2023

Title:	Governor Code of Conduct – Annual Review
Responsible Director:	Kate Southgate Associate Director of Quality and Corporate Affairs
Author:	Sue Grahamslaw Assistant Company Secretary

Purpose of the report and summary of key issues:	To review the Governor Code of Conduct, last reviewed September 2021. Changes noted in red – summary of key changes: • Update of term "Chairman" to "Chair" • Update of Trust purpose / vision (section 5) • Inclusion of ICS and public at large in Governor duties and liabilities (section 6) • Move Register of Interests to before Conflicts of Interests (sections 9 and 10) • Inclusion of "Chief Executive" in Governors having regard to advice provided by people (section 12 – Personal Conduct) • Addition of procedure relating to non-compliance with code (Appendix A)
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	
Digital transformation to integrate care and improve patient, child and staff experience	
Healthcare innovation to improve quality	

Corporate Risks	None
Report History:	The Governor's Code of Conduct should be reviewed and, if necessary, updated on an annual basis for Governors to sign and agree to abide by the reviewed Code.
Recommendation:	The Council of Governors is requested to approve the updated Code of Conduct which will be circulated in due course for individual Governors to sign acknowledging their agreement to abide by the Code.

Harrogate and District NHS Foundation Trust

Governor Code of Conduct

1. Introduction

The role of the NHS Foundation Trust Governor is a fundamental part of the governance of Foundation Trusts. While the role is entirely voluntary, a clear and agreed Code of Conduct ('the Code') is an important part of that governance enabling public confidence and assurance.

The purpose of this Code is to provide clear guidance on the standards of conduct and behaviour expected of all Governors. It seeks to outline the appropriate conduct for Governors of Harrogate and District NHS Foundation Trust ('the Trust'). It addresses both the requirements of office and of personal behaviour.

This Code, with the Board Code of Conduct and the NHS constitution, forms part of the framework designed to promote the highest possible standards of conduct and behaviour within the Trust. The Code is intended to operate in conjunction with the Trust's Constitution, Standing Orders and the Code of Governance for NHS Foundation Trusts. The Code applies at all times when Governors are carrying out the business of the Trust or representing the Trust.

2. Undertaking & compliance

All Governors are required to give an undertaking that they will comply with the provisions of this Code. In accordance with section 11.9.1.6 of the constitution a person elected or appointed as a Governor cannot join the Council of Governors until they have signed and delivered confirmation of their acceptance of this Code.

Furthermore, failure to comply with the Code may result in disciplinary action in accordance with agreed procedure (see Appendix A), including the removal of the Governor in question from office.

3. Interpretation & concerns

Questions and concerns about the application of the Code should be raised with the Company Secretary. The Chair~~man~~ will be the final arbiter of interpretation of the Code.

4. Principles of public life

The principles underpinning this Code of C~~c~~onduct are drawn from the 'Seven Principles of Public Life'[1.] as follows:

- ***Selflessness*:** Holders of public office should act solely in terms of the public interest.

- ***Integrity*:** Holders of public office must avoid placing themselves under any obligation to people or organisations that might try inappropriately to influence them in their work. They should not act or take decisions in order to gain financial or other material benefits for themselves, their family, or their friends. They must declare and resolve any interests and relationships.
- ***Objectivity*:** Holders of public office must act and take decisions impartially, fairly and on merit, using the best evidence and without discrimination or bias.
- ***Accountability*:** Holders of public office are accountable to the public for their decisions and actions and must submit themselves to the scrutiny necessary to ensure this.
- ***Openness*:** Holders of public office should act and take decisions in an open and transparent manner. Information should not be withheld from the public unless there are clear and lawful reasons for so doing.
- ***Honesty*:** Holders of public office should be truthful.
- ***Leadership*:** Holders of public office should exhibit these principles in their own behaviour. They should actively promote and robustly support the principles and be willing to challenge poor behaviour wherever it occurs.

5. The Trust's vision & values

The Trust's ~~vision is excellence every time~~ purpose is "the patient and child first", meaning improving the health and wellbeing of our patients, children and communities. To do this the Trust's ambitions are to provide:

- Best quality, safest care;
- Person-centred, integrated care; strong partnerships;
- A great start in Life.

The Trust's values lie at the heart of who we are, what we do, and the culture we want to establish, having a direct impact upon both colleagues and the public we service.

Our KITE values are:

- ***Kindness*** - We show compassion, and are understanding and appreciative of other people.
- ***Integrity*** - We display personal and professional integrity, are honest and bring a positive attitude.
- ***Teamwork*** - We are helpful to each other, listen intently and communicate clearly.
- ***Equality*** - We show respect, we are inclusive and we act fairly

6. The Council of Governors, directors' duties and liabilities

The general duties of the Council of Governors are to hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors and represent the interests of the members of the Trust as a whole and the interests of the public, both those in the Trust's locality as well as the public within the Integrated Care

System and the public at large. The role of Governors is set out in detail in the Trust's Constitution, Standing Orders, and the Foundation Trust Code of Governance and is further addressed in NHS Improvement's guidance for Governors. In carrying out its work, the Council of Governors needs to take account of, and respect, the statutory duties and liabilities of the Board of Directors and individual Directors.

7. Confidentiality

Governors must comply with the Trust's confidentiality policies and procedures. Governors must not disclose any confidential information, except in specified lawful circumstances, and must not seek to prevent a person from gaining access to information to which they are legally entitled.

Nothing said in this Code precludes Governors from making a protected disclosure within the meaning of the Public Disclosure Act 1998. The Company Secretary or the Freedom to Speak Up Guardian should be consulted for guidance.

8. Fit and proper person

It is a condition of the Trust's licence that each Governor serving on the Council of Governors is a 'fit and proper person'. A person may not continue as a member of the council if they are:

(a) a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged,

(b) a person who has made a composition or arrangement with, or granted a trust deed for, his creditors and has not been discharged in respect of it,

(c) a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him/her,

(d) subject to an unexpired disqualification order made under the Company Directors' Disqualification Act 1986.

Governors must certify on appointment, and each year, that they are/remain a fit and proper person. If circumstances change so that a Governor can no longer be regarded as a fit and proper person, or if it comes to light that a Governor is not a fit and proper person, they are suspended from being a Governor with immediate effect pending confirmation and any appeal. Where it is confirmed that a Governor is no longer a fit and proper person, their membership of the Council of Governors is terminated in accordance with the Constitution.

9. Register of interests

Governors are required to register all relevant interests in the Trust's register of interests in accordance with the provisions of the Constitution and the Trust's Conflicts of Interest

Policy. It is the responsibility of each Governor to provide an update to their register entry (within 7 days) if their interests change. A pro forma is available from the Deputy Company Secretary/Company Secretary. Failure to register a relevant interest in a timely manner may constitute a breach of this Code.

10. Conflicts of interest

Governors are required to comply with the Trust's Conflicts of Interest Policy. In particular, Governors must avoid a situation in which they have a direct or indirect interest that conflicts or may conflict with the interests of the Trust. Governors must not accept a benefit from a third party by reason of being a Governor for doing (or not doing) anything in that capacity. Governors must not offer a benefit to a third party by reason of being a Governor for doing (or not doing) anything in that capacity.

Governors are required to declare the nature and extent of any interest at the earliest opportunity. If such a declaration proves to be, or becomes, inaccurate or incomplete, a further declaration must be made. It is then for the Chair~~man~~ to advise whether it is necessary for the Governor to refrain from participating in discussion of the item or withdraw from the meeting. Failure to comply is likely to constitute a breach of this Code.

11. Meetings

Governors have a responsibility to attend meetings of the Council of Governors and of any committees or working groups to which they are appointed. When this is not possible, apologies should be submitted to the Deputy Company Secretary/Company Secretary in advance of the meeting. Persistent absence from Council of Governors meetings without good reason is likely to constitute a breach of this Code.

12. Personal conduct

Governors are expected to adopt and promote the values of the Trust and the NHS. Moreover, Governors are expected to conduct themselves in a manner that reflects positively on the Trust and not to conduct themselves in a manner that could reasonably be regarded as bringing their office or the Trust into disrepute. Specifically, Governors must:

- Treat each other, Directors and Trust staff with respect; not breach the equality rights and not bully any person.
- Not seek to use their position improperly to confer an advantage or disadvantage on any person and must comply with the Trust's rules on the use of its resources.
- Uphold the seven principles of public life (see above).
- Be honest and act with integrity and probity at all times;
- Respect and treat with dignity and fairness, the public, service users, relatives, carers, NHS staff and partners in other agencies.
- Seek to ensure that fellow Governors are valued as colleagues and that judgements about colleagues are consistent, fair and unbiased and are properly founded;
- Accept responsibility for their actions.
- Show their commitment to working as a team member by working with colleagues in the NHS and wider community.
- Seek to ensure that the membership of the constituency they represent is properly informed and able to influence services.

- Seek to ensure that no one is discriminated against because of their religion, belief, race, colour, gender, marital status, disability, sexual orientation, age, social or economic status or national origin.
- Comply with the Standing Orders and Standing Financial Instructions of Harrogate and District NHS Foundation Trust.
- Respect the confidentiality of individual patients and comply with the confidentiality policies of the Trust.
- Not make, permit, or knowingly allow to be made, any untrue or misleading statement relating to their duties or the functions of the Trust.
- Seek to ensure that the best interests of the membership, general public, service users, stakeholders and staff are upheld in decision making and the decisions are not improperly influenced by gifts or inducements.
- Acknowledge that Harrogate and District NHS Foundation Trust is an apolitical organisation.
- Support and assist the Accountable Officer of the Trust in their responsibility to answer to the Independent Regulator, Commissioners and the public in terms of fully faithfully declaring and explaining the use of resources and the performance of the total NHS in putting national policy into practice and delivering targets.
- Must have regard to advice provided by the Chair~~man~~, Chief Executive and Company Secretary pursuant to their duties.

It is essential that the conduct and behaviour of Governors at all times support the ethos and values of the Trust. Should there be any concern about the activities of a Governor the nature of which might undermine public confidence then the Chair~~man~~'s decision on that person's role will be final.

13. Training & development

The Trust is committed to providing appropriate training and development opportunities for Governors to enable them to carry out their role effectively. Governors are expected to undertake to participate in training and development opportunities that have been identified as appropriate for them. To that end, Governors will participate in the appraisal process and any skills audit carried out by the Trust.

14. Reimbursement of Expenses

Governors do not receive payment for their role, however they receive reimbursement of any out of pocket expenses incurred as stated in the Trust's Constitution and in accordance with further guidance issued to Governors about reclaiming expenses.

15. Visits to Harrogate and District NHS Foundation Trust Premises or other services provided by the Trust

Where Governors wish to visit the premises or services of Harrogate and District NHS Foundation Trust in a formal capacity, as opposed to individuals in a personal capacity, the Governor should make arrangements in advance.

16. Review and revision of the Code

This Code has been agreed by the Council of Governors on ~~*6 September 2021*~~*6 June 2023*. The Company Secretary, supported by the Remuneration, Nominations and Conduct Committee will lead an annual review of the Code. It is for the Council of Governors to agree to any amendments or revisions to the Code.

17. Declaration

I hereby confirm that I will adopt and comply with this Code of Conduct for Governors.

Signed: Name:

…… ……

Date: ……..…

1. https://www.gov.uk/government/publications/the-7-principles-of-public-life/the-7-principles-of-public-life--

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Appendix A

Non Compliance with the Code of Conduct

Introduction

1. This section should be read in conjunction with Annex D of the HDFT Constitution, as it provides further clarification on the mechanism for dealing with concerns which may lead to the termination of office for a Governor.

2. It lays out the formal steps associated with non-compliance with this Code of Conduct and acknowledges that appropriate informal steps facilitated by the Company Secretary must have been utilised previously.

3. Steps

   a. Any complaint or concern relating to the conduct of a Governor should be presented, in writing, to the Chair and/or the Company Secretary.
   b. A review will be undertaken by the Chair and Company Secretary to determine if the complaint has been made in good faith. An investigator will be appointed to investigate the complaint. The investigator will present the written complaint to the Governor concerned and will invite the Governor to comment on it in writing. The investigator's findings will be presented in writing to the Chair, Company Secretary and to the Governor concerned.
   c. The Chair, with advice from the Company Secretary, will review the findings. If the Chair concludes that there are reasonable grounds for presenting a proposal for the removal from office to the full Council of Governors, a written case will be presented to the full Council of Governors. The Chair will consider other courses of action which may include, for example, a written self-reflection, a period of suspension from duties or a removal of membership of relevant committees. The Chair will consider, with advice from the Company Secretary, as to whether these sanctions should be reported to the Council of Governors' Remuneration, Nomination and Conduct Committee.
   d. The investigation findings, the written case and the recommendation to the Council for the Governor's removal will be served on the Governor concerned, clearly setting out the grounds for the proposed removal and the recommendation for action to the Council.
   e. The Governor will be given sufficient time to prepare their written response to the case made against them. Prior to the meeting the Council will receive the written case and recommendation for the removal of the Governor as well as the Governor's written response.
   f. Where there is any disagreement as to whether the proposal for removal is justified, an independent assessor agreeable to both parties shall consider the evidence and determine whether the proposed removal is reasonable. If the independent assessor concludes that the case was unreasonably brought and not justified, the proposal will not be presented to the Council and will be

withdrawn. If the independent assessor concludes the case to have been reasonably brought and justified, then the presentation will proceed, as set out below.

g. The Chair will present the proposal for the Governor's removal and the Governor will have the opportunity to present his/her case to all the members of the Council present at the meeting.
h. After hearing both cases, the Council of Governors will then vote on the recommendation. If three quarters of the Governors present vote in favour of the recommendation, then the Governor's term of office shall be terminated forthwith. If less than three quarters of Governors present vote in favour of the recommendation, then the Governor shall continue in office