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**	TBC at Trust Board July 23
Executive Committee	Quality Management Group (QGMG)	**Summary:** The safe domain has the most risks escalated to the corporate register. 4 of the 5 risks are related to health and safety. This month one health and safety risk (CHS4 – Control of contractors / construction workers) has been removed from the register, the panel was satisfied the actions undertaken, in progress and planned reduced the score sufficiently. This area remains a high priority for the trust and it is noted the KRI for CHS1, and CHS8 WILL be met over a longer term due to financial restraints and workforce development. CRR5 is also a key area of priority and has impacts on risks associated with resource use.				
Initial Date of Assessment	1st July 2022					
Last Reviewed	June 2023					

Corporate Risk ID	**Strategic Ambition**	**Principle Risk:**	**Initial Rating**	**May Rating**	**June Rating**	**Target Rating**
CRR5: Nursing Shortages	Best Quality, Safest Care	Risk to service delivery and patient care due to failure to fill registered nurse vacancies due to the national labour market shortage. The plans and actions are well defined. With the increase in student nurse placement and the Harrogate student Pathway in place the in addition to the current position improving the panel agreed to monitor the score for possible reduction. The actions and plans will continue and will be monitored.	12	12	12	8

Key Targets	**Current Position**	**Plans to Improve Control and Risks to Delivery**
1.Vacancy Rate improvement 2.Turnover stability 3.Increased recruitment and retention	The data from May shows a decrease in vacancies (by percentage) for nursing and support workers. Student nurse (placements) and 3rd year students have also increased. Support worker vacancies have decreased in May by 10.85wte and this is solely due to an increase in staff in post. The areas with the greatest increase to staff in post compared to the previous month is Bolton Ward and Littondale Ward. Bolton Ward saw 4.60wte support worker new starters in May, of which 2.00wte wo are international nurses and Littondale Ward saw 3.00wte support worker new starters in May, of which 2.00wte who are international nurses. The international nurses will join the Trust as supernumerary until they have passed their OSCE exams. Realignment of templates following SNCT have led to the ratios of HCSW on the wards changing in some areas, resulting in in an overall decrease of HCSW's . 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) Increased Student nurse placements and 3rd year students have increase. Targeted recruitment events in place twice yearly. Legacy mentorship for all nurses available to improve recruitment and retention. Roster KPI meetings now embedded locally and now used as part of the resource meetings.	1.HCSW position to improve with international recruitment programme 2. Business case approved for 10 RNA to RN posts to commence programme in June '23 and 8 HCSW to RN apprenticeship programme to commence in January '24 4. Roster KPI's now part of the resource review process – commenced 5/23 5. Increase in Student Nurse placements leading to recruitment (Harrogate Pathway students). Student Nurse recruitment Event on 5/6/23 Excellent turnout – job offers to be confirmed (approx. 10) Further event in October '23 6. Realignment of establishments and budgets following SNCT. Next review planned October '23

Corporate Risk ID	Strategic Ambition	Principle Risk:	Initial Rating	May Rating	June Rating	Target Rating
CRR75: CHS1 Health and Safety	**An Environment that promotes wellbeing**	**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.	16	16	12	8

Key Targets	Current Position	Plans to Improve Control and Risks to Delivery
Sufficient compliance of contractors Environmental Audits Replacement of the existing SALUS risk management system, to ensure all have access to the relevant risk assessments.	The suitability of SALUS H&S folders results in the assessments not meeting legislative requirements and do not reflect current practices or relevant guidance. A new system (EVOTIX) is to be introduced. A draft Implementation pack and project timeline have been produced.	Temporary control measure are being introduced for current risk assessments. Business case being developed for the purchase of EVOTIX (approx. cost is 23k annually) and awaiting confirmation of cost based on 250 users – 250 users will be £28,957.75 (first year), initial 5 year term

Corporate Risk ID	Strategic Ambition	Principle Risk:	Initial Rating	May Rating	June Rating	Target Rating
CRR75: CHS2 Health and Safety	**An Environment that promotes wellbeing**	**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.	16	12	12	8

Key Targets	Current Position	Plans to Improve Control and Risks to Delivery
Board level lead for Health and Safety Annual Audit programme for Health and Safety Health & Safety Committee	Risk assessment has been completed for the goods yard and temporary measures have been implemented. 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. With plans to include this in backlog maintenance work.

Corporate Risk ID	Strategic Ambition	Principle Risk:	Initial Rating	May Rating	June Rating	Target Rating
CRR75: CHS3 Health and Safety	**An Environment that promotes wellbeing**	**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 others, and the unauthorised access of persons to restricted areas of the hospital through the loading bay entrance.	20	15	15	10

Key Targets	Current Position	Plans to Improve Control and Risks to Delivery
Updated Fire Safety Policy and associated management protocols Completion of fire assessments Appointment of competent Fire Manager and Authorising Engineer Completion of assessments Implementation of fire procedures and policies	Fire risk assessments are not currently available for all areas of HDH Fire safety measures have been identified and are in the process of being implemented fully, of these fire compartmentation and fire door safety measures are inadequate. There is no clear picture of the Fire safety standards in properties leased by the Trust 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 system	Review of all current fire safety provisions Review of HDH fire compartmentation being carried out, to result in action plan for required remedial work. Production of evacuation plans and training on evacuation. Mott MacDonald have produced a Fire and Life Safety Strategy Report – this details a number of urgent issues which require remedial action. To seperate fire risk in to individual risk entries – General Fire (RA's/Evac Plans/Training), Fire Alarm System, Fire strategy for HD site, including compartmentation/fire doors/remedial work to fire dampers. These will be added to the H&S Risk Register and escalated where appropriate. Work on this will be reported via the Fire Safety Group/H&S Committee/Environment Board. Costs for the remedial work for compartmentation, fire doors and fire dampers are being obtained

Corporate Risk ID	Strategic Ambition	Principle Risk:	Initial Rating	May Rating	June Rating	Target Rating
CRR75: CHS8 Health and Safety	**An Environment that promotes wellbeing**	**CHS8**: Organisational risk to compliance with legislative and NHSE 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.	16	16	12	8

Key Targets	Current Position	Plans to Improve Control and Risks to Delivery
Structural inspection / surveying Health & Safety Committee surveying and ultimately to record plank condition Results from Regular progress reports to board and sub committees of the current position on RAAC Plans and the Risks	The HDH sit has been surveyed by WSP and an identification and deflection survey is on going. Some temporary safety measures have been implemented to support the roof. Areas of immediate action have been identified and at risk areas have also been identified. (ALL initial RAAC emergency work is complete) Responses from community landlords are being received (reminder email sent by Director of Strategy)- Data Collection Questionnaire for NHSE has been completed and sent	To undertake and annual survey of every plank; or more frequently as advised by your structural engineer 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 Strategic plan in place to identify remedial action needed, with long term plan to eliminate RAAC from site by 2035. 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 – intention is to incorporate backlog maintenance work where possible

Harrogate and District NHS Foundation Trust Corporate Risk Register June 2023

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**	TBC at Trust Board July 23
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	June 2023						

Corporate Risk ID	**Strategic Ambition**	**Principle Risk:**	**Initial Rating**	**May Rating**	**June Rating**	**Target Rating**
CRR6: The impact of Covid and Operational Pressures on Workforce Wellbeing	**At Our Best – Making HDFT the Best Place to Work**	The impact of Covid and Operational Pressures on Workforce Wellbeing Risk to patient care and safety due to potential impact of staffing levels, including the impact of current/future strike action and increased reliance on agency workers. Potential for lower colleague engagement due to increased workload, post pandemic burn-out and poor working environment. Risk of: • potential increase in lapses in delivery of safe and effective care to patients and service users • both short and long term mental and physical health impacts on staff The conditions that need to be in place to ensure workforce risks are managed are: • The right numbers of competent and qualified colleagues present and fit to work in the workplace. • Colleagues having the right environment/equipment/tools to enable them to fulfil their roles effectively. • Colleagues feeling valued and appreciated for the work they are doing.	12	16	16	12

Key Targets	**Current Position**	**Plans to Improve Control and Risks to Delivery**
Staff Engagement – Survey Scores (Benchmark Group Acute & Community Trusts) Turnover Sickness Appraisals Vacancy rate	Staff Engagement – The scores for staff engagement over kindness, teamwork, integrity and kindness are higher than the benchmark. Turnover - Target 12% Turnover Rate has had a further small decrease from 15.12% to 14.73% as at 31 May 2023. The Trust has seen a general decreasing trend since October Sickness - Target 3.9% - Sickness has seen a decrease from 4.55% to 4.22% in May. Sickness has seen a decreasing trend since peaking in December at 5.32%. All Directorates with the Appraisals - Target 90% Appraisal Rates have seen an increase in May to 83.90% from 84.76% in April. Vacancy rate - has decreased from 8.75% in April to 8.03% in May and equates to 361.25wte vacancies. The reason for the decrease in vacancies is solely due to an increase in the staff in post WTE.	Staff Engagement Turnover Sickness Appraisals Vacancy rate

	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**	TBC at Trust Board July 23
Executive Committee	Operational Management Group (OMG)					
Initial Date of Assessment	1st July 2022					
Last Reviewed	June 23					

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 increased to 16 from 12 in April 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.

Corporate Risk ID	Strategic Ambition	Principle Risk:	Initial Rating	May Rating	June Rating	Target Rating
CRR34: Autism Assessment	**Great Start in Life**	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)	12	16	16	8

Key Targets	Current Position	Plans to Improve Control and Risks to Delivery
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 Longest wait of CYP having commenced assessment Longest projected wait of CYP joining the waiting list	• Numbers on the waiting list: 924 • Longest wait: 63 weeks • May activity - 35 completed assessments against plan of 40, YTD 78 against plan of 80 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	The projected waiting list and the lack of resources provided to the trust, with limited future planning is known and documented. The meeting with ICB commissioning experts will discuss and highlight next possible steps, the trust will also now need to consider the future of the service and sustainability of delivery.

Corporate Risk ID	Strategic Ambition	Principle Risk:	Initial Rating	May Rating	June Rating	Target Rating
CRR41: RTT	**Person Centred, Integrated Care, Strong Partnerships**	Risk to patient safety, performance, financial performance, and reputation due to increasing waiting times across a number of specialties, including as a result of the impact of Covid 19 (added 13/03/2020)	12	12	12	6

Key Targets

RTT to meet constitutional standards, Reduction in waiting list size

92% 18 week incomplete performance standard
52+ Waits

78+ Waits (zero by March 23)

104+ Waits (zero by July 22)

Current Position

	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	*May-23 (provisional)*
Total incomplete RTT pathways	25,388	24,951	24,854	25,139	25,504	25,951	*26,792*
> 52 weeks	1,201	1,228	1,186	1,112	997	998	*1,054*
> 65 weeks	401	477	399	362	193	202	*214*
> 78 weeks	100	118	101	65	4*	5*	*1**
> 104 weeks	0	0	0	0	0	0	*0*

Elective recovery work continues to be a major focus, and the Trust continues to, where possible, increase elective admissions to reduce the gap to pre-COVID levels.

104+ week waiters
The target has been met, HDFT currently have no 104 week patient waits

78 week waiters (clearance target March 2023)
Zero position achieved by end of March 23 (excluding patient who have opted to remain on waiting list)

201 patients on waiting list between 65-77 weeks (T&O, Community Dental, Maxillofacial and Gynaecology account for 75%)

Plans to Improve Control and Risks to Delivery

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 has taken place with approximately a 1-3% closure of pathways similar to that seen elsewhere.

• 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. 2 substantive posts start in the next month.

• 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- this project has no commenced

Corporate Risk ID	Strategic Ambition	Principle Risk:	Initial Rating	May Rating	June Rating	Target Rating
CRR61: ED 4-hour Standard	**Best Quality, Safest Care**	Risk of increased morbidity/ mortality for patients due to failure to meet the 4 hour standard	12	12	12	8

Key Targets

A&E 4 hour target to be met, 6 hour breaches <102 per month and 0 x 12 hour breaches

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%.

Current Position

The national ED 4 hour performance target has been met for April and May

12 Hour DTA and 12 hour total waits have seen a gradual reduction since Dec 22 from 165 to 5 and 431 to 30.

- May 2023 was a good month in terms of performance on all three of our key 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.
- The three bank holidays in May led to variation in performance and times of increased pressure, particularly when combined with other operational challenges including CT scanner downtime and breakdowns in the hospital lifts.
- The ED Minors stream is currently operating within Fit2sit due to ongoing closures and disruption associated with the building works.

Plans to Improve Control and Risks to Delivery

Support streaming with outreach work to improve streaming pathways to HDFT 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)
- The plans for improvement in performance are likely to take 3-6 months to address the different elements contributing to poor performance

The revised risk reduction target date reflects the timescale of implementing the new streaming model; the completion of phases 1 – 3 of the ED works (new workstation will open in March 2023, however disruption from building work expected until October 2023); and the impact of hospital occupancy and patient flow.

	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**		TBC at Trust Board July 23
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. This month CRR86 has been raised to the corporate risk register based on the principle risk arising from not delivering on the financial plan. However the risk will be reviewed by the director of finance to establish the lint of this risk with CRR76.					
Initial Date of Assessment	1st July 2022							
Last Reviewed	June 23							

Corporate Risk ID	**Strategic Ambition**	**Principle Risk:**	**Initial Rating**	**May Rating**	**June Rating**	**Target Rating**
CRR 71: Agency Usage	**Overarching**	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	15	15	15	9

Key Targets	**Current Position**	**Plans to Improve Control and Risks to Delivery**
1. Monthly agency ceiling performance 2. Weekly price cap compliance 3. Datix	The Trust is currently spending in excess of the agency ceiling. Reporting against the monthly agency return has been limited – internally this is well understand but from an external governance perspective improvements required. Agency oversight part of resource review directorate sessions. No datix reported as a result of agency staff not meeting substantive staff obligations.	1.Review at directorate resource review sessions 2.Substantive recruitment as per other risks 3.Nursing oversight to be embedded 4.Medical e-rostering to be implemented during 2023/24

Corporate Risk ID	**Strategic Ambition**	**Principle Risk:**	**Initial Rating**	**May Rating**	**June Rating**	**Target Rating**
CRR 76: Underlying Financial Position	**Overarching**	Underlying financial position – the Trust remains dependant on non-recurrent funding to achieve a breakeven position.	15	15	15	5

Key Targets	**Current Position**	**Plans to Improve Control and Risks to Delivery**
1. Monthly financial reporting 2. NHSE productivity analysis	The Trust has mitigated many of the above pressures through non recurrent means. Key drivers of underlying deficit include: 1. Underfunded acute bed capacity - £7m 2. Initial critical care capacity - £1m 3. Drugs previously described as pass through - £2m 4. Underfunded historic inflation - £6m The above assumes a funded pay award for all staff and a recurrent delivery of CIP – both are risks within directorate risk registers	**TBC**

Corporate Risk ID	Strategic Ambition	Principle Risk:	Initial Rating	May Rating	June Rating	Target Rating
CRR 86: Underlying Financial Position	**Overarching**	2023/24 financial position – likelihood of achieving the 2023/24 financial plan As part of finalising the 2023/24 financial plan the Trust ultimately set budgets to achieve a break even position. Added to this the Trust was then asked to stretch this and achieve a £6m surplus position. Both positions required significant savings and are therefore a risk.	20	20	20	15

Key Targets	Current Position	Plans to Improve Control and Risks to Delivery
1. Monthly financial reporting	Internal delivery of operational plan, currently an issue in relation to … 1. Operational deployment of Emergency Medicine expenditure 2. Non recurrent additional payments associated with additional work and doctors strike 3. Funding associated with maternity services 4. Pay award associated with 0-19 services 5. Local operational issues External prioritisation against ICB financial plan opposed to other funding priorities	**TBC**

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**	TBC at Trust Board July 23
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	June 23						

Corporate Risk ID	**Strategic Ambition**	**Principle Risk:**	**Initial Rating**	**May Rating**	**June Rating**	**Target Rating**	**Target Date**

Key Targets	**Current Position**	**Plans to Improve Control and Risks to Delivery**

Harrogate and District NHS Foundation Trust Corporate Risk Register June 2023

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**	TBC at Trust Board July 23
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	June 23						

Corporate Risk ID	**Strategic Ambition**	**Principle Risk:**	**Initial Rating**	**May Rating**	**June Rating**	**Target Rating**	**Target Date**

Key Targets	**Current Position**	**Plans to Improve Control and Risks to Delivery**

Board of Directors held in Public
26 July 2023

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

Purpose of the report and summary of key issues:	The Trust Board is asked to note the items contained within this report.	
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	Y
	Person Centred, Integrated Care; Strong Partnerships	Y
	Great Start in Life	Y
	At Our Best: Making HDFT the best place to work	Y
	An environment that promotes wellbeing	Y
	Digital transformation to integrate care and improve patient, child and staff experience	Y
	Healthcare innovation to improve quality	Y
Corporate Risks	None	
Report History:	A draft version of this report was presented to Senior Management Team earlier this month.	
Recommendation:	The Trust Board is asked to note the items contained within this report.	

Integrated Board Report - June 2023

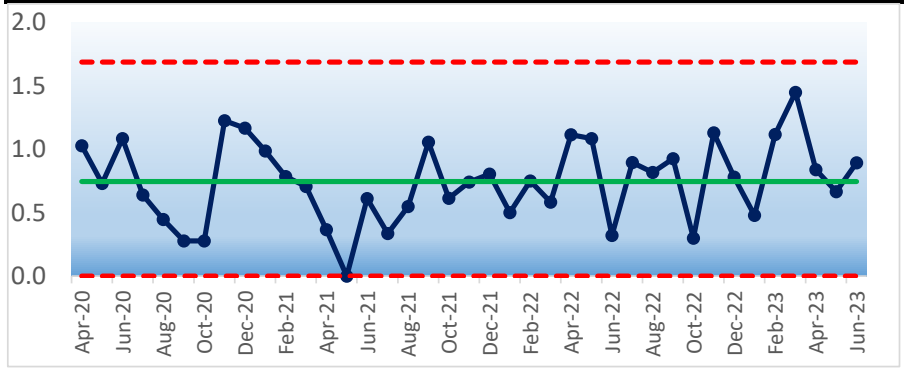
Domain 1 - Safe

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	Jun-23
Value / RAG rating	0.89

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 significant increase in HAPU reported in June 2023, with 50 pressure ulcers (all categories) reported via DATIX. 35 of these were reported as category 2 pressure ulcers and therefore not reviewed by TVN to ensure correct categorisation. The extreme weather conditions should be considered as a contributing factor for this increase as additional moisture caused by high temperatures can increase the risk of developing a pressure ulcer.

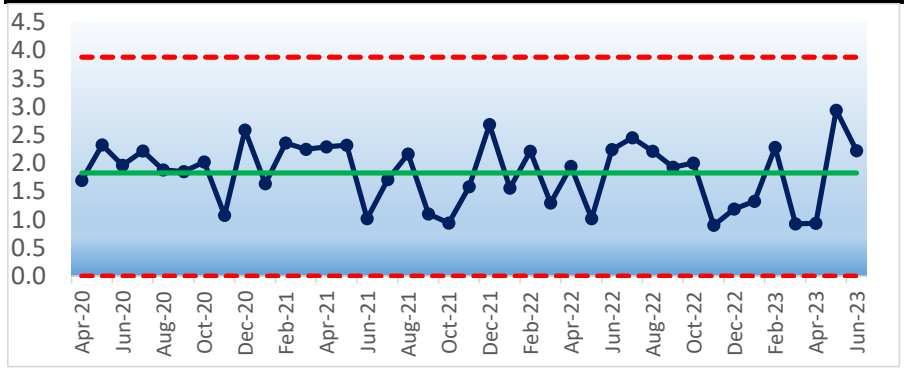
8 pressure ulcers were verified as category 3 or above, an increase from May 2023. Of these, 2 triggered the PULT process following review by TVN based on the levels of pain experienced by the patient. The outcome and identified learning from these reports will be disseminated to relevant areas to ensure meaningful learning. A significant increase in mucosal device related pressure ulcers was seen in June and work with the fundamentals of care team is underway to explore this and ensure education is in place across acute clinical areas.

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	Jun-23
Value / RAG rating	2.22

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 38 pressure ulcers (all categories) which developed or deteriorated in HDFT community care in June 2023 (reduction from May 2023). Of 38 CAPU, 14 were verified as category 3 or above. One incident triggered the PULT process, this report is underway to identify if any omissions in care led to the development or deterioration of pressure damage.

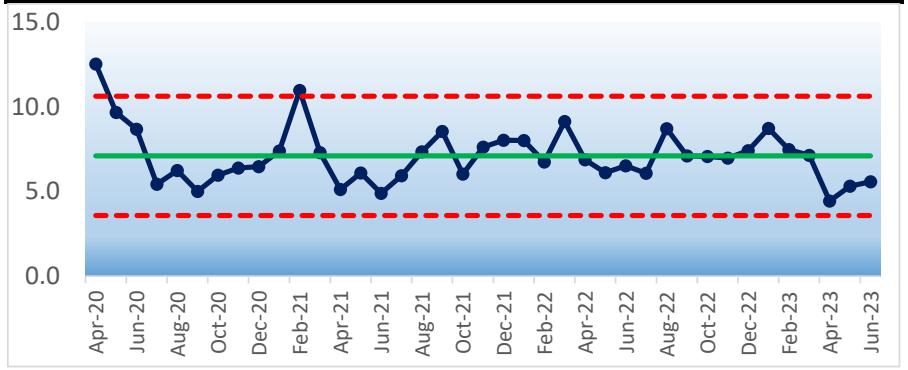
Capacity and skill mix continues to be a challenge across the CCTs and the TVN team have developed a rolling programme of wound care education to support new colleagues in community teams.

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	Jun-23
Value / RAG rating	5.6

Indicator description

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

SPC chart



Narrative

There has been a slight increase in falls this month. However we remain below the trust average of 7.2 and of the 57 falls reported, 42 of these were no harm.

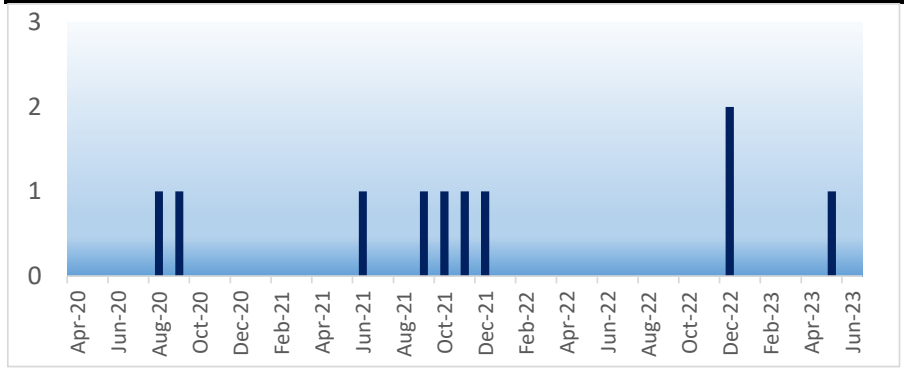
Falls training remains ongoing, and new on ward training is due to be commence w/c 17th July 2023, with a focus on the use of Bedrails, L/S BP and mobility assessments/ assessments for walking aids. This should help with improving deconditioning whilst in hospital and therefore is predicted to reduce the number of falls. L/S BP compliance continues to improve currently.

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	Jun-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 is a maximum of 26 hospital acquired cases - including avoidable, unavoidable and indeterminable causes.

Trend chart



Narrative

There was 1 hospital acquired cases of C.difficile reported in June. RCAs have been completed and agreed with the CCG for all 2023/24 cases to date. 1 May case was deemed to be avoidable with a contributory lapse in care related to inappropriate antibiotic prescribing. This is the first avoidable case reported in 2023/24.

HDFT's C. difficile trajectory for 2023/24 has now been confirmed as a maximum of 26 hospital acquired cases - including avoidable, unavoidable and indeterminable causes.

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	Jun-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

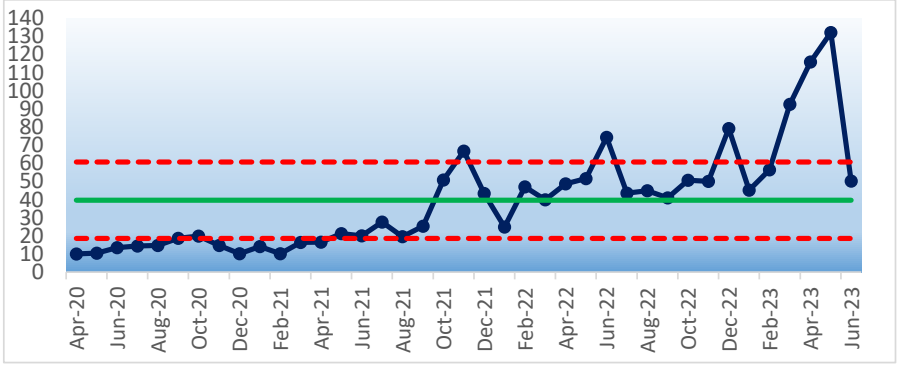
There were no hospital acquired MRSA cases reported in June.

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	Jun-23
Value / RAG rating	50.2

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, i.e. a higher rate for this metric is good.

SPC chart



Narrative

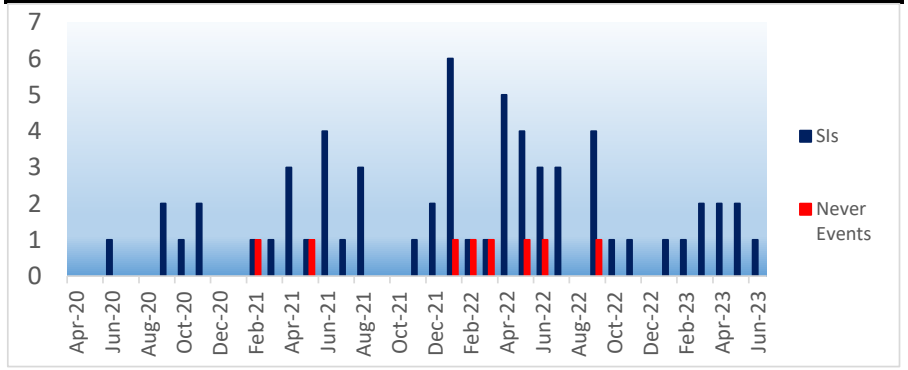
There has been a decrease in reporting no and low harm incidents throughout the month of June. However, we have seen an increase in our moderate and above incidents for June, therefore data continues to be reviewed at our Quality and Learning Summit.

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	Jun-23
Value / RAG rating	1 (SI), 0 (Never Events)

Indicator description

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

Trend chart



Narrative

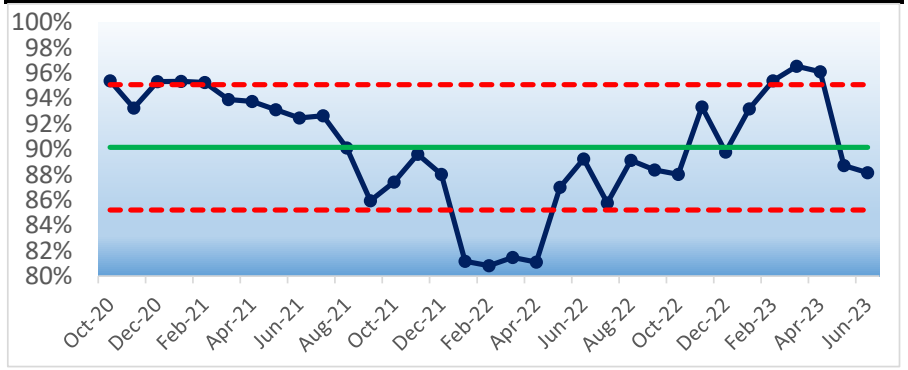
The Trust declared one serious incident in June. This is currently under investigation and was due for completion in September, however due to delay in appointing a lead investigator, an extension has been granted till October.

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	Jun-23
Value / RAG rating	88.2%

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

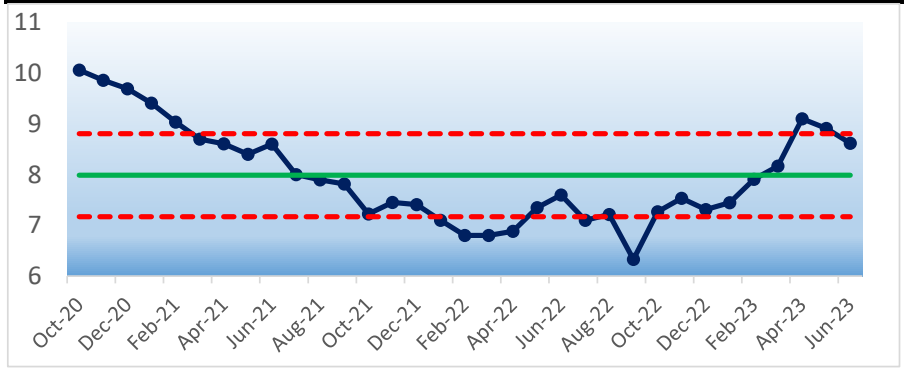
Realignment of budgets and establishment have helped to improve fill rates . Good pick up from NHSP along with improving rostering behaviours.

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	Jun-22
Value / RAG rating	8.62

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

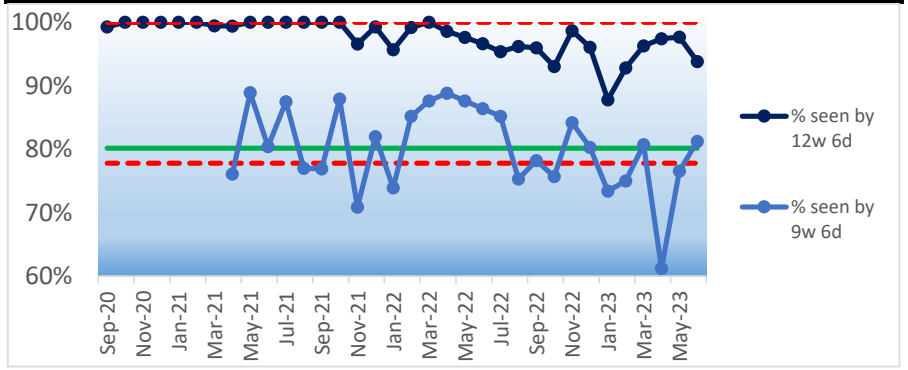
CHPPPD continues to stabilise following the output of the SNCT and the newly budgeted establishments. Reduced bed occupancy throughout June has enabled the CHPPD to stabilise.

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	Jun-23
Value / RAG rating	93.8%

Indicator description

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

SPC chart



Narrative

Variation is continuing to be seen as a result of the issues with the medical clerks working in antenatal clinic. SOPs have been developed and additional staff have been allocated to overcome the backlog of women needing allocation to an appointment. Staffing issues over the coming weeks due to annual leave have been arranged to be covered by clinincal staff. The medical records clerks are currently under consultation and it is hoped that the resolution of this will assist in continuing to move the service forward.

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	Jun-23
Value / RAG rating	5.0%

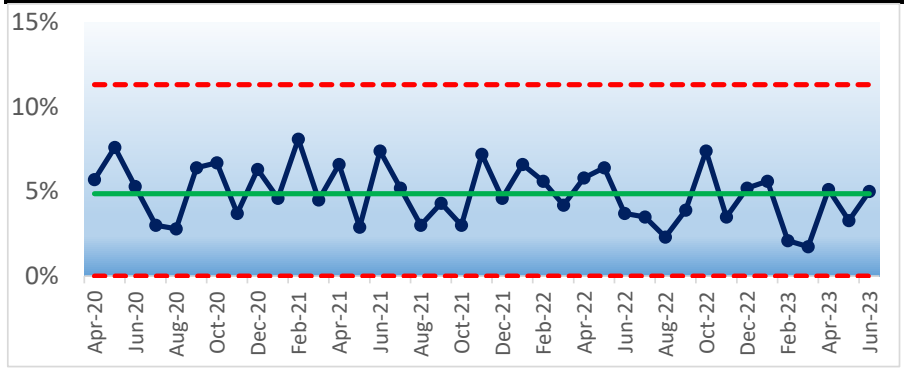
Indicator description

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

Narrative

The smoking at birth rates are continuing to show normal variation. Over 76% of midwives have been trained in offering 'very brief advice'. The Public Health Specialist Midiwfe is now in post and working closely with the HDFT Project Manager for Tobacco Dependency and Livingwell Health to continue to improve our stop smoking offer.

SPC chart

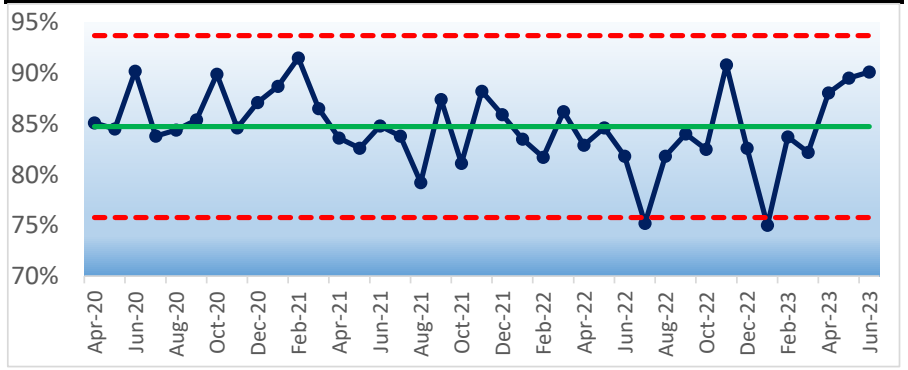


Indicator	**1.12 - Maternity - % women initiating breastfeeding**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Jun-23
Value / RAG rating	90.1%

Indicator description

The % of women initiating breastfeeding

SPC chart



Narrative

The % of women initiating breastfeeding at birth is at a high level, although this continues to see normal variation. Staff audits and training have been completed recently. There has been a move back to face to face training following it being identified via audit that staff who had only received online training since starting with the Trust had less robust knowledge. This improved staff training is hopefully positively impacting the current position.

Indicator	**1.13 - VTE risk assessment - inpatients**
Executive lead	Jacqueline Andrews, Medical Director
Board Committee	Quality Committee
Reporting month	Jun-23
Value / RAG rating	94.6%

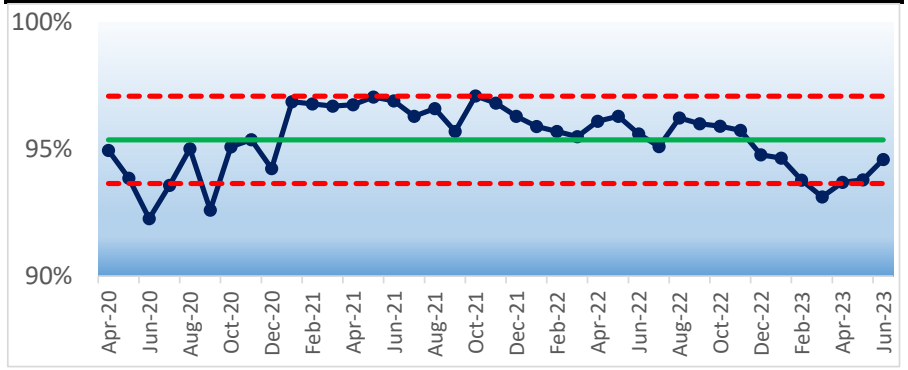
Indicator description

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

Narrative

Ongoing work to digitise the recording of VTE assessment - inpatient digital records due to be implemented from Sep-23.

SPC chart

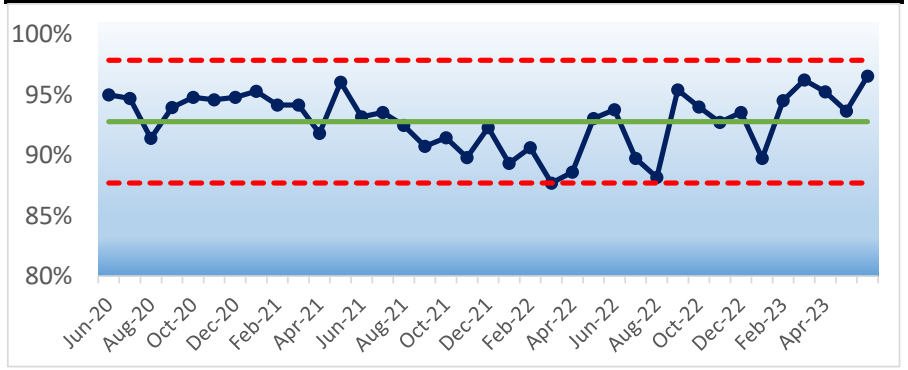


Indicator	**1.14 - Sepsis screening - inpatient wards**
Executive lead	Emma Nunez, Executive Director of Nursing, Midwifery & Allied Health Professionals
Board Committee	Quality Committee
Reporting month	Jun-23
Value / RAG rating	96.5%

Indicator description

The percentage of eligible inpatients who were screened for sepsis.

SPC chart



Narrative

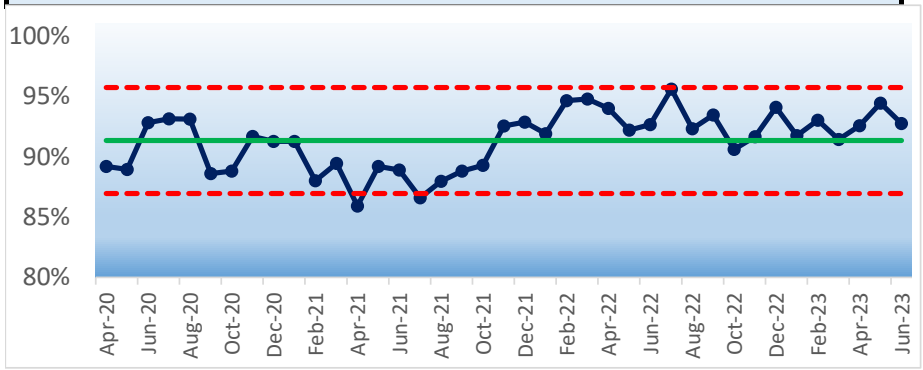
Remains consistently within control limits and performing above target.

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	Jun-23
Value / RAG rating	92.7%

Indicator description

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

SPC chart



Narrative

Remains consistently within control limits and performing above target.

Integrated Board Report - June 2023

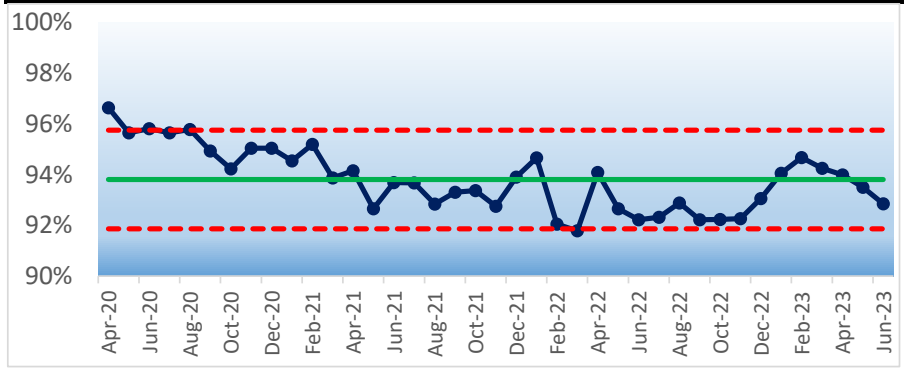
Domain 2 - Caring

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	Jun-23
Value / RAG rating	92.8%

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 remain mostly steady.

Positive comments from the FFT in June describe staff as attentive, dedicated, welcoming and supportive. Patient's described their care as exceptional and felt well looked after. They described the environment as caring.

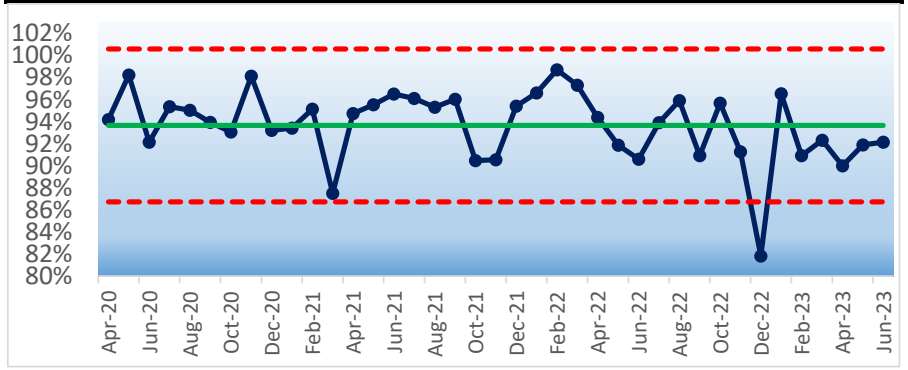
Less positive comments received via the FFT related to the relocation of the Phlebotomy department, parking, wayfinding and waiting times.

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	Jun-23
Value / RAG rating	92.1%

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

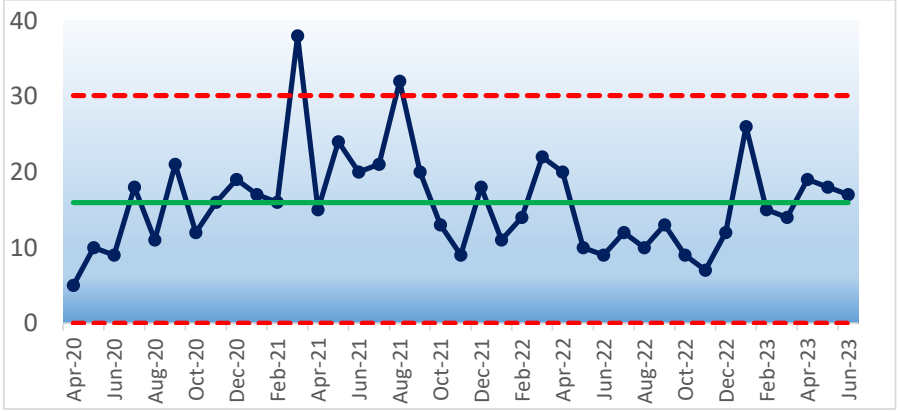
The response rate remains steady

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	Jun-23
Value / RAG rating	17

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

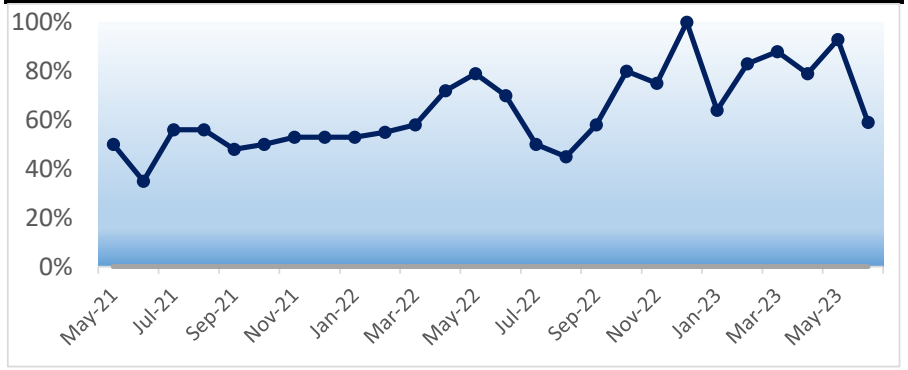
In total, there were 17 standard complaints received in June 23. 6 complaints came under Community and Children's, 7 complaints came under Long Term and Unscheduled Care and 4 complaints came under Planned and Surgical Care.

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	Jun-23
Value / RAG rating	59%

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

June saw a drop in complaints responded to in time compared to recent months, with 59% of monitored complaints responded to in time. This was due to a number of late responses into PET and two cases requiring further work that were returned to the directorates.

Integrated Board Report -June 2023

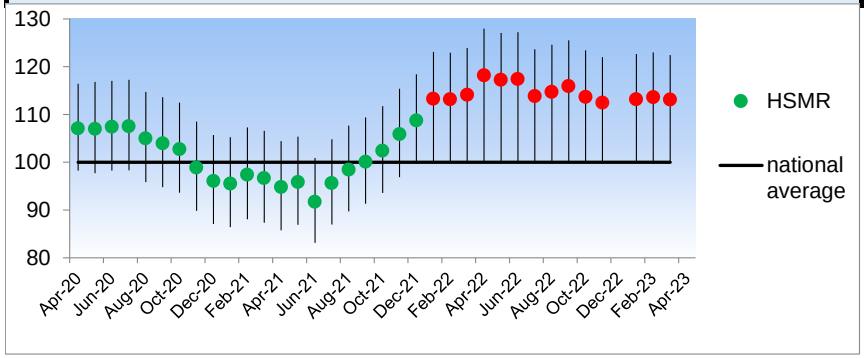
Domain 3 - Effective

Indicator	**3.1 - Hospital Standardised Mortality Ratio (HSMR)**
Executive lead	Jacqueline Andrews, Medical Director
Board Committee	Quality Committee
Reporting month	Mar-23
Value / RAG rating	113.12

Indicator description

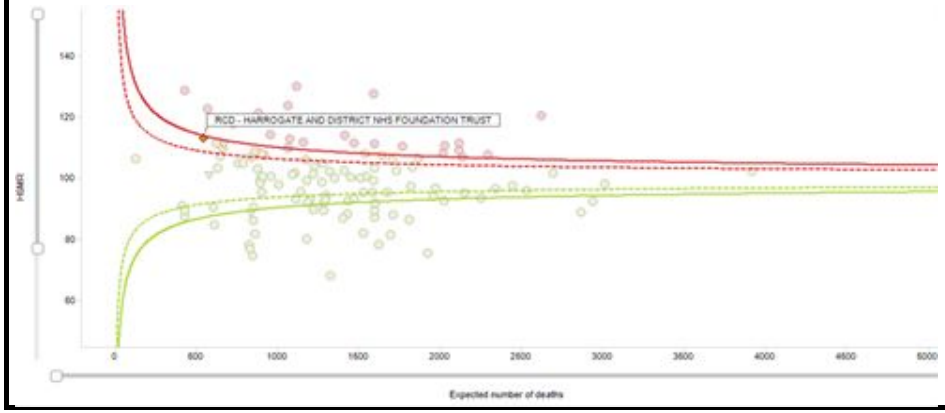
The HSMR looks at the mortality rates for 56 common diagnosis groups that account for around 80% of in-hospital deaths and standardises against various criteria including age, sex and comorbidities. The measure also makes an adjustment for palliative care.

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. HDFT's mortality data will be discussed in more detail in the quarterly Learning from Deaths paper.

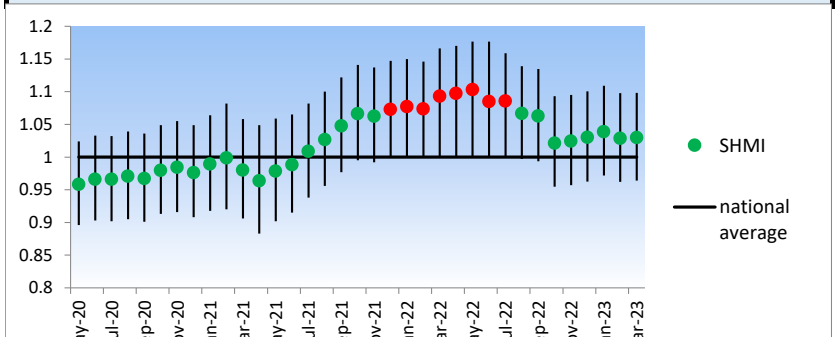


Indicator	**3.2 - Summary Hospital Mortality Index (SHMI)**
Executive lead	Jacqueline Andrews, Medical Director
Board Committee	Quality Committee
Reporting month	Mar-23
Value / RAG rating	1.029

Indicator description

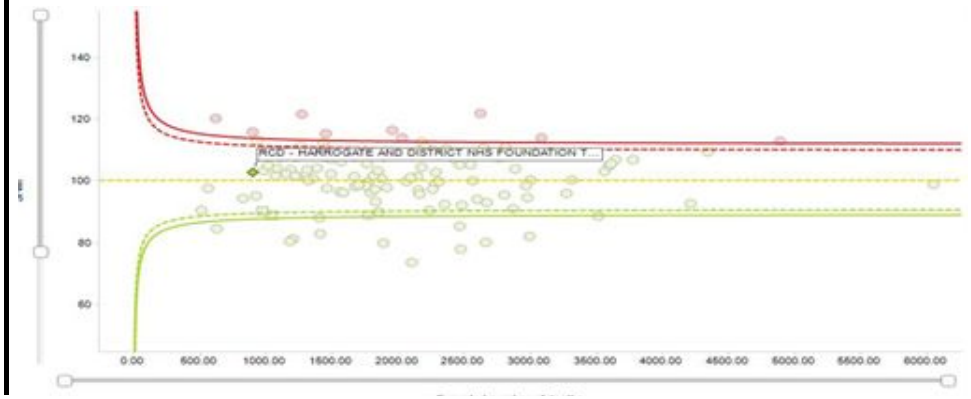
The SHMI looks at the mortality rates for all diagnoses and standardises against various criteria including age, sex and comorbidities. The measure does not make an adjustment for palliative care.

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. HDFT's mortality data will be discussed in more detail in the quarterly Learning from Deaths paper.

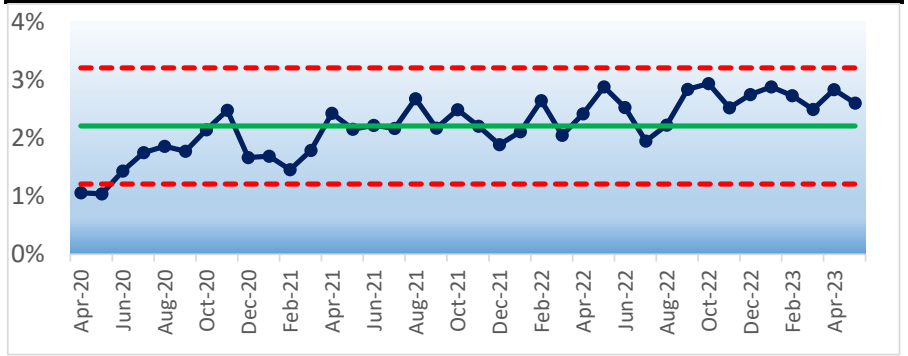


Indicator	**3.3.1 - Readmissions to the same specialty within 30 days - following elective admission**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	May-23
Value / RAG rating	2.6%

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

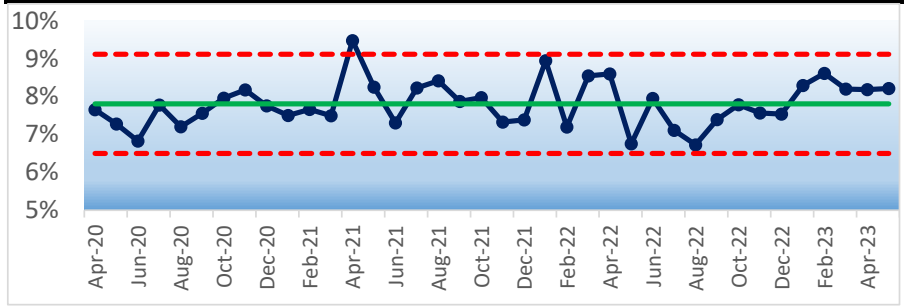
Readmissions following an elective admission decreased to 2.6% in May and remain within control limits and less than national average.

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	May-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 remained at 8.2% in May, within the control limits.

Indicator	**3.4 - Returns to theatre**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	May-23
Value / RAG rating	13

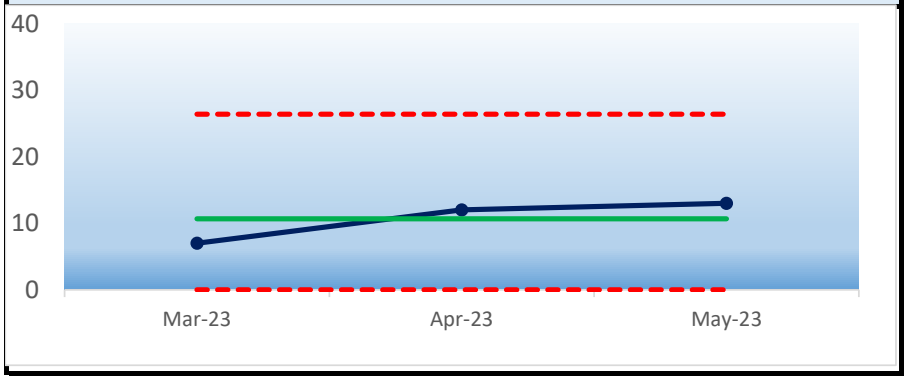
Indicator description

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.

Narrative

A process has been developed that will allow us to report on this metric going forward. May data has been reviewed and 13 cases of unexpected returns to theatre within 30 days were identified.

SPC chart

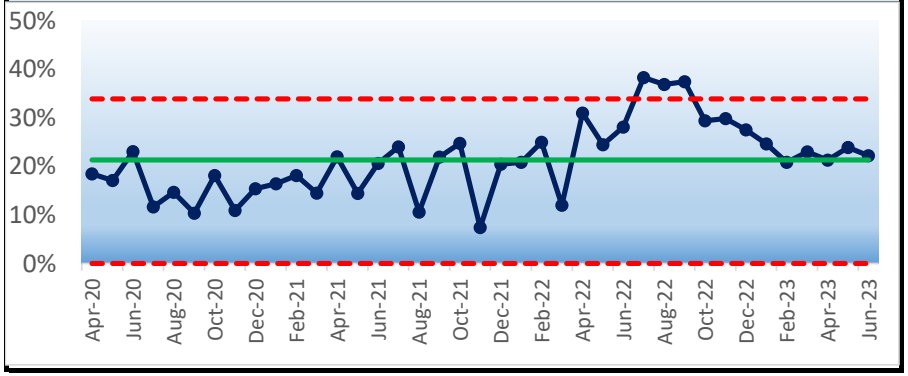


Indicator	**3.5 - Delayed transfers of care**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Jun-23
Value / RAG rating	22.2%

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

22% of inpatients did not meet the criteria to reside when the snapshot was taken in June, 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.

INFECTION PREVENTION & CONTROL ANNUAL REPORT

2022/23

Contents

Abbreviations

HCAI Healthcare associate infection

IPCT Infection Prevention and Control Team

DIPC Director Infection Prevention Control

IPCC Infection Prevention Control Committee

QGMG	Quality Governance Management Group
QC	Quality Committee
SMT	Senior Management Team
IBR	Integrated Board Report
APSG	Antimicrobial Prescribing Sub-Group
APC	Area Prescribing Committee
CEF	Clinical Effectiveness Forum
MRSA	Meticillin Resistant Staphylococcus Aureus
MSSA	Meticillin Sensitive Staphylococcus Aureus
UKSHA	UK Security Heath Agency
NHSE	National Health Service Executive
LTUC	Long Term Unscheduled Care
HiF	Harrogate Integrated Facilities
CC	Children and County Wide
PSC	Planned and Surgical Care

1.0 Introduction

Harrogate and District NHS Foundation Trust recognises that effective prevention of healthcare associated infections (HCAI) is essential to ensure that patients using our services receive safe and effective care. Effective infection prevention and control must be an integral part of everyday practice and applied consistently to ensure the safety of our patients.

This annual report covers the period 1st April 2022 to 31st March 2023 and has been written in line with the ten criteria outlined in the Health and Social Care Act 2008 Code of Practice in the

Prevention and Control of infection (updated 2015). The ten criteria outlined in the code are used by the Care Quality Commission to judge a registered provider on how it complies with Cleanliness and Infection Prevention & Control requirements detailed in the legislation.

The ten criteria of the Health Act are below and will be discussed in more detail in the next section of this report.

Criterion	Detail
1	There are systems to monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other may pose to them
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections
3	Ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events of antimicrobial resistance
4	Provide suitable accurate information on infections to service user, their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion
5	Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people
6	Systems to ensure that all care workers including contractors and volunteers are aware of and discharge their responsibilities in the process of preventing and controlling infection
7	Provide or secure adequate isolation facilities
8	Secure adequate access to laboratory support as appropriate
9	Have and adhere to policies designed for the individuals care and provider organisations that will help to prevent and control infections
10	Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection

2.0 Criterion 1

There are systems to monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other may pose to them

Infection Prevention and Control Team

The Infection Prevention and Control Team (IPCT) provided advice on all aspects of infection prevention and control (IPC) to the Trust Directorates, wards, departments and Harrogate Integrated Facilities (HIF). This year has been one of transition as the healthcare system adjusted to *living with COVID-19.* There has been a gradual return to pre-pandemic healthcare operating systems.

The Director of Infection Prevention and Control (DIPC) has overall responsibility for the IPC team, this role is undertaken by the Medical Director. The DIPC is supported by the Deputy DIPC, this role is undertaken by the Deputy Chief Nurse. The Matron for IPC manages the IPC team. A Consultant Microbiologist works for the IPC team on a part-time basis as the Infection Prevention and Control Doctor (IPCD). In addition to the IPCD, three other Consultant Microbiologists continue to provide support to the IPC team. There have been no significant personnel changes this year.

The structure for the IPCT is shown in Appendix 1.

External Reviews

There have been no external reviews of the IPCT during the 2022/23 period.

Infection Prevention and Control Committee

The Trust Infection Prevention and Control Committee (IPCC) is held monthly and is chaired by the DIPC. (Appendix 2 – Terms of Reference for IPCC, Appendix 3 - meeting record for 2022/23). The IPCC is responsible for maintaining the IPC Board Assurance Framework and the IPC risk register. The IPCC is responsible for the monthly review of IPC performance across the Trust. (Appendix 4 – IPC Board Assurance Framework)

The IPCC reports to Quality Committee (QC), which is chaired by a Non-Executive Director (NED). Infection Prevention and Control is a standing agenda item at this committee and IPC are represented by the DIPC. QC has responsibility for obtaining assurance that the Trusts IPC service is meeting the Standards set out in the Code of Practice. Assurance is provided through the monthly IPC report and Trust Integrated Board Report (IBR).

IPCC is also directly linked into the Quality Governance Management Group (QGMG). The monthly IPC report is presented at this meeting.

The IPC service is provided through a structured annual programme of work, which includes expert advice to staff, patients and visitors, audit, education, training, surveillance, policy development and review. The annual work plan is developed to address gaps in the IPC Board Assurance Framework and is agreed by the IPCC. (Appendix 5)

The majority of the intended plan of work has been delivered. There are still some policies which require routine review and transferring to the new Trust procedure template. The review of these policies do not involve significant changes to the content. There is a major piece of work to do around asepsis training and assurance, the scope of this work is far greater than anticipated and so will become the main project for 2023-24.

Trust Board

The code of practice requires that the Trust Board has a collective agreement recognising its responsibilities for Infection Prevention and Control. The Chief Executive has overall responsibility for the control of infection at the Trust. The Trust has a designated DIPC and this role is undertaken by the Medical Director who attends Trust Board meetings with detailed updates on IPC performance and matters.

Antimicrobial Prescribing Sub-Group (APSG)

The Antimicrobial Prescribing Sub-Group (APSG) is a multidisciplinary group responsible for the monitoring and review of good antimicrobial stewardship within the Trust. The group meets bi-monthly and is Chaired by the Trust Lead for Antimicrobial Stewardship. The Antimicrobial Medicines Code describes the Trusts policy for antimicrobial stewardship. APSG is responsible for monitoring and auditing compliance with prescribing guidance and post-prescribing reviews. To realign the antimicrobial stewardship work more closely with IPC, APSG now reports directly to IPCC. APSG produces a biannual report to the IPCC demonstrating compliance with the Code of Practice.

Decontamination Committee

The Trusts Decontamination Lead is the Chief Operating Officer. The management of Decontamination and compliance is overseen by the Decontamination Committee which also now reports directly to IPCC. The Chair of the Decontamination Committee produces a quarterly assurance report for IPCC.

Water and Ventilation Safety Group

The Trust has a multi-disciplinary Water and Ventilation Safety Group. It is chaired by the Deputy Director of Estates and meets bi-monthly. The IPCD represents the IPCT on this group. This group produces a quarterly assurance report for IPCC.

Harrogate Integrated Facilities (HIF): Cleanliness and Estate Services

Harrogate Integrated Facilities is a wholly owned subsidiary of Harrogate and District NHS Foundation Trust (HDFT). Cleaning and maintenance of the patient environment is the responsibility of HIF. The Trust has implemented the National Standards for Cleanliness.

Infection Prevention and Control Assurance

To demonstrate compliance with the Trust IPC policies there is an IPC programme of audit in place. The audits are undertaken by both the clinical and IPC teams and are summarised in the table below. Compliance with completion of the monthly audits (especially the general IPC audit) had been challenging but for the last quarter of 2022-2023 compliance across all three audits was in excess of 90%.

Table 1.0

Audit	**Completed**	**Average Overall score April 2022 –March 2023 (all directorates)**
General IPC Inspection (including hand hygiene)	Monthly	94%
Commode	Monthly	98%
Cannula Insertion	Monthly	88%

Audit results are reviewed at the monthly IPC team meeting. Where issues are identified an action plan is devised by the IPCT and fed-back to the Matron and Ward/Department Manager. Wards/Departments of concern are escalated to the IPCC.

Compliance with the completion of the monthly audits has improved significantly over the last year and are sustained at >90% for all three directorates.

Hand Hygiene Audits

Hand hygiene audits are included in the monthly general IPC inspection which includes staff and patient hand hygiene, the overall score from April 2022 – March 2023 was 97%

Healthcare Associated Infection Surveillance (including mandatory reporting)

The IPC team monitors all alert organisms (defined as organisms of IPC significance). This is currently a very manual and time consuming process, involving daily lists generated by the Microbiology Laboratory which are emailed to the IPC team. The Trust does not have an automated surveillance system which would be a more efficient system for tracking patients and infections across the Trust. A business case is under development for ICNet which would provide the team with a single management and surveillance system.

(summary of HCAI trends this year compared to last year)

COVID-19

COVID-19 continued to challenge both the Trust and IPC team throughout 2022-2023. The focus changed with COVID-19 becoming endemic within the population and much of the work this year has been around safely returning to "*normal*" operational systems. There has been a much greater

emphasis on protecting those most vulnerable to severe disease. The IPC team continue to work closely with the site management team optimising safe flow and placement of patients.

Other work the IPC have undertaken in relation to COVID-19 includes:

- Responding to NHSE updated guidance on testing, PPE and management of staff infection, prompt review and implementation of changes has been undertaken.
- Support and advice to individual services and departments to help them implement the COVID-19 guidance according to their specific needs.
- Support and advice to Line Managers and Staff in order to reduce the risk of cross infection between staff.

Clostridioides difficile

Clostridioides difficile (*C.difficile)* is a bacterium found in the gut which can cause diarrhoea after receiving antibiotics, particularly broad spectrum antibiotics. It can rarely cause a severe and life-threatening inflammation of the gut called pseudo-membranous colitis. The bacterium is capable of forming spores which are very resistant and can survive in the environment for prolonged periods of time. The spores require effective (sporicidal) cleaning products to remove them from the environment and prevent transmission to others.

The Trust reports all cases of *C.difficile* diagnosed in the laboratory to Public Health England via the national Data Capture System (DCS). Every Trust is given a threshold level which it should not exceed over the course of one year. The Harrogate threshold level for *C.difficile* in 2022/23 was 40.

At the end of March 2023 there were 27 cases of *C.difficile* apportioned to the Trust. This means we came under our threshold by 13 cases. All 27 cases were subject to a post-infection review (PIR). The majority of cases (92.6%) were deemed to be unavoidable. PIR's are presented to the ICB on a monthly basis. It is the role of the ICB to determine if there have been any lapses in care. There are two types of lapses in care, 1. Contributory lapse in care, this is where as a result of inappropriate action (usually inappropriate antimicrobial prescribing or patient placement) the patient has acquired *C.difficile*. 2. Non-contributory lapse in care, this is where our action has not directly resulted in the acquisition of *C.difficile* infection but it did not represent "best" care. The total number of healthcare associated cases has reduced from the previous year with a small reduction in the number of avoidable cases and small increase in the unavoidable cases.

Table 2.0

ICB Decision	Number (%) 2022-2023	Number (%) 2021-2022
Avoidable	2 (7.4%)	4 (11%)
Unavoidable	25 (92.6%)	33 (89%)

Table 3.0

Lapse in care (avoidable cases)	Number (%) 2022-2023	Number (%) 2021-2022
Inappropriate antibiotic prescribing	2 (100%)	4 (100%)

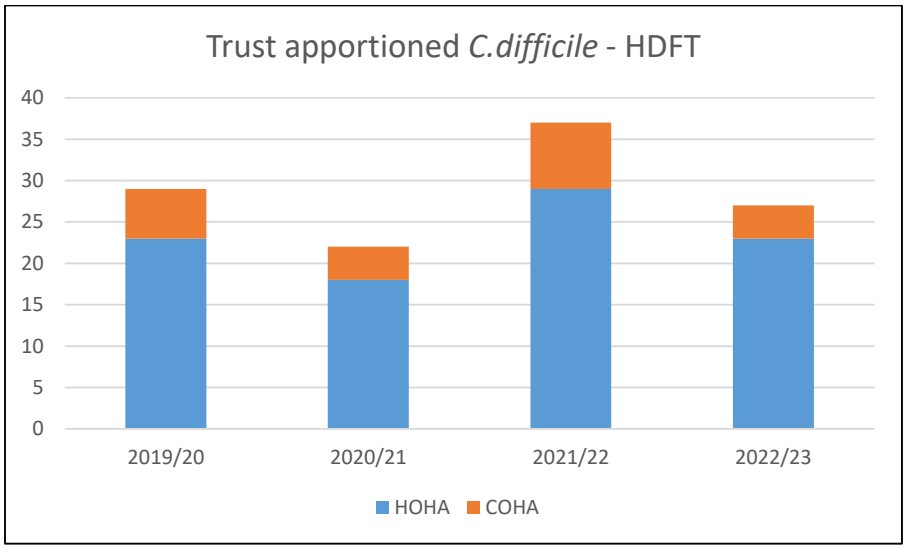
Table 4.0

Lapse in care (unavoidable cases)	Number (%)	Number (%)

	2022-2023	2021-2022
Delay in stool sampling	9 (36%)	13 (38%)
Delay in isolation	7(28%)	10 (29%)
Delay in starting C.diffiicle treatment	4 (16%)	2 (6%)

*some cases have more than one type of lapse in care.

Figure 1.0



There is continuous work by the IPC team to reduce the cases *of C.difficile*. This relies on the prompt identification, sampling and isolation of patients with loose stools and the appropriate use of antimicrobials. *C.difficile* diagnosis continues to be a major focus of the IPC education programme.

There have been no instances of known patient to patient transmission of *C.difficile* or outbreaks of *C.difficile*.

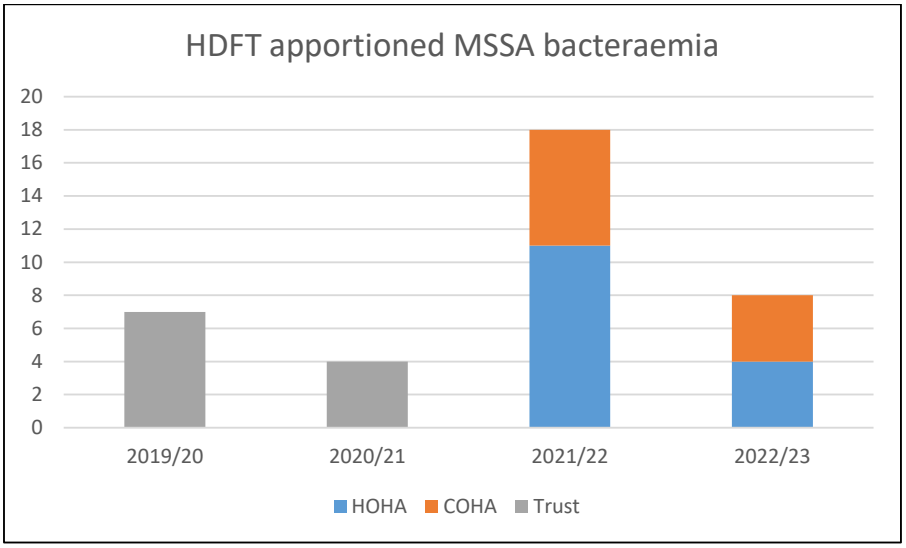
MRSA bacteraemia

In 2022/23 there were two trust apportioned MRSA bacteraemia's, both were community onset-hospital acquired cases (COHA). The threshold level for MRSA bacteraemia for all Trusts in England is zero. Post infection review was undertaken for both cases and presented to the ICB. The outcome decision for both cases was – No contributory lapse in care identified.

MSSA bacteraemia

MSSA (methicillin sensitive *Staphylococcus aureus*) is the much more common and antibiotic sensitive version of Staphylococcus aureus and less likely to be hospital acquired. 8 MSSA bacteraemia's were apportioned to the Trust in 2022/23, this is a significant reduction on the previous year. There is no national threshold for MSSA bacteraemia.

Figure 2.0



Gram negative bloodstream infections

There are three Gram negative organisms that are monitored. *E.coli, Klebsiella sp* and *Pseudomonas aeruginosa*. Thresholds for Gram negative bacteraemia were introduced for the first time this year. A significant reduction in the number of E.coli bacteraemia's has been observed this year with the majority of cases remaining community in onset. There has been a slight increase in the number of *Klebsiella* bacteraemia's, this trend has been seen in other hospitals across the region, the explanation for this is not clear. Post infection review of the HOHA cases did not reveal any common themes or contributory lapses in care. The number of Pseudomonas aeruginosa bacteraemia's has remained stable.

Figure 3.0

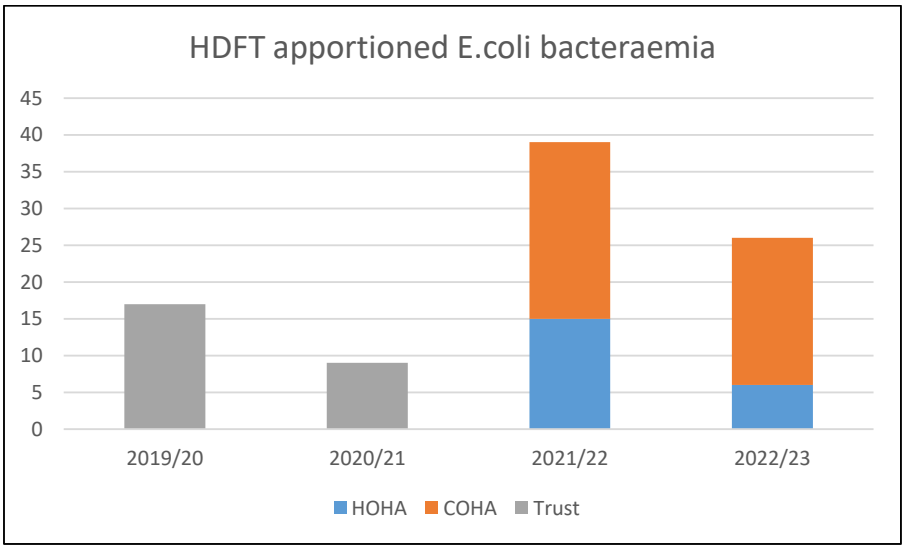


Figure 4.0

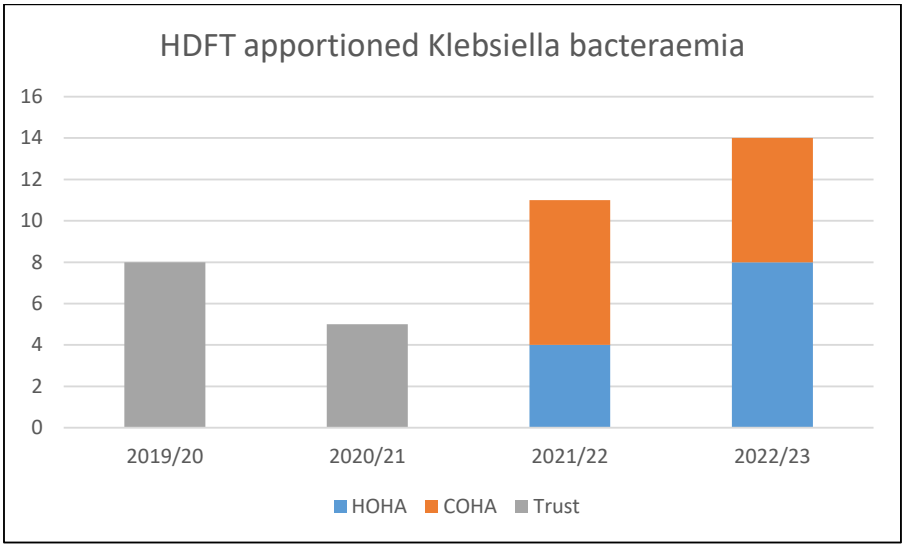
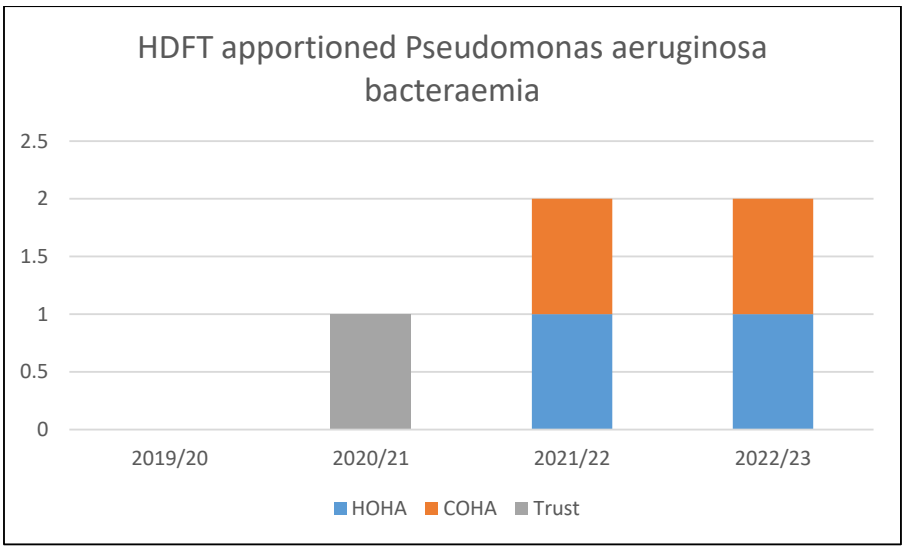


Figure 5.0



Carbapenemase producing Enterobacteriaceae (CPE) cases

CPE are Gram negative bacteria which are so resistant to antibiotics that even our last line of defence, carbapenem antibiotics are ineffective. It is therefore extremely important to detect patients carrying these bacteria and prevent spread through isolation and cleaning. The Trust has a policy on the screening and management of patients with CPE which reflects the guidance produced by UKHSA. HDFT has a very low incidence of CPE and zero new cases were detected in 2022/23.

3.0 Criterion 2

Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections

The cleaning provided at HDFT for all clinical and non-clinical areas is the responsibility of Harrogate Integrated Facilities (HIF) and completed by the in-house Domestic Services team,. Domestics are responsible for ensuring that cleaning is performed in accordance with standard operating

procedures. All Domestic staff play an essential role in ensuring the Trust reduces hospital acquired infections. This year the Trust has successfully implemented the National Standards for Cleanliness. Audit results are presented monthly to the IPCC.

Cleanliness assurance

Role of the Domestic Supervisor –The Domestic Supervisors undertake weekly quality monitoring of the hospital wards and departments. The Matron walkabouts undertaken with the Domestic Supervisors are undertaken monthly.

NSC Cleanliness figures 2022/23:

Q1	Q2	Q3	Q4
97.7%	98.2%	98.1%	95.9%

The IPC Team also have a role in the provision of cleanliness assurance. The monthly general IPC audit includes sections to monitor compliance with the standard of cleanliness. This provides additional and *out of team* scrutiny to the NSC audits.

Deep Cleans

The Trust has an agreed list of circumstances / infections where a deep clean is required of a bed space or bay. When a patient has an infection identified on the list the requirement for a deep clean on discharge or transfer is discussed with the ward and site coordinator. On discharge or transfer the IPC Team, Ward or Site Coordinator arrange the deep clean with the Domestic Supervisor.

Number of deep cleans carried out 2022/23 was 6962 a decrease from the previous year which reflects the reduced burden of COVID-19.

4.0 Criterion 3

Ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events of antimicrobial resistance

Antimicrobial Prescribing Sub-Group (APSG)

This group includes representation from pharmacy, microbiology, nursing and medical staff in both primary and secondary care. Its remit is to oversee the use of antimicrobial agents within the trust and promote prudent, safe and cost-effective prescribing of these drugs.

Assurance reports are received by IPCC on a biannual basis and are mapped to the code of practice criteria. APSG also produce an annual report.

Annual Report of the Antimicrobial Prescribing Subgroup 2022-23

The purpose of this annual report is to provide assurance that this group is working effectively within its terms of reference and achieving the required outcomes and impact.

Remit of the Group

To oversee the use of antimicrobial agents within the Trust and promote prudent, safe and cost-effective prescribing of these drugs.

Meetings held, membership and attendance

Title	June 2022	Sept 2022	Nov 2022	Jan 2023	March 2023
Consultant Microbiologist (Chair)	✓	✓	✓	✓	✓
Director of Pharmacy (Deputy Chair)	Apologies	Apologies	✓	✓	✓
Director of Infection Prevention & Control	Omitted from e-mail distribution list				
Antimicrobial Pharmacist	✓	✓	✓	✓	✓
Chair of MTG	✓	✓			
CCG Pharmacist	✓	✓	✓	✓	✓
CCG Lead General Practitioner	Unable to attend				
Lay Representative	Apologies	✓	✓	✓	✓
Directorate Antimicrobial Link Physicians			✓	✓	
Junior Doctor(s)	✓	✓	Apologies	✓	Apologies
Nursing Representative	✓		✓	✓	Apologies

Terms of Reference

Reviewed in September 2022; next due for review September 2024.

Key Areas of Responsibility

1. Development and implementation of evidence-based guidelines for antimicrobial use.
2. Monitoring antimicrobial use and compliance with guidelines within the Trust through a programme of audit.

3. Development of education and training resources for antimicrobial stewardship (AMS) and the means to deliver them.
4. Identification of antimicrobial agents for restricted use only and monitoring to ensure there is compliance with restriction policies.
5. Review of root cause analyses following cases of *Clostridioides difficile* infection.
6. Reviewing trends in local antimicrobial resistance patterns as well as data on prevalence of selected multi-resistant bacteria.
7. Encouraging and, wherever possible, supporting good antimicrobial prescribing in primary care settings.

Summary of Work during 2022/23

1. <u>Development and implementation of evidence-based guidelines for antimicrobial use.</u>

Revisions to antimicrobial guidelines:

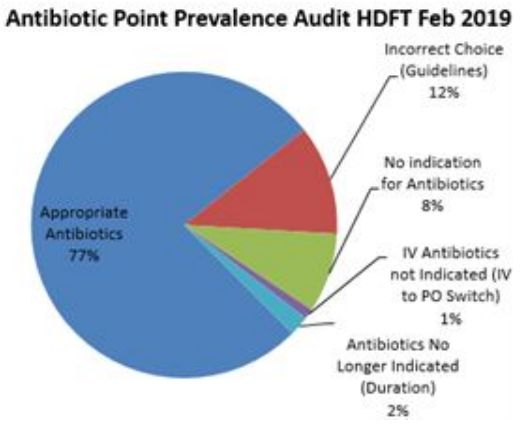
- Change to first and second line therapy for prosthetic joint infection
- Extended interval gentamicin protocol expanded to include required action in the event of missed levels
- Addition of guidelines for management of influenza, and prophylaxis for patients exposed to influenza
- Change to first line orthopaedic arthroplasty surgical prophylaxis

The AMS Lead contributed to a community prescribing pathway for non-diabetic foot ulcers.

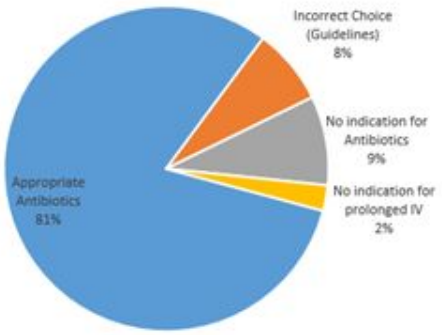
2. **<u>Monitoring antimicrobial use and compliance with guidelines within the Trust through a programme of audit.</u>**

Trust-wide antibiotic point prevalence audit, September 2022 and April 2023 (Antimicrobial Stewardship Team)

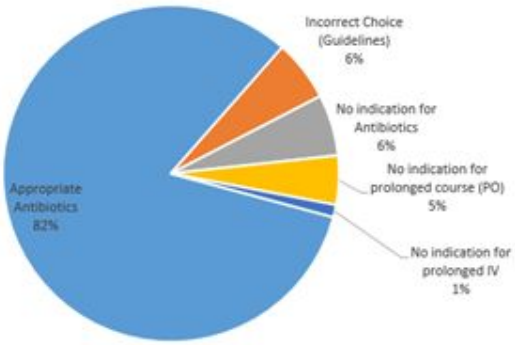
All inpatient antibiotic prescriptions were reviewed on a given day. The results demonstrate appropriate prescribing in over 80% of cases; this is a slight improvement from earlier audits.



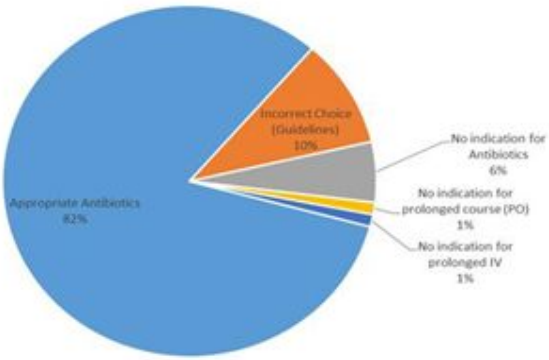
Antibiotic Point Prevalence Audit HDFT May 2021



Antibiotic Point Prevalence Audit HDFT March 2022



Antibiotic Point Prevalence Audit Sept 2022



Report for April 2023 awaited

Antibiotic Prescribing in ED, October 2022 (Pre-Registration Pharmacist)

Data was collected over a two week period (November 2021) using ePMA and WebV to determine which antibiotics were prescribed for patients admitted through ED, and the documented indication. 39% of admitted patients were prescribed antibiotics in ED and 75% of those prescriptions were in line with Trust guidelines.

Key successes

- The majority of prescribing was in accordance with guidelines

Key Concerns

- 25% of prescribing was not according to guidelines
- Prescribing according to penicillin allergy despite no allergies being recorded
- Prescribing only two agents of a triple therapy regimen

Recommendations

- Send the report to all staff working in the ED department to make them aware of the findings
- Signpost prescribers to the guidelines and suggest they download the MicroGuide™ app on to their personal phones to make the guidance more easily accessible
- Create an information bulletin which can be put in various areas of the hospital to help remind prescribers to use and familiarise themselves with the guidelines

The ED junior and middle grade doctor AMS teaching has been arranged for August 2023.

Urology antibiotic prophylaxis audit, September 2022 (Urology Junior Doctor and Clinical Effectiveness Facilitator)

Retrospective review of notes of patients who had surgery in a 2 week period in May 2022. 91% of prophylactic antibiotics prescribed according to guidelines. 29% were prescribed on ePMA.

Key successes

- Antibiotic prophylaxis was administered appropriately on most occasions i.e. correct indication, antibiotic, and dose.

Key Concerns

- Antibiotic prophylaxis was prescribed on ePMA for very few patients. This is consistent with other specialties and previous cycles of the audit.

Recommendations

- Re-audit by June 2023

General Surgery Antibiotic Prophylaxis Audit (September 2022, Surgical Junior Doctor and Clinical Effectiveness Facilitator)

Retrospective review of surgical prophylaxis for all patients admitted under General Surgery in June 2022. Prophylaxis was prescribed for 100% of patients for whom it was indicated. Antibiotic prophylaxis was prescribed for 26% of patients for whom it was not indicated. Overall 86% of patients were administered antibiotics according to guidelines.

Key successes

- Where indicated, antibiotic therapy was prescribed in 100% of cases
- The choice of agent was consistent with guidelines in 92% of cases
- 87% of antibiotic prophylaxis was administered using the correct dose
- 81% of antibiotic prophylaxis was prescribed on ePMA

Key Concerns

- Prophylaxis was prescribed for over one quarter of patients for whom it was not indicated

Recommendations

- Re-audit by June 2023
- AMS Lead to present and discuss at surgical audit meeting

3. **Development of education and training resources for antimicrobial stewardship and the means to deliver them**

Alongside the antimicrobial stewardship training already provided for F1 doctors, enhanced training in prescribing and monitoring of gentamicin continues to be provided. An interactive teaching session was given to final year medical students on the Post Finals Assistantship (PFA) programme in May 2022 and this was repeated for all F1s in December 2022.

Antimicrobial stewardship teaching was given to the Harrogate GP Scheme trainees in March 2023.

Weekly antimicrobial stewardship ward rounds were introduced with the surgical junior doctors in September 2022. These focus on duration of antibiotics, timing of iv to oral switch, restriction of gentamicin course length to 5 days, review of microbiology culture results and discussion of complex cases. These offer a further opportunity to provide education, as well as discussing patient cases.

Weekly antimicrobial stewardship ward rounds were undertaken on the medical admissions unit September 2022-March 2023 with a registrar in Acute Medicine. Particular focus was given to inappropriate prescribing for patients with viral respiratory tract infections in conjunction with procalcitonin testing, sending appropriate microbiology specimens, iv to oral switch and de-escalation of unnecessarily broad spectrum antibiotics.

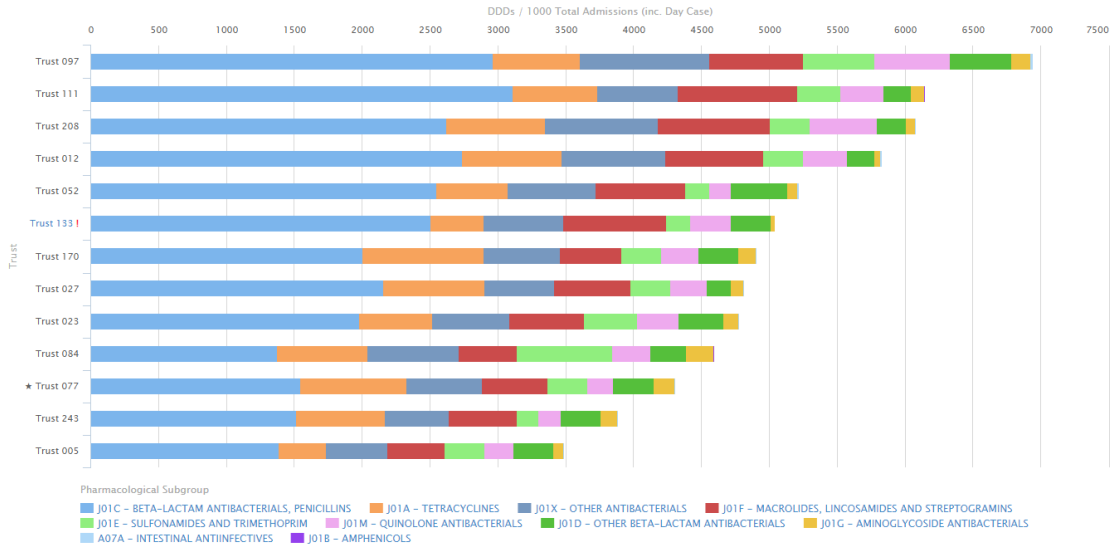
4. Identification of antimicrobial agents for restricted use only and monitoring to ensure there is compliance with restriction policies.

The following charts compare antibiotic consumption at HDFT with other Trusts in the region. HDFT is Trust 077.

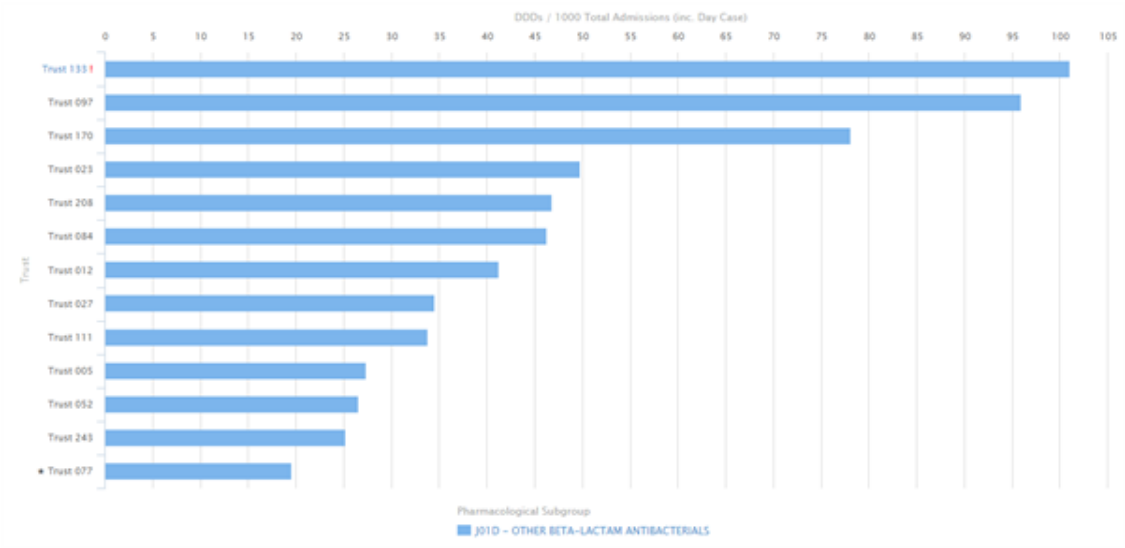
HDFT continues to compare favourably to other Trusts in the region in terms of antibiotic use, particularly with regards to low use of broad spectrum agents (e.g. meropenem and piperacillin/tazobactam).

Total Antimicrobial Use in DDD/1000 Admissions

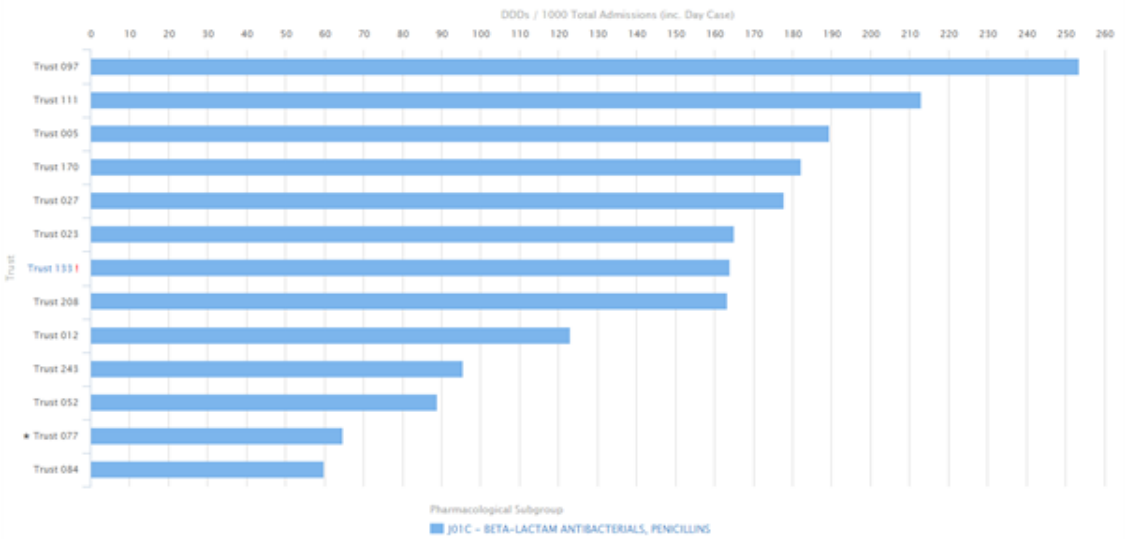
Breakdown of Antimicrobial Consumption into Antimicrobial Classes



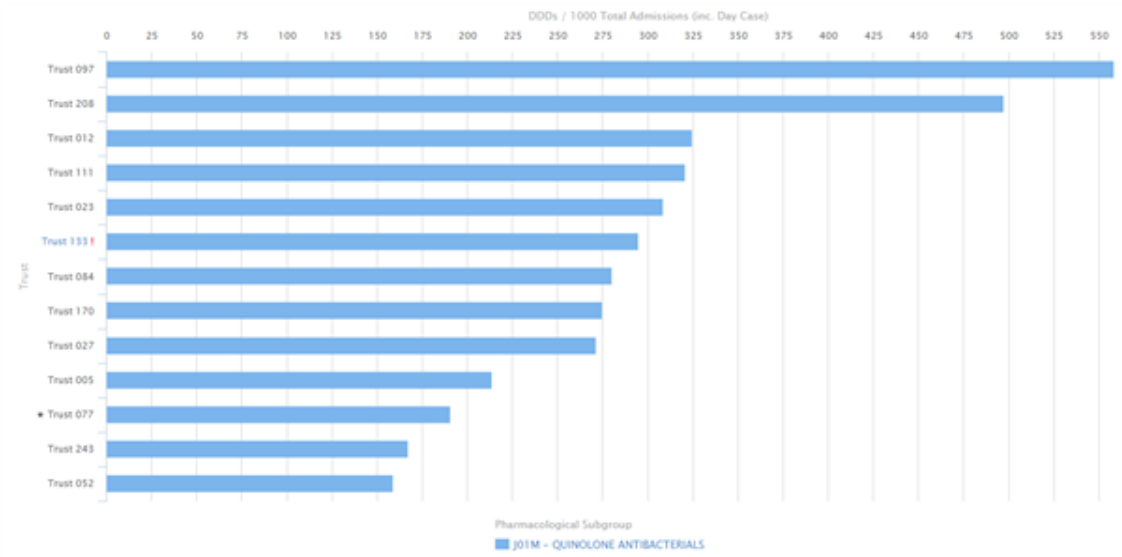
Meropenem



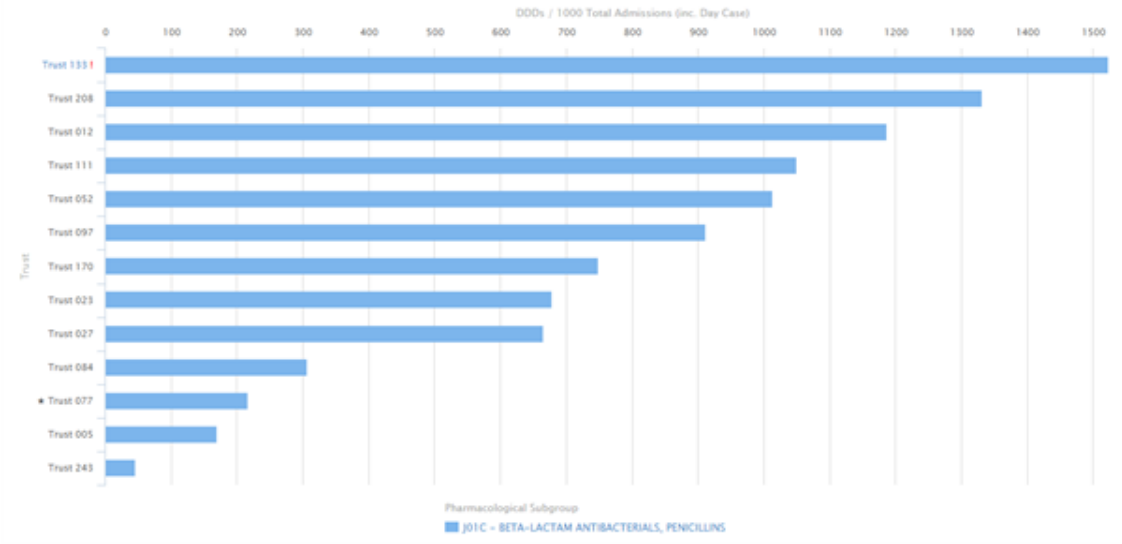
Piperacillin/tazobactam



Fluoroquinolones



Co-amoxiclav



AWaRe Categories

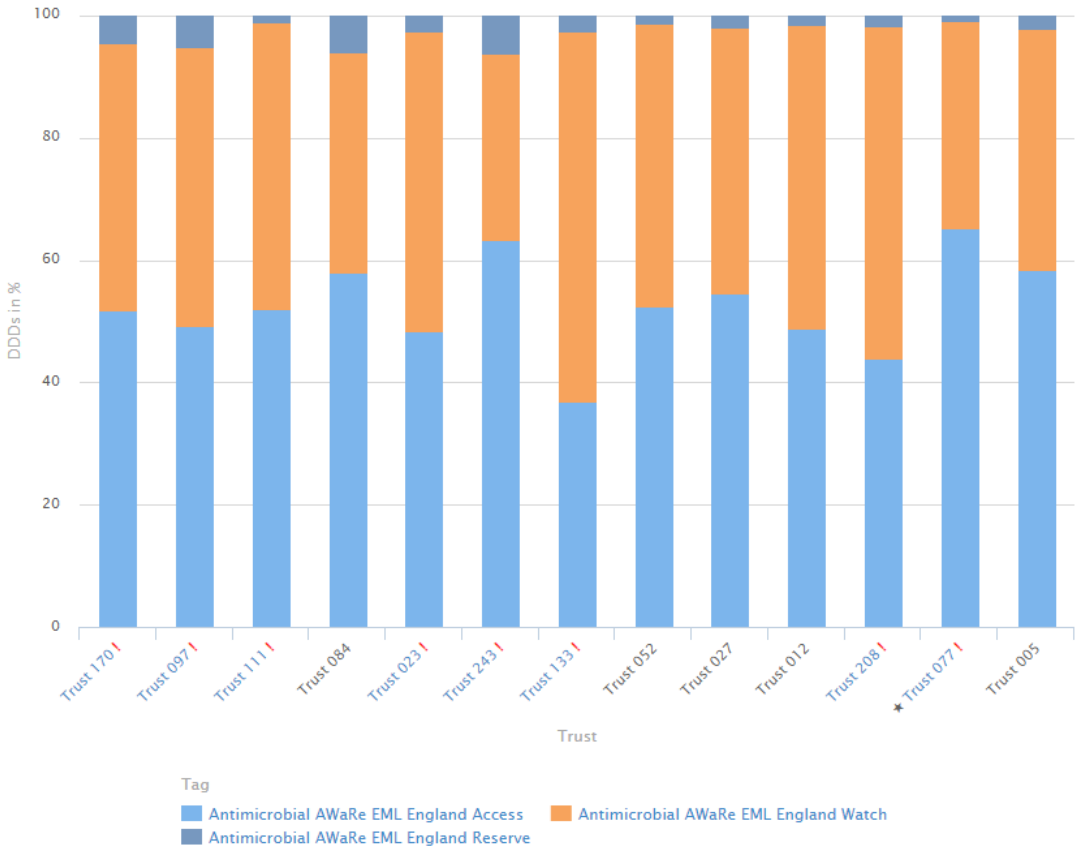
The AWaRe Classification of antibiotics was developed in 2017 by the WHO Expert Committee on Selection and Use of Essential Medicines as a tool to support antibiotic stewardship efforts at local, national and global levels. Antibiotics are classified into three groups, Access, Watch and Reserve, taking into account the impact of different antibiotics and antibiotic classes on antimicrobial resistance, to emphasize the importance of their appropriate use.

Access – first and second choice antibiotics for the empiric treatment of most common infectious syndromes;

Watch – antibiotics with higher resistance potential whose use as first and second choice treatment should be limited to a small number of syndromes or patient groups

Reserve – antibiotics to be used mainly as 'last resort' treatment options.

The following chart shows that HDFT has the highest use of 'access' antimicrobials, and the lowest use of 'reserve' antimicrobials in the region.



5. **Review of cases of *Clostridioides difficile* infection where inappropriate antibiotic prescribing has been highlighted during post-infection review.**

Since January 2022, antimicrobial prescribing lessons learnt from the CDI post-infection reviews have been formally fed back to the AMS team for discussion at APSG.

6. **Reviewing trends in local antimicrobial resistance patterns as well as data on prevalence of selected multi-resistant bacteria.**

This is reported annually and uploaded to the HDFT intranet under 'Antibiograms' at:

https://nww.hdft.nhs.uk/long-term-and-unscheduled-care/infection-prevention-control-tb-service/hospital-and-hdft-community-staff-resources/antibiograms/

7. **Encouraging and, wherever possible, supporting good antimicrobial prescribing in primary care settings.**

National antibiotic prescribing data shows that the North Yorkshire Sub Integrated Care Board Level (SICBL) performs well against national antimicrobial prescribing targets, and is one of the lowest prescribers in the region. It should be noted that this is a much larger geographical area than the Harrogate and Rural District CCG for which data was previously reported.

The North Yorkshire Antibiotic Prescribing Guideline for Primary Care is overdue review (expired September 2019) and is currently archived. Review was delayed because of redeployment of key authors during the COVID pandemic. With the introduction of ICSs, the guidelines will apply to a much wider geographical area than before. With the recent establishment of the Humber and North Yorkshire ICS Antimicrobial Stewardship Steering Group, plans are currently underway to set up a working group involving all stakeholders to review the guidelines. Primary Care are directed to use the NICE guidelines in the meantime.

The Outpatient Parenteral Antimicrobial Therapy (OPAT) MDT meets every week. There is continued representation from Bionical, who provide the nursing service in the community. This has vastly improved communication between the hospital and community and therefore positively impacted on patient care.

Progress Towards Proposed Objectives for 2022/23

Objective	Progress
Add requirement for automatic stop dates for antimicrobial prescriptions on ePMA	This function is not possible on ePMA. Instead a setting will be added to remind p-prescribers to include duration of therapy on antibiotic prescriptions. This will generate a pop-up prompt. A rule will be added to prescriptions for iv antibiotics for clinical review at 72 hours.
Introduce weekly targeted antimicrobial stewardship ward round with junior doctors in general surgery/urology	Introduced September 2022 - ongoing
Explore possibility of restarting weekly antimicrobial stewardship ward round on AMU	Introduced September 2022. There has been a pause from April 2023 due to other work commitments and redeployment of the registrar in Acute Medicine to a Consultant acting-up role.
Continue work towards setting up OPAT database on MicroGuide™	Ongoing
To address antibiotic prescribing in ED, including access to MicroGuide™ and use of broad-spectrum agents such as piperacillin/tazobactam and co-amoxiclav outside of guidelines	ED Middle Grade and Junior Doctor teaching arranged for Summer 2023
Support of antimicrobial audit in clinical specialties	Ongoing
A pilot of dermatology review of patients prescribed antibiotics for lower limb cellulitis who have a low CRP – to rule out non-infective causes	53 patients were reviewed. Dermatology review was requested for 12 and advice was given to stop antibiotics in 3 patients (outcome information awaited for 4 patients).

Dr Katharine Scott, Consultant Microbiologist, May 2023

5.0 Criterion 4

Provide suitable accurate information on infections to service user, their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion

Communication

Advice leaflets have been produced for patients on a number of organisms / infections e.g. MRSA, CPE, *C. difficile* which are available to download from the website. This provides useful information to the patient and their family on the precautions required whilst they are in hospital and when they are discharged home. Notification of a patient's infectious status is documented in the discharge letter. A patient's infectious status is documented as an IR Flag on their electronic notes.

The team have developed a system for COVID-19 patients documenting on a large visible green sticker in the medical notes the date of the positive result and date the isolation can end. This has

provided a really useful quick highly visible reference guide which has been y well received by all staff.

IPC Guidance is kept up to date on the intranet and is easily accessible. COVID-19 guidance has been incorporated into guidance for Respiratory Virus Infections and is updated in line with any new national guidance.

6.0 Criterion 5

Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people

Alert organism system

The Infection Prevention and Control team are alerted on a daily basis by the laboratory when an alert organism is isolated on an inpatient. The notes are then electronically tagged with an IR Flag which alerts ward staff that the patient has an infection. The notes are labelled by the Team with a coloured sticker on the inside of the front cover with the type of infection e.g. MRSA.

Surgical Site Infection Surveillance (SSIS)

The Trust's mandatory Orthopaedic SSI was knee replacements in 2022. There were a total number of 102 operations, 2 SSI's were identified which is an infection rate of 1.9%.

Outbreak Management

The IPC team are involved in the identification and management of outbreaks and periods of increased incidence. The IPC team monitors (via the HCAI tracker) alert organisms to identify trends and potential links between cases based on their location. This is a manual task and is completed without the aid of an automated surveillance system. If links are identified then an investigation is undertaken to ascertain if the outbreak threshold has been reached. Outbreaks are managed in accordance with the IPC Outbreak policy.

In 2022/23 we had no *C.difficile* transmission events.

COVID-19 outbreaks have continued to dominate throughout 2022/23 with 22 outbreaks affecting inpatient wards. We have also had a single outbreak of Influenza A and RSV.

There were two "period of increased incidence" events during 2022-2023.

Isolation of Serratia sp. in critical care: In May 2022 we identified two patients on the critical care unit from whom Serratia sp. had been isolated. Serratia are environmental bacteria and an important cause of nosocomial infection. Due to the withdrawal of typing services from the reference laboratory we were unable to establish if there had been patient to patient transmission but took the opportunity to review infection control practice on the unit. We found that multi-patient use bottles of ultrasound gel were still in use (despite these being replaced with single-use sachets in 2021) and poor compliance with labelling equipment as "clean" prior to storage. These issues were rectified and no further epidemiologically linked cases were identified.

Isolation of Pseudomonas aeruginosa from water outlets in Oakdale ward (augmented care annexe): During 2022 it was identified that an increased number of outlets in the augmented care area of Oakdale were testing positive for Pseudomonas aeruginosa (on routine 6 monthly water testing). A multi-disciplinary working group met to explore the possible reasons and required remedial action. No patient infections were identified. The reasons for increased isolation were identified as 1. Poor cleaning technique of outlets 2. Short staffing levels (high proportion of

temporary staff) and lack of awareness regarding to correct use of a hand wash basin. 3. Backlog of regular maintenance (i.e. descaling of taps/showers) 4. Gaps in flushing compliance 5. Lack of training for Ward Managers regarding their water safety responsibilities. A package of support and training was implemented and the frequency of Pseudomonas aeruginosa isolation in this unit has significantly reduced.

7.0 Criterion 6

Systems to ensure that all care workers including contractors and volunteers are aware of and discharge their responsibilities in the process of preventing and controlling infection

At the Trust, Infection Prevention responsibilities are included in all job descriptions.

In relation to contractors, documented IPC advice is provided to the person managing the contractors which covers current guidance on COVID-19 and other general IPC issues.

Staff Induction

All clinical staff receive IPC training on induction to the Trust. This is in the format of a national IPC e-learning package which provides information on Standard Precautions and hand hygiene including video clips and an assessment.

Staff Training and Education

All staff are required to complete a Mandatory Training session on Infection Prevention and Control which includes Hand Hygiene. Level 1 is for non-clinical staff and is required every 3 years. Level 2 is for clinical staff and is required annually. Compliance with mandatory training has been a focus for the Directorate teams this year and this is reflected in the improvements seen across the year.

Table 5.0 – figures as of 31/3/23.

	Level 1	Level 2
Corporate	99%	88%
HiF	93%	93%
LTUC	97%	89%
PSC	98%	96%
CC	99%	96%
Total Compliance	98%	91%

The Team continued to deliver ‘tool box’ talks in wards and departments covering the basics of IPC and highlighting lessons learnt from post infection review’s. Due to staff not being able to be released from the wards we were unable to deliver any study days which we had previously done pre-COVID-19.

8.0 Criterion 7

Provide or secure adequate isolation facilities

At HDFT all inpatient wards have single room (isolation) facilities. The proportion of single rooms available across our inpatient beds is 26% of these single rooms 60% are en-suite.

This can, at times of high demand, significantly impact the ability to isolate all patients who should be isolated according to national guidance. When demand exceeds single room occupancy a risk assessment is carried out to ensure the most appropriate patient is allocated a single room. The IPC Team work closely with the Clinical Site Team to support the risk assessment and decision making. A

priority isolation list is available to help the Clinical Site Team out of hours and ensure that practice is consistent.

Specialist isolation rooms are available in the Emergency Department and the Intensive Care unit. The Emergency Department has three single rooms in resus which can be put into negative pressure mode (*This is the mode you want when caring for a patient with a suspected/confirmed infection which spreads via the airborne route*). Intensive Care has two single rooms which can be put into negative pressure mode.

9.0 Criterion 8

Secure adequate access to laboratory support as appropriate

Laboratory services for HDFT are located on-site. The Microbiology Laboratory has full UKAS ISO 15189 accreditation.

The IPC nurses work closely with the Consultant Microbiologists and the Senior Biomedical Scientists. One of the Consultant Microbiologists has the additional role (awarded 3PA's) of being the Infection Control Doctor and is the primary link between the IPC team and the laboratory service. The Microbiology Department successfully appointed a new Consultant, who commenced work with the team in November 2022.

The Laboratory department have continued to work flexibly with the Trust and have maintained an extended working hours rota to provide on-site COVID and respiratory virus testing until 9pm seven days per week. This has been key to maximising safe patient flow.

10.0 Criterion 9

Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections

The Trust has commissioned a large project this year to review in detail all of the policies, procedures and SOP's available via the intranet. This work has culminated in a standardised framework for policies, procedures and SOP's.

The IPC team have a total of 36 "policies". The majority of the information within these policies actually falls under the definition of a procedure. The IPCC have decided that the IPC Team will have a single overarching policy describing the structure, role and governance of the IPC Service. Underneath this policy will sit a series of procedures which will be aligned to the National Manual for Infection Prevention and Control. Where appropriate a procedure will be accompanied by a quick reference guide "procedure on a page"

The review of policies and converting them into procedure documents has been a major work stream for 2022/23 and significant progress has been made. The work plan for 2023-2024 includes objectives to review the remaining policies.

11.0 Criterion 10

Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection

The Trust has an Occupational Health Department who have responsibility for carrying out pre-employment health assessments and immunisation needs. Staff are able to self-refer to the Occupational Health service at any time for additional advice and support.

The Occupational Health department are an integral part of the multi-disciplinary team who have been responsible for the delivery of successful COVID-19 and Influenza staff vaccination campaigns. All HDFT employees were offered both vaccinations to protect themselves and the patients they look after.

A major objective for 2023-2024 is to embed the new Occupational Health Manager as a core member of the IPCC.

12.0 IPC Work Plan for 2023/24

A new national IPC Board Assurance Framework has been released and this provides the basis for the IPC team annual work plan. The IPCC will routinely review the IPC BAF biannually (and by exception where necessary). The IPCC have responsibility for overseeing progress with the IPC annual plan of work.

Hospital Infection Prevention and Control Team (HIPCT) – Work Plan 2023-2024

The HIPCT Work Plan describes the IPC improvement work to be undertaken in 2023-2024. The plan is ratified at the Infection Prevention and Control Committee (IPCC). The IPCC review progress against the plan on a quarterly basis.

Item	Task	Task Lead	Target Date	Progress
	Policy and Guidelines			
1	Section 003: Procedure for individual diseases – redraft	LH	31-3-24	
2	Section 004: Blood borne virus and inoculation incident policy – transfer to Occupational Health	JB	30-9-23	
3	Section 009: C.difficile – routine review	AG	31-7-23	
4	Section 017: Communicable diseases in staff and exclusion policy – amalgamate with Occupational Health policy – Infectious diseases in Staff.	JB	30-11-23	
5	Section 024: Carbapenemase producing Enterobacteriaceae (CPE) – routine review	LH	30-09-23	
6	Section 025: Pest control – routine review	SA	31-07-23	
7	Section 027: Hospital Outbreak Policy – routine review	LH	30-08-23	
8	Section 029: Handling bodies after death – routine review	SA	31-08-23	
9	Section 030: Infection Control and Legionellosis – routine review	LH	31-07-23	
10	Section 031: Principles of asepsis – routine review	LH/SA	31-3-24	
11	Section 032: Prevention of Infection for Visitors, Visiting staff, Volunteers and work experience student – routine review	SA	30-09-23	
12	Section 037: Prevention of surgical site infection	LH	31-10-23	
13	Section 044: Prevention of infection in the mortuary and post-mortem room	SA	30-10-23	
	Quality Improvement and Audit			
14	Embed the new departmental IPC monthly audit	SA	30-09-23	
15	Reduce the rate of Blood culture contamination to <1%	LH	31-03-24	
16	Review and refine the ward IPC monthly audit tool on Tendable	LH/SA	30-10-22	
17	Develop and embed a new process for asepsis training and competency assurance	LH/SA	31-03-24	
18	Prepare a business case for ICNet (to be submitted when new LIMS system has been installed at HDH)	RH	31-03-24	
19	Create an appendix for the IPC Policy describing the IPC audit cycle	AG	31-07-23	
20	Occupational health - establish collaborative working relationship and agree assurance reporting process	LH/SA	30-09-23	
21	Complete annual mandatory SSI surveillance audit	IG	31-03-24	
22	Review and improve the PIR process for community onset cases of C.difficile	LH/SA	30-06-23	
23	Review guidance for sampling patients with loose stools	SA/AG	31-07-23	
24	Start to document IPC (patient specific) advice in WebV. To start with patient placement decisions	SA	30-10-23	
	Education and Training			
	Develop and embed an annual IPC training program	SA	31-03-24	
	Provide all ward managers with Water Safety training	AG	30-09-23	

13.0 Conclusion

The IPC team along with colleagues from many other specialities and disciplines have continued to drive improvements to the IPC service and governance processes throughout this year. The IPCC is a well attended, well run committee obtaining a high level of assurance ensuring we continue to demonstrate compliance with the code of practice. The COVID-19 pandemic has remained with us for the majority of this year but learning to live and work with it has become the focus. Removing

additional IPC measures is often much more challenging than introducing them but the team have worked with directorate colleagues and the senior management team to help restore normal working practices in a considered, evidence based and safe manner. The IPC team are committed to continuing the journey of improvement in order to deliver high quality care to the patients we serve.

14.0 Reference

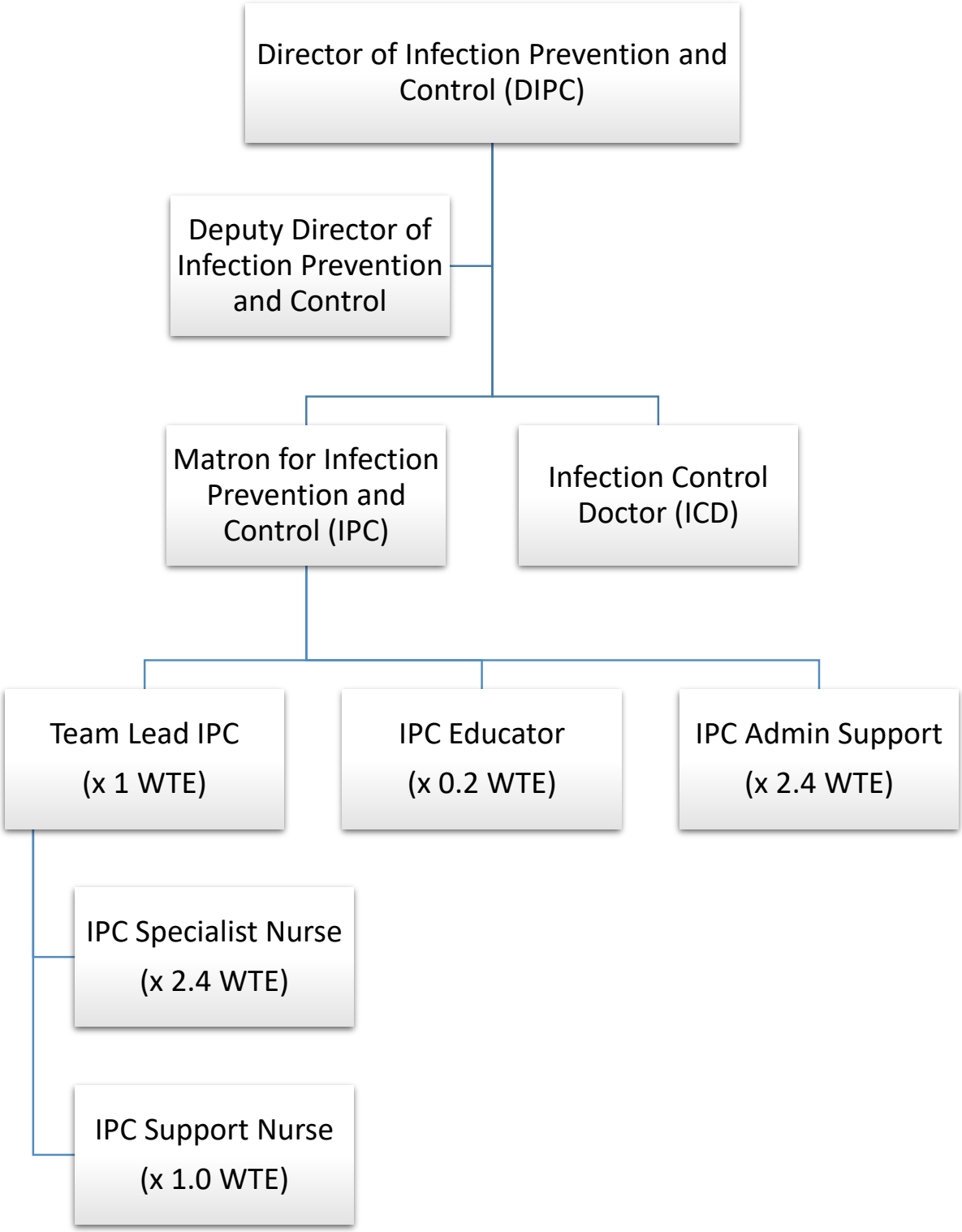
Department of Health: The Health and Social Care Act 2008. Code of Practice on the prevention and control of infections and related guidance.

http://www.gov.uk/government/publications/the-health-and-social-care-act-2008-code-of-practice-on-the-prevention-and-control-of-infections-and-related-guidance

13.0 Appendices

1.0 Structure of IPCT
2.0 Terms of reference IPCC
3.0 IPCC meeting attendance record 2022/23
4.0 IPC annual plan of work 2022/23

Appendix 1 –Structure of IPC Team



Appendix 2 – IPCC Terms of Reference:

Terms of Reference

Infection Prevention and Control Committee (IPCC)

1. Accountable to:

- Quality Committee (QC)
- Board of Directors

2. Purpose of the group

The purpose of the IPCC is to provide strategic leadership and direction on infection prevention and control activities across the trust to ensure that the risks posed by transmission of avoidable infection is minimised.

Specifically to include the following:

- To ensure compliance with the Health and Social Care Act 2008 Code of Practice (CoP) on the prevention and control of infections and related guidance by having appropriate monitoring and management systems in place to identify risk of infection to susceptible service users and any risk that their environment may pose to them.
- To approve and monitor the IPC Board Assurance Framework (BAF) to ensure CQC registration compliance with the Code's criteria.
- To approve and monitor the IPC Annual Plan of Work (APW) and any incidents arising which would impact upon compliance with the code of practice.

3. Responsibilities

The key responsibilities of the group are *to lead and monitor the work of its subgroups and* to:

- Set annual objectives and a plan of work.
- Report effectiveness against objectives and terms of reference at year end.
- Produce and annual report for the Trust Board.
- *Approve annual objectives, work plan and terms of reference of subgroups.*
- Show leadership in setting a culture of continuous improvement in delivering high quality care.
- *Lead work to ensure compliance with the following CQC fundamental standards*.
- Set relevant strategy, policies and processes to support the objectives of the Trust, and ensure that these are reviewed and updated appropriately.
- Support the delivery of the Trusts annual quality improvement priorities.
- Promote high reliability processes to deliver consistent high quality care by using standard operating procedures, pathways, checklists etc.
- Employ performance and outcome measures through dashboards to triangulate quality information and benchmark against other organisations, and share with relevant staff and stakeholders.
- Promote actions to reduce risk.
- Identify and escalate risks that present a threat to Trust objectives, including from audit results.
- Identify and disseminate learning to relevant staff.
- Address substandard performance.
- Empower staff to make changes to improve quality.

- Ensure participation in national and local audits, patient surveys and quality improvement projects.
- Identify audits for the clinical audit plan.
- Track performance against standards by reviewing audit reports and ensuring the development and progression of action plans.
- Provide information and assurance to the Quality Committee as required.

The key standards for this group are:

- The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance (UKHSA 2015)
- Mandatory enhanced MRSA, MSSA, and Gram negative bacteraemia, and Clostridium difficile infection surveillance. (PHE 2016)
- HM Government (2019): Tackling antimicrobial resistance 2019-2904: The UK's 5 years National Action Plan

4. Membership

The core membership comprises:

Title	**Deputy**
Director of Infection Prevention and Control (DIPC)(Chair)	Deputy DIPC (Deputy Chair)
Executive Director of Nursing, Midwifery and Allied Health Professionals (Deputy Chair)	Deputy Director of Nursing, Midwifery and Allied Health Professionals
Matron for IPC and TB services	Infection Control Doctor (ICD)
Infection Control Doctor	Matron for IPC and TB services
Head of Nursing (LTUC)	LTUC Matron
Head of Nursing (PSC)	PSC Matron / Associate Director of Midwifery
Head of Nursing (CC)	Matron for Paediatric Services
Deputy Director of Estates and Facilities	Head of Estates / Head of Facilities

Head of Health and Safety	Health and Safety Advisor
Deputy Chief Operating Officer	Clinical Operations Manager
PA to the Executive Team (Administration Support)	N/A

Ad hoc attendance may be by invitation of the Chair.

5. **Quorum**
   To be decided by the Chair according to representation present and agenda content

6. **Administrative support**
   PA to the Executive Team

7. **Subgroups**
   Hospital Infection Prevention and Control Team

   - Group responsible for implementation of the IPC APW and acute IPC service

   Antimicrobial Prescribing Sub-Group (APSG)

   - Group responsible for developing and implementing the Trusts antimicrobial stewardship strategy

   Water and Ventilation Safety Group

   - Group responsible for the provision of safe water and air by the management of water/ventilation related risk.

   Decontamination Committee

   - Group responsible for ensuring the reusable medical devices undergo effective decontamination

8. **External relationships**
   ICB

   North East and Yorkshire IPC Team

9. **Frequency of meetings**
   Monthly

10. **Communication**
    Minutes and action log to be produced for each meeting by the administration support.
    Escalation of issues to Quality Committee.

11. **Review**
    Annually (April)

12. **Date**
    January 2023

Appendix 3 – IPCC Meeting Record 2022/23

	26/4	31/5	30/6	25/7	23/8	27/9	25/10	22/11	19/12	23/1	27/2	27/3
DIPC	R											
Deputy DIPC and Deputy Director of Nursing	R	A	R			R			R	R	R	
Matron IPC												R
ICD		R					R		R			
Director of Nursing, Midwifery and AHP		A			A							
Deputy Chief Operating Officer	A								A			
LTUC HoN		A										
PSC HoN							R		R	R	R	
CC HoN		A					R		R	R	R	R
Quality Matron		A										
Deputy Director of Estates and Facilities (HiF)	A			R		A	R		R	A	R	R
Head of Health and Safety												

Key:

R – Representative sent

A – Apologies received

Appendix 4: IPC Board Assurance Framework:

Infection Prevention and Control Board Assurance Framework – 2022-2023

The Infection Prevention and Control (IPC) Board Assurance Framework(BAF) has been developed to support HDFT self-assess compliance with the 10 criteria set out in the Health and Social Care Act (2008) Code of Practice on the prevention and control of infection.

Health and Social Care Act 2008: code of practice on the prevention and control of infections - GOV.UK (www.gov.uk)

The Infection Prevention and Control Committee (IPCC) is responsible for overseeing the implementation, of the BAF by engagement of the relevant stakeholders across the organisation, The IPC BAF was presented to the IPCC on 30/6/22 and to the Trust Board on (July 2022)

Abbreviations:

APC	Area prescribing committee	IPCD	Infection prevention and control doctor
APSG	Antimicrobial prescribing sub-group	KPI	Key performance indicator
BAF	Board assurance framework	LIMS	Laboratory management system
BBV	Blood borne virus	MRSA	Methicillin resistant Staphylococcus aureus
BOD	Board of Directors	PILS	Patient information leaflet
CDI	Clostridioides difficile	PIR	Post infection review
CEF	Clinical effectiveness forum	QC	Quality Committee
CJD	Creutzfeldt-Jakob disease	QGMG	Quality governance management group
CPE	Carbapenemase producing enterobacteriaceae	SGSS	Second generation surveillance system
DCS	Data capture system	SMT	Senior management team
DIPC	Director of infection prevention and control	SOP	Standard operating procedure
ESR	Electronic staff record	TEG	Trust equipment group
HCAI	Healthcare associated infection	UKAS	United Kingdom accreditation service
HDFT	Harrogate and District NHS Foundation Trust	UKHSA	United Kingdom Health Security Agency
HIF	Harrogate Integrated Facilities	VHF	Viral haemorrhagic fever

ICS	Integrated care system	VRE	Vancomycin resistant enterococci
IPC	Infection prevention and control	WSG	Water safety group
IPCC	Infection prevention and control commitee	WSP	Water safety plan

Compliance Criterion 1: Systems to manage and monitor the prevention and control of infection. These systems use risk assessment and consider the susceptibility of service users and any risks that their environment and other users may pose to them.		
Sub-duties	**Evidence/Assurance**	**Gaps/Action**
The organisation outlines its collective responsibility for keeping to a minimum the risks of infection and the means by which the trust will prevent and control such risks	HDFT IPC Policy – Section 001. This policy describes the management and organisation of HCAI prevention and control at HDFT.	Policy- Section 001 is beyond review date. **Planned Action:** Review of this policy is an action on the IPC annual work plan. **ACTION COMPLETE**
The organisation has a clear governance structure and accountability that identifies a single lead for infection and cleanliness and be accountable directly to the head of the registered provider	Single lead for infection and cleanliness accountable to the Chief Executive is the Director of Infection Prevention and Control (DIPC) Dr Jacqueline Andrews (Medical Director). The DIPC has direct access to the Board of Directors (BoD) Supported by a Deputy DIPC – Jenny Nolan (Deputy Chief Nurse) Infection Prevention and Control Committee (IPCC) is chaired by the DIPC and reports to Quality Governance Management Group (QGMG) and Quality Committee (QC).	Current governance structure not described in the HDFT IPC Policy – Section 001. **Planned Action:** Review of this policy is an action on the IPC annual work plan. **ACTION COMPLETE**

The organisation has comprehensive policies in place for the prevention of infection.	The trust has 35 evidence based policies which cover all aspects of prevention of infection. Policies are available on the Trust Intranet page and reviewed every three years (sooner if new guidance is published). New policies/policy reviews are presented to the IPCC. The IPCC makes a recommendation to the Senior Management Team (SMT) in accordance with the Trust "policy on policies" document.	Due to the pandemic the routine review of policies has been suspended. 27 of the 35 policies are beyond their review date. **Planned Action:** Overdue policy reviews are captured on the IPC risk register. Policy review plan is included in the IPC annual work plan. **ACTION PARTIALLY COMPLETE**
The organisation has a clear process for detecting and reporting HCAI	The Trust has a surveillance system in place to routinely detect and report HCAI. It includes both mandatory and locally agreed surveillance. MB – BSOP-140 describes how organisms causing HCAI are communicated to the Clinical microbiologists and IPC Team. Microbiology T-card system ensures HCAI alert emails are sent. The IPC Tracker is the central document for the recording of all HCAI data. The IPC team are responsible for mandatory reporting on HCAI in accordance with UKSHA criteria and do this via the UKSHA Data Capture System (DCS) The IPC team produce a monthly IPC report of HCAI infections and provide analysis/interpretation of this data.	Current HCAI reporting arrangements not described in the IPC policy – Section 001. **Planned Action:** Review of this policy is included on the IPC annual work plan. **ACTION COMPLETE** Although not mandatory, no local surveillance system in place for ventilator acquired pneumonia (VAP) or surgical site infection (SSI) **Planned Action:** Address in the 2023-24 annual plan of work.
The organisation has mechanisms in place to provide assurance that IPC policy is implemented and adhered to	Assurance of adherence to IPC Policy is obtained via regular audit, post infection review and matron inspections.	Disruption to monthly General IPC Inspection audit with the move to the Tendable system.

	Each ward/department completes a monthly General IPC Inspection audit. The results are collated by the IPC team and analysed at both the IPC Team meeting and IPCC. The IPC team also conduct monthly commode and cannula insertion audits. The results are analysed at both the IPC Team meeting and IPCC. The IPC team have a process in place for the routine review of HCAI's – The Post-infection review (PIR) which is an additional mechanism to assess compliance with IPC Policy. Completion of PIR's is one of the IPC KPI's. Zero avoidable HCAI's is another Trust KPI. Performance against the KPI's is included in the monthly IPC report. Matron "walk-arounds" take place in order to directly observe compliance with IPC policy.	**Planned Action:** IPCT to undertake General IPC Inspection audits via Tendable for first 6 months of this year. Wards to take over this process thereafter with a peer-to-peer assessment model. Ward to continue to submit monthly paper based IPC General Inspection Audit until Tendable system is fully implemented. **ACTION COMPLETE** Matron "walk arounds" have not taken place or been re-established during the pandemic. **Planned Action:** Re-establishment of the Matron walk around is included on the IPC annual work plan. **FOR DIRECTORATES TO IMPLEMENT IF REQUIRED.** IPC audits of departments (for example radiology/outpatients) is not established. **Planned Action:** work ongoing to get an audit proforma on tendable so these audits can be implemented. **ACTION PARTIALLY COMPLETE**
The organisation has a designated Decontamination lead	Decontamination Lead – Russell Nightingale (Chief Operating Officer)	The Decontamination Committee does not link in with the IPCC at present. **Planned Action:** IPCD to establish where the Decontamination Committee sits within the Trust Governance Structure and then how the IPCC can obtain assurance regarding Decontamination process at the Trust . **ACTION COMPLETE**

The organisation has a designated Water Safety Group (WSG) and Water Safety Plan	Water Safety Group (WSG) – established and meets bi-monthly. The IPCD is a core member of the WSG. The WSG oversees the implementation of the Water Safety Plan (WSP)	The WSG does not provide assurance to the IPCC. **Planned Action:** IPCD to establish where the WSG sits within the Trust Governance Structure and then how the IPCC can obtain assurance regarding compliance with the WSP. **ACTION COMPLETE**
The organization has a designated Ventilation Safety Group (VSG) and Ventilation Safety Plan		Group not yet established and ventilation safety plan not in place. **Planned action:** Lack of established ventilation safety group to be added to the HiF risk register. **WVSG ESTABLISHED**
Criterion 2: Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections		
The organisation implements and ensures it is cleaned in accordance with the National Standards for Healthcare Cleanliness	Cleaning of the patient environment is the responsibility of Harrogate Integrated Facilities (HiF). HiF are responsible for the Trust Cleaning Policy. Cleaning of the environment specific to the spillage of blood/body fluid is the responsibility of clinical staff and described by IPC Policy – Section 019. Cleaning and decontamination of equipment used for diagnosis and treatment is the responsibility of the Decontamination Committee and the IPC Team. IPC Policy – Section 020 describes the method, frequency and responsibility for the cleaning/decontamination	Trust Cleaning Policy – Policy is beyond review date and is not compliant with the National Standards for Cleanliness published 2021. **Planned Action:** Incomplete implementation of the National Standards for Cleanliness (2021) to be added to the HiF risk register. **NSC IMPLEMENTED.** IPC Policy – Sections 019 and 020 are beyond review date.

	of items outside of the remit of Decontamination Committee. Core members of the Decontamination Committee include an IPC Nurse and Consultant Microbiologist. The trust has a standard process for the application to purchase a new piece of patient equipment. "TEG form". Cleaning and/or decontamination of the equipment is a mandatory consideration and requires approval from the IPC team.	**Planned Action:** Policy review program is included in the IPC annual plan. **ACTION COMPLETE** IPCC is not currently provided with assurance regarding the cleaning of the patient environment. **Planned Action:** HiF have been asked to provide the IPCC monthly audit reports with cleaning scores. **ACTION COMPLETE**
Criterion 3: Ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance		
The organisation has a system to manage and monitor the use of antimicrobials to ensure inappropriate and harmful use is minimised.	Specialist Antimicrobial Pharmacist – Paul Golightly. Designated Lead for Antimicrobial Stewardship – Dr Katharine Scott (Consultant Microbiologist) Antimicrobials are prescribed via the Trusts electronic prescribing system (ePMA) in all locations aside from the Emergency Department. Live antimicrobial prescribing report allows antimicrobial prescriptions to be reviewed across all inpatient settings in the Trust.	None.

	Twice weekly Antimicrobial Stewardship ward rounds take place. The Antimicrobial Pharmacist uses the Live prescribing report to identify patients whose prescribing is outside of Trust guidelines or potentially harmful. Antimicrobial prescribing is a mandatory component of HCAI PIR's.	
The organisation should have an antimicrobial stewardship committee responsible for the organisations stewardship programme.	Antimicrobial Prescribing and Stewardship Group (APSG) established. The group meets bi-monthly and is Chaired by the Trust Lead for Antimicrobial Stewardship. This group reports to the Area Prescribing Committee (APC) which in turn reports into the Trust's Clinical Effectiveness Forum (CEF). The Trusts Stewardship Program is described in the Antimicrobial Medicines Code and is overseen by APSG.	None.
The organisation should have in place an antimicrobial stewardship policy. Adherence to prescribing guidance and compliance with post-prescribing review should be monitored and audited on a regular basis.	The Antimicrobial Medicines Code (review date December 2022) describes the Trusts policy for antimicrobial stewardship. APSG has responsibility for monitoring and auditing compliance with prescribing guidance and post-prescribing reviews.	IPCC currently does not receive assurance from APSG regarding compliance with prescribing guidelines and post-prescribing reviews. **Planned Action:** IPCC to receive a bi-annual report from APSG with audit results. **ACTION COMPLETE**
The organisation should have access to timely microbiological diagnosis, susceptibility testing and reporting of results. Prescribers should have access at all times to suitably qualified individuals who can advise on appropriate choice of antimicrobial therapy.	Microbiological diagnosis and susceptibility testing is available on-site 7 days per week in a UKAS accredited laboratory. Advice regarding the prescription of antimicrobial therapy is available 24 hours per day, 7 days per week	None.

	and 365 days per year from both a pharmacist and Clinical Microbiologist.	
The organisation should report local antimicrobial susceptibility data and information on antimicrobial consumption to the national surveillance body. This information should be communicated back to prescribers in primary and secondary care to improve prescribing quality.	Susceptibility data reported to the national surveillance body (SGSS) via electronic link directly from the Laboratory information management system (LIMS). Annual susceptibility report is produced and presented to APSG. Antimicrobial consumption data is collected by the Antimicrobial Pharmacist and presented to APSG. The Antimicrobial Stewardship Team undertake the annual mandatory point-prevalence audit of antibiotic use. Results are presented to APSG. Core membership for APSG includes representatives from Secondary care Directorates and the Community. They are responsible for the cascade of antimicrobial consumption and surveillance data in order to improve prescribing quality.	IPCC currently does not receive reports from APSG with information regarding antibiotic susceptibility and consumptions. **Planned Action:** IPCC to receive a bi-annual report from APSG covering antibiotic consumption and surveillance. **ACTION COMPLETE**
Providers should ensure that all prescribers receive induction and training in prudent antimicrobial use.	The trust has a mandatory induction session on Antimicrobial prescribing which is given by one of the Consultant Microbiologists. An e-learning module regarding the appropriate use of antimicrobials is required by all prescribers every 3 years.	IPCC does not currently receive assurance of compliance with 3 yearly antimicrobial prescribing training. **Planned Action:** IPCC to receive a bi-annual report from APSG covering compliance with 3 yearly training module. **ACTION COMPLETE**
Criterion 4: Provide suitable accurate information on infections to service users, visitors and any person concerned with providing further support or nursing / medical care in a timely fashion		

Produce and provide accurate information for patients, service users and providers	IPC information on Trust Internet IPC information displayed on posters within the Trust Patient advice leaflets (PILS) – provided to all patients with alert organisms (CDI, CPE, MRSA, VRE). Discharge documentation includes information in relation to infection status and treatment. Transfer checklist includes information in relation to infection status and treatment.	Review of IPC information on internet and within the trust is reviewed on an ad-hoc basis. **Planned Action:** Review of IPC information on internet and within the trust to be included in the annual IPC work plan. **ACTION COMPLETE** PILS have not been reviewed and updated throughout the pandemic. **Planned Action:** Review of PIL's to be included on the annual IPC work plan. **ACTION COMPLETE** No audit in place to assess the compliance with including IPC information on discharge documentation and transfer checklists. **Planned Action:** Annual audit of IPC information on discharge and transfer documentation to be included on the annual IPC work plan. **TO CARRY OVER to 23-24**
Criterion 5: Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people		
Identification of people who have or are at risk of developing infection.	IPC requirements for the isolation of patients is described in Section 002 Isolation Policy and Section 003 Procedures for Individual Diseases. Patients who have a history of an alert organism are flagged on iCS and the IPC team is notified electronically when they are admitted.	Section 002 and 003 are beyond the review date. **Planned Action:** Policy review program is included in the IPC annual plan. **ACTION PARTIALLY COMPLETE** No SOP for how an alert organism flag is applied to a patient.

	Patients who require isolation have appropriate signage on single room doors to advise staff and visitors of the precautions in place. IPC team audit compliance with isolation precautions on a quarterly basis and report the results to the IPCC. Instances where isolation is required but cannot be fulfilled (lack of single room beds) must be reported via Datix. IPC team review the Datix events quarterly and report them to the IPCC. IPC Nurses attend the daily bed meetings to support and advise the clinical site managers on the appropriate placement of patients.	**Planned Action:** SOP for adding an organism flag to be included on the annual IPC work plan. **ACTION COMPLETE** Audit of compliance with isolation policy is not currently being performed. **Planned Action:** Quarterly audit of compliance with isolation policy to be included on the annual IPC work plan. **INTERNAL AUDIT MAR 23** Datix records of failure to isolate are not currently reviewed by the IPC team. **Planned Action**: Quarterly review of isolation Datix to be performed by the IPC team and presented at the IPCC. **ACTION COMPLETE**
Criterion 6:Systems to ensure all care workers including contractors and volunteers are aware of and discharge their responsibilities in the process of preventing and controlling infection:		
The organization shall ensure that its staff are equipped with the necessary knowledge and skills to be fully involved in the process of prevention and controlling infection	Staff induction – IPC session is included in the mandatory staff induction package. Staff are not permitted to start work until this package has been completed. Mandatory IPC Training – National IPC Training modules are used via e-learning. Level 1 is for non-clinical staff and should be completed every 3 years. Level 2 is for clinical staff and should be completed annually. Compliance with Mandatory Training is one	IPCC does not currently receive assurance that Trust Volunteers are complaint with IPC training. There is no IPC training renewal agreement in place for volunteers. **Planned Action:** Matron for IPC to work with Volunteer coordinator and develop a mechanism for IPCC to receive assurance regarding training compliance. To agree that volunteers complete IPC training on an annual basis. **PARTIALLY COMPLETE**

	of the local IPC KPI's and is reported via the monthly IPC report. Trust volunteers have a bespoke IPC training package which is undertaken at induction. Non-mandatory IPC training: - Care support worker fundamentals of care training - Monthly IPC newsletters - Toolbox talks	Non-mandatory IPC training is provided in an ad-hoc manner and attendance is not recorded. **Planned Action**: Matron for IPC to develop a non-mandatory IPC training schedule and develop a mechanism to record attendance. **COMPLETE BUT FOR EXPANSION 23-24**
Infection prevention needs to be included in the job descriptions for staff and contractors working in service user areas need to be aware of any issues with regard to infection prevention and obtain "permission to work"	Infection prevention responsibilities is included as standard in the Trust Job Description Template. HiF have responsibility for making contractors aware of any issues with regards to infection prevention and control and grant "permission to work".	None.
Where staff undertake procedures which require skills such as aseptic technique staff must be trained and demonstrate proficiency before being allowed to undertake the procedures independently.	Asepsis training and assurance: Nursing Staff – Line manager required to complete competency assessment every three years and upload the evidence to ESR. FY1 Doctors – Trust Clinical Educators train and assess at induction. Evidence if uploaded on ESR. Doctors have to be re-assessed every 3 years.	IPCC does not currently receive assurance of compliance with asepsis training. Asepsis training is not included in Mandatory training, there is no system to remind staff when it is due. No process for training and assessing Allied health professionals who undertake aseptic procedures is in place. No process for training and assessing Doctors (beyond Fy1) in aseptic procedures. **Planned Action:**

		Lack of asepsis assurance to go on to the IPC risk register. Proposal for asepsis training and assurance to become part of mandatory training to be made via the IPCC. This could be delivered along the same model as resuscitation training. **TO CARRY OVER TO 23-24**
Criterion 7:Provide or secure adequate isolation facilities		
The organization should ensure it is able to provide adequate isolation precautions and facilities to prevent or minimise the spread of infection.	Isolation facilities are available in the Emergency Department including two negative pressure isolation rooms in resus. Every in-patient ward has a number of single rooms which are neutral pressure and available for the isolation of patients with infection. Some of these rooms are en-suite. The Intensive Care Unit has three negative pressure single rooms and a further two neutral pressure single rooms. Two single en-suite rooms are available in the Sir Robert Ogden Macmillan Centre.	A description of the number of single rooms, their ventilation status and location is not included in any of the IPC policies. **Planned Action**: IPC in collaboration with Estates to assess the number and status of single rooms within the inpatient setting and include this within the IPC Policy, Section 002.This will be captured on the IPC annual work plan. **PARTIALLY COMPLETE**
Criterion 8:Secure adequate access to the laboratory support as appropriate		
The organisation should ensure that the laboratory used to provide a microbiology service have in place appropriate protocols and	The Trust Microbiology Laboratory is accredited to UKAS ISO 15189.	None.

operates to the standards required by the relevant national accreditation bodies.	The work of the Laboratory is governed by a comprehensive set of Standard Operating Procedures (SOP's) for the examination of specimens. The Laboratory uses an electronic document management system (Q Pulse) for storage of all its procedures. Timeliness of reporting is regularly audited and results are presented at the Monthly Senior Laboratory Meetings.	
Criterion 9: Have and adhere to policies, designed for the individuals care and provider organisations that will help to prevent and control infections		
The organization should have in place appropriate policies covering the following matters. All policies should be clearly marked with a review date and the review date adhered to. Each policy should indicate ownership, authorship and by whom the policy will be applied. Implementation of policies should be monitored and there should be a rolling programme of audit. • Standard infection prevention and control precautions • Aseptic technique • Outbreaks of communicable infection • Isolation of service users with infection • Safe handling and disposal of sharps • Prevention of occupational exposure to blood borne viruses (BBV's) and management should exposure occur	The Trust has the following policies in place which cover the matters described in criterion 9 - Section 014 Standard precautions including hand hygiene and PPE - Section 031 Principles of asepsis - Section 027 Hospital outbreak policy - Section 002 Isolation of patients policy and principles of notification - Section 004 BBV and inoculation incident policy - Section 019 Decontamination and body fluid spillage - Section 020 Decontamination policy, procedures for items in general use - Antimicrobial medicines code	Majority of these policies are beyond their review date. **Planned Action:** Overdue policy reviews is captured on the IPC risk register. Policy review program is included in the IPC annual work plan. MRSA screening compliance and positivity rate are not routinely reported. **Planned Action:** To set up MRSA screening compliance audits and include the results in the monthly IPC report. To review how to report on positivity rate in the annual plan 2023-24 **ACTION COMPLETE**

• Closure of rooms, wards, departments and premises to new admissions • Disinfection • Decontamination of reusable medical devices • Single use medical devices • Antimicrobial prescribing • Reporting of infection to local health protection team and mandatory reporting to UKSHA • Control of outbreaks and infections associated with specific alert organisms (MRSA, C.difficile, GRE, CPE, VHF, CJD, TB, Respiratory viruses, Diarrhoeal infection) • CJD/vCJD • Safe handling and disposal of waste • Packaging, handling and delivery of laboratory specimens • Care of deceased persons • Use and care of invasive devices • Purchase, cleaning, decontamination,maintanence and disposal of equipment • Surveillance and data collection • Dissemination of information • Isolation facilities • Uniform and dress code • Immunisation of service users	- Section 001 Management and organization of the prevention and control of HCAI - Section 024 CPE Policy - Section 003 Procedures for individual diseases - Section 012 MRSA Policy - Section 010 Respiratory Virus Policy - Section 039 VHF Policy - Section 009 C.difficile policy - Section 013 CJD Policy - Section 023 Healthcare Waste Disposal Policy - BS-COSHH-001- Handling blood, blood products, urine and faeces - Section 029 Handling of bodies after death - Section 044 Prevention of infection in the mortuary - Section 015 Infection control in IV procedures - MB-LP-BSOP-140 – Communication of results from the microbiology department - Trust Dress Code Policy - SOP for School based immunization programme management	

	- Antibiotic and immunization advice for patients with absent/dysfunctional spleen.	
Criterion 10: Have a system in place to manage occupational health needs and obligations of staff in relation to infection		
All staff can access Occupational Health Services and Occupational Health Advice	The Trust commissions an Occupational Health Service for staff. Staff can access the service via their line manager or self-referral.	None.
The organisation has an Occupational Health Policy on the prevention and management of communicable infections in care workers	The Occupational Health Department have responsibility for the Staff Communicable Diseases and Immunisation Policy. The Occupational Health Department and IPC team have shared responsibility for the Communicable Disease in Staff and Exclusion Policy. Section 017. The IPC team have responsibility for the Policy on prevention and management of occupational exposure to blood and body fluids. Section 004.	Occupational Health Team do not provide assurance to the IPCC regarding the compliance with the Staff Communicable diseases and Immunisation Policy. **Planned Action:** IPCD to investigate how the Occupational Health Department currently fit into the Trusts Governance structure. **TO CARRY OVER** IPC Policies 017 and 004 are beyond the review date. **Planned Action:** Policy review program is included in the IPC annual work plan. **TO CARRY OVER**

Appendix 5: IPC Annual Work Plan 2022-23

Infection Prevention and Control Team – Work Plan 2022-2023

The Infection Prevention and Control Committee (IPCC) have responsibility for the HDFT IPC Board Assurance Framework. This framework provide the basis for the IPC annual work plan. The IPCC are responsible for overseeing progress against the work plan.

Appendix 1: Detailed IPC policy/procedure and SOP review plan.

Abbreviations:

AG	Amanda Gooch	LH	Lauren Heath
APSG	Antimicrobial Prescribing Sub-Group	MIU	Minor Injuries Unit
CAUTI	Catheter associated urinary tract infection	MRGNB	Multi-resistant Gram negative bacteria
CDI	Clostridioides difficile	MRSA	Methicillin resistant Staphylococcus aureus
CJD	Creutzfeldt-Jakob disease	PIR	Post infection review
CPE	Carbapenemase producing enteriobacteriaceae	PPE	Personal protective equipment
HCAI	Healthcare acquired infection	RCA	Root cause analysis
HDFT	Harrogate and District NHS Foundation Trust	SA	Sonya Ashworth
HIF	Harrogate Integrated Facilities	SMT	Senior Management Team
iCS	Integrated care system	SOP	Standard operating procedure
IG	Iona Goodwin	SSI	Surgical site infection
IPC	Infection Prevention and Control	VHF	Viral haemorrhagic fever
IPCC	Infection Prevention and Control Committee	VRE	Vancomycin resistant enterococci
JC	Jane Cozens	VZV	Varicella zoster virus

Work Plan Item Number	Task	Task Lead	Target Date	Progress
1	IPC Policy – Section 001 • Content reviewed and updated • Transferred to the new trust policy template • Approved at IPCC and then ratified at SMT	LH	Aug-22	15/11/22: Draft completed and circulated for comment. Complete and on intranet
2	Review and update IPC Policies which are beyond their routine review date • Refer to detailed policy review plan (appendix 1)	SA	Mar-23	27/9/22: In progress by order of priority. National IPC manual has been made available on the intranet.
3	Transfer the monthly IPC general inspection audit to Tendable	SA	Jun-22	23.6.22: General IPC inspection on Tendable. Not all wards have access. Aim for all August inspections to be done via Tendable. Scoring issue raised with Tendable team. 19.7.22 Complete
4	Hand back the responsibility for completion of the monthly IPC general inspection audit to ward managers with a peer-to-peer assessment model	SA	Sept-22	27/9/22: Partially complete, Ward Managers are now responsible for completion of the monthly audit. Peer-to-peer assessment still to implement. IPCC 27/2/23 – Peer to peer audit strategy not to be pursued
5	Establish monthly IPC audits at Ripon MIU and Selby UTC	SA	Aug-22	27/9/22: Sonya to speak to Steph Davies. Option 1: Ripon and Selby to complete the tendable IPC audit. Option 2: (if no access to tendable) paper audit to be sent in monthly. Assurance for completion falls under LTUC HoN.
6	Re-establish a programme of Matron “walk arounds”	SA	Jul-22	27/9/22: Sonya to ask LTUC and PSC HoN if these are established. Complete: Matron walk-around are done. IPC do not attend routinely but can on request. HoN to feedback by exception issues to IPCC.
7	IPCC to receive assurance report from Decontamination Committee at an agreed frequency	LH	Jul-22	18.7.22: Currently receiving exception reports from the decontamination committee. Still need more information on where decontamination committee reports - ?Health and Safety Committee (what do they ask for?) 9.8.22: Proposal that decontamination committee report to IPCC. Ant Walker preparing some KPI’s to guide what assurance IPCC need on a regular basis. 27/9/22: On hold pending appointment of health and safety manager and establishment of the health and safety committee.

				10.1.22 LH and Chair of Decontamination committee have agreed on a quarterly report containing assurance over the decontamination of endoscopes and surgical equipment and escalation of matters of concern where resolution is proving challenging. There will also be a requirement to produce an annual report.
8	IPCC to receive assurance report from Water Safety Group at an agreed frequency	LH	Aug-22	9.8.22: Proposal that WSG report directly to IPCC. Ant Walker preparing some KPI's to guide what assurance IPCC need on a regular basis. 27/9/22: WSG/VSG to dual report to IPCC and Health and Safety Committee pending full review of H&S committee governance structure.
9	IPCC to receive quarterly cleaning assurance report from HiF	LH	Jun-22	23.6.22: Andy Colwell informed the IPCC that cleaning assurance would be provided monthly. Complete
10	IPCC to receive bi-annual assurance report from APSG	LH	Sept-22	28/7/22: Complete Katharine Scott will provide this report for the IPCC meetings in July and January.
11	Review of IPC information on Trust Website	SA	Oct-22	27/9/22: Full review of documents on the intranet has been undertaken. Out of use documents archived.
12	Review of IPC information displayed within the trust	SA	Jun-22	23.6.22: Review of signage in progress (IG) IPC noticeboards on wards to be tackled after the signage. 19.7.22: Signage complete. Noticeboards to do. 27/9/22: Complete, IPC educator has ongoing responsibility for updating the IPC elements of ward noticeboards. Wards without boards have had them ordered.
13	Review and update Patient information leaflets for alert organisms (CDI,CPE, MRSA and VRE)	SA	Nov-22	Complete
14	Develop an annual audit of IPC information on discharge and transfer documentation	SA	Nov-22	23/3/23 – To be carried over to next year
15	Produce an SOP for adding an iCS flag to a patient with an alert organism	AG	Jun-22	Complete
16	Develop a quarterly audit programme for compliance with isolation policy	SA	Oct-22	15.11.22: Action changed. Internal audit to be undertaken on the correct isolation of patients.
17	Develop a quarterly programme for the review of Datix incidents at IPCC	AG/IG	Jul-22	19.7.22: Not started 9.8.22 Complete
18	Develop an assurance process for volunteers and compliance with IPC training	SA	Dec-22	27/9/22: Voluntary services manager has an IPC training program tailored to the different types of volunteers. IPC Team provide face-to-face training for volunteers who support feeding patients at their induction. Outstanding

				is confirmation that the voluntary Services Manager maintains a record of IPC training completion.
19	Produce a non-mandatory IPC training package and assurance framework	SA	Aug-22	9.8.22 Complete
20	Proposal for asepsis training to be included in Mandatory training	LH	Jun-22	23.3.23 – To be carried over to next year.
21	Produce a document describing the number and status of single rooms within the inpatient setting for inclusion in IPC Policy-Section 002.	LH	Jul-22	23.3.23 – In progress. HiF have supplied site drawings.
22	IPCC to receive assurance report from Occupational Health at an agreed frequency	LH	Sep-22	23.3.23 – To be carried over to next year.
23	Complete annual mandatory SSI surveillance audit	IG	Dec-22	15/11/22: Audit in progress. Monitoring completion date 31/1/23. Data submission deadline 31/3/23. 23.3.23 – Completed.
24	Re-establish the IPC Link person programme	JC	Mar-23	Complete. IPC virtual noticeboard for IPC Link Nurses has been set up.

IPC Policy Review Plan

Policy/Procedure number	Policy Title	Review date	Progress
001	Management and organisation of the prevention and control of HCAI	31/10/24	Complete
002	Procedure for Isolation of patients	31/10/25	Complete
003	Procedures for individual diseases	31/12/24	23.3.23: in-progress
004	Blood borne virus and inoculation incident	30/04/22	
005	Tuberculosis	29/02/24	In date
~~006~~	~~Meningococcal disease~~	-	23.3.23: To be archived as information will be included in 003
~~007~~	~~Haemophilus influenze Type b (Hib) Disease~~	-	
008	Chickenpox and Shingles (VZV)	01/01/26	Complete
009	Clostridium difficile	30/04/22	5.12.22: in-progress
010	Respiratory virus guidelines	12/12/24	Complete
011	Procedure for Scabies and other ectoparasites	25/11/25	Complete
012	Procedure for MRSA	31/01/26	In date
013	CJD	31/1/26	Complete
014	Standard precautions including hand hygiene and PPE	30/11/25	Complete
016	Transmission based precautions (new)	30/11/25	Complete
015	Infection Control in Intravenous Procedures	30/09/24	In date
017	Communicable diseases in staff and exclusion policy	30/04/22	
018	Procedure for MRGNB / GRE	22/11/25	Complete
019	Procedure for decontamination (cleaning, disinfection and sterilisation)	01/03/26	Complete
~~020~~	~~Decontamination policy – procedures for items in general use~~	-	Procedure archived and information merged into 019.
021	Bed management and movement of patients	30/12/25	Complete
022	Laundry	22/12/25	Complete

023	Healthcare waste disposal	30/04/24	Complete
024	CPE	31/08/24	Complete
025	Pest Control	01/04/23	Complete
026	Animals and pets in hospital and community settings	05/01/26	Complete
027	Hospital outbreak	31/11/22	
029	Handling of bodies after death	31/10/21	
030	Infection control and Legionellosis	30/04/22	
031	Principles of asepsis	30/04/22	
032	Prevention of infection for Visitors, visiting staff, volunteers and work experience students	30/04/22	
037	Prevention of surgical site infections	30/11/22	
038	Prevention of CAUTI	23/01/26	Complete
039	VHF	31/10/2024	Complete
~~042~~	~~RCA of hospital acquired infection~~	-	Archived
~~043~~	~~HCAI Data Sheets for patient information~~	-	Archived
044	Prevention of infection in the mortuary and post-mortem room	30/04/22	

3

Board of Directors
26th July 2023

Title:	Infection Prevention and Control Annual Report
Responsible Director:	Jackie Andrews
Author:	*Lauren Heath*

Purpose of the report and summary of key issues:	*Provide the committee with:* • *Annual summary of compliance with the IPC Code of Practice.* • *Annual summary of IPC work against plan* • *IPC Work plan 2023-2024.*	
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	
	Great Start in Life	
	At Our Best: Making HDFT the best place to work	
	An environment that promotes wellbeing	
	Digital transformation to integrate care and improve patient, child and staff experience	
	Healthcare innovation to improve quality	
Corporate Risks	None	
Report History:	Quality Committee	
Recommendation:	Report for information and noting.	

Integrated Board Report - June 2023

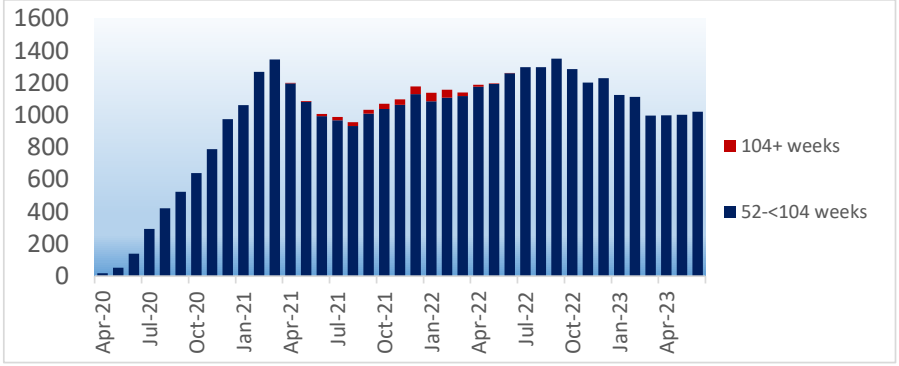
Domain 5 - Responsive

Indicator	**5.1 - RTT Incomplete pathways - 52+ weeks**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Jun-23
Value / RAG rating	1020

Indicator description

The number of incomplete pathways waiting over 52 weeks.

Trend chart



Narrative

The overall RTT waiting list reduced in June to 25,860 (25,876 last month). The focus on clearing the longest waiters continues and we continue to report zero over 78 weeks. The number of patients waiting over 65 weeks was 210 at the end of June, significantly below the plan of 470.

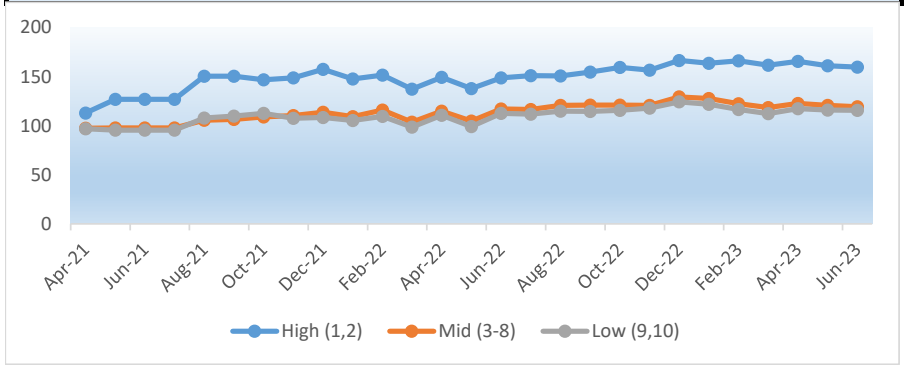
There is ongoing work to improve the speed and accuracy of validation:
- 2 substantive posts commenced in RTT team in July
- AI solution continues to be developed to include information from letters
- Outpatient outcomes real time collection digitally - Q3
- Reducing follow ups to support more new outpatient activity

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

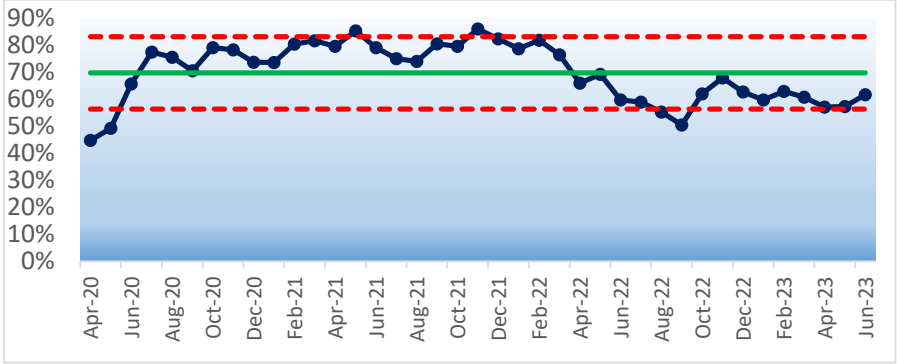
Work also continues in improving the recording of ethnicity and use of the learning disabilities flag across our clinical systems (this will improve further with the reinstatement of patient kiosks- end of Q2).

Indicator	**5.3 - Diagnostic waiting times - 6-week standard**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Jun-23
Value / RAG rating	61.8%

Indicator description

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

SPC chart



Narrative

Performance against the 6-week standard improved this month. The main areas of concern continue to be DEXA scans (large numbers compared to weekly activity) and CT(issues with scanner resilience).

Indicator	**5.5 - Data quality on ethnic group - inpatients**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Jun-23
Value / RAG rating	91.5%

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.

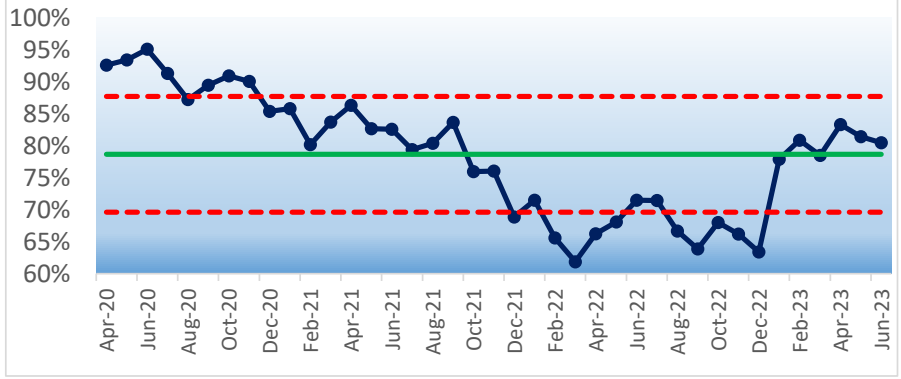
- Made contact with the lead at Central London Community NHS Trust (CLCH) who have improved their ethnicity recording rates on their patient records – they are organising a webinar to talk through their actions
- Reminded staff of the process regarding the collection of this data including reception 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	Jun-23
Value / RAG rating	80.5%

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 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:

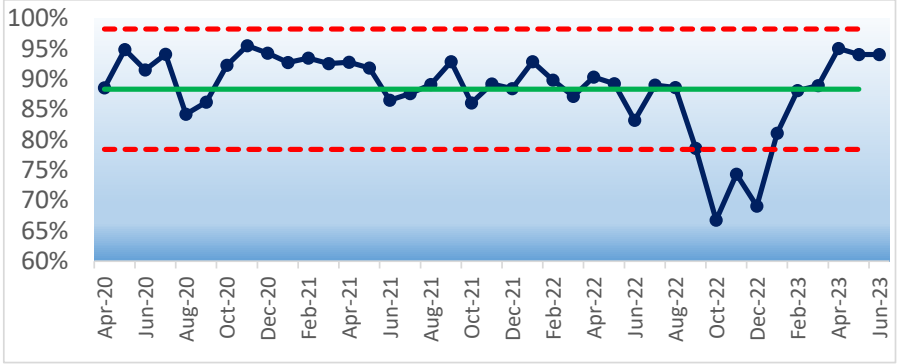
- delivering 7 day SDEC service and a direct to SDEC pathway with YAS;
- streaming of minors at the front door (now in place);
- utilising Criteria to Reside flow software to identify patients no longer requiring hospital care;
- developing a 2 hour crisis response service, expanding ARCH in-reach to 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);
- ED middle grade resilience overnight increases (August 23).

Indicator	**5.7 - Ambulance handovers - % within 15 mins**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Jun-23
Value / RAG rating	94.0%

Indicator description

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

SPC chart



Narrative

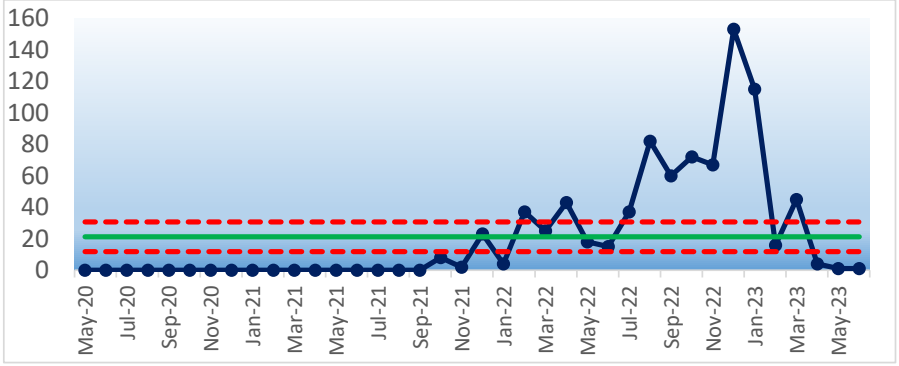
94% of ambulance handovers took place within 15 minutes in June. There were 9 over 30 minute handover breaches and none over 60 minutes, a significant improvement on the winter months. Prevention of ambulance handover delays continues to be a focus with the Trust operational processes being shared across 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	Jun-23
Value / RAG rating	1

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

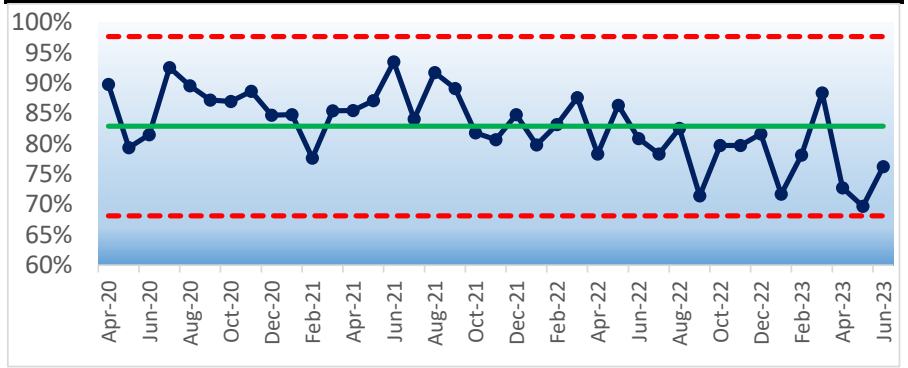
1 over 12 hour trolley waits was reported in June, a sustained improvement on recent months. The RCA has commenced and will be reviewed at internal quality and performance meetings.

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	Jun-23
Value / RAG rating	76.2%

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 June (76.2%). There were 61.0 accountable treatments (73 patients) in June with 46.5 accountable treated within 62 days. Of the 9 accountable tumour sites treated in June, performance was below 85% for 6 sites (Colorectal - 27.3%; Gynaecology - 33.3%; Head and Neck - 33.3%; Lung - 44.4%; Upper GI - 33.3%; Urology - 84.6%).

Provisional data indicates that 50% (11/22) of patients treated at Tertiary centres in June were transferred for treatment by day 38, compared to 18.8% (3/16) last month.

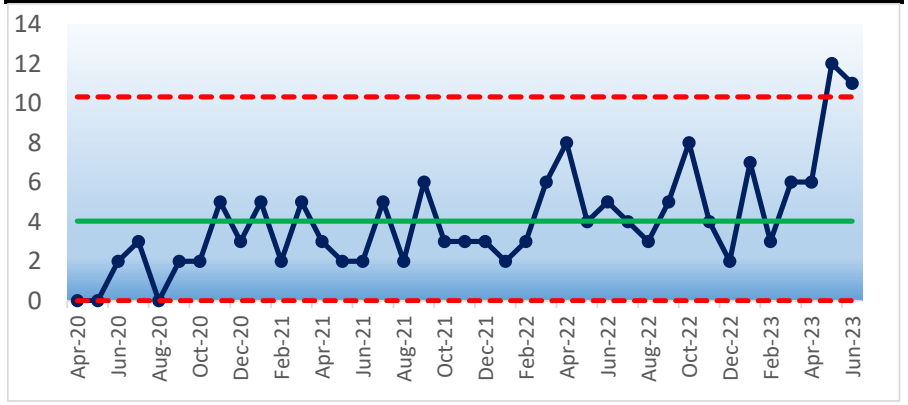
The latest published provisional data reports that national performance for the 62 day standard for all providers was at 61.0% in April. Of 139 providers, HDFT was the 30th best performing Trust. 107 of these providers had 50 or more accountable treatments, and of these, HDFT was the 17th best peforming Trust. This reflects the demand driven pressures on the 2 week wait standard which have now started to improve.

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	Jun-23
Value / RAG rating	11

Indicator description

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

SPC chart



Narrative

11 patients waited 104+ days for treatment in June (3 x Harrogate Colorectal; 2 x Gynae - 1 x Leeds, 1 x HDFT; 1 x Lung Leeds; 2 x Upper GI Leeds; 2 x Prostate Leeds; 1 x Bladder Harrogate. The delay reasons were as follows:

- Bladder: Complex pathway
- Colorectal: Diagnostic delay and elective capacity; Patient fitness; Delay to first OPA (capacity)
- Gynaecology: Delays to hysteroscopy; Outpatient capacity
- Lung: Complex pathway
- Prostate: Surgical capacity at Leeds, Provider delay at Leeds
- Upper GI: Complex; Delay to first OPA (Colorectal capacity)

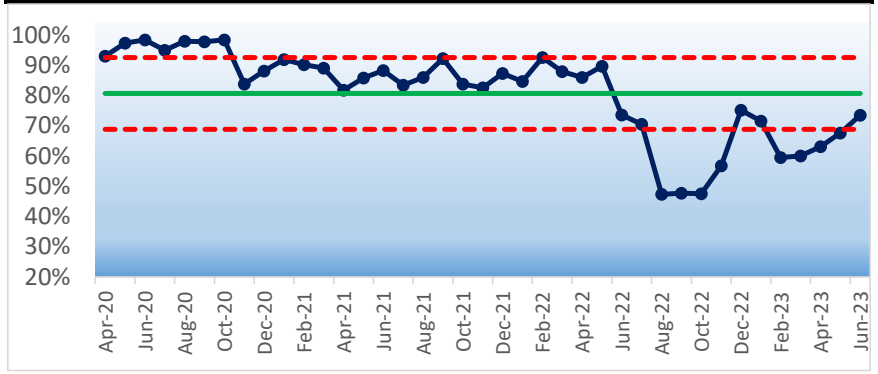
All patients have now received treatment. Following the implementation of a new cancer system in October (Somerset Cancer Registry) and the time constraints on the tracking team, it has been agreed to stand down breach panel meetings until further notice.

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	Jun-23
Value / RAG rating	73.4%

Indicator description

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

SPC chart



Narrative

1,042 patients attended their first appointment for suspected cancer in June which is a small increase on last month (1,027). Of the 1,042 patients seen in June, 277 were seen outside 14 days (73.4%). 14 day capacity continues to be challenging in June with 5 suspected cancer sites below the 93% standard with more than 10 attendances (Breast, Colorectal, Gynae, Lung, Upper GI), and 2 sites less than 60% with more than 10 attendances (Breast - 10.3%; Gynaecology - 47.5%). Non-cancer breast symptomatic performance was at 8.9%. Dermatology performance further improved in June with 98.1% of patients seen within 14 days.

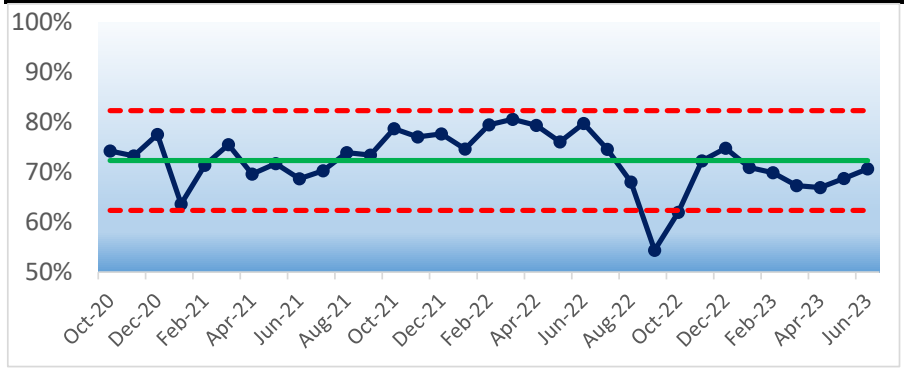
The latest published provisional data reports that national performance for the 2WW suspected cancer standard for all providers was at 77.7% in April. Of 141 providers, HDFT was the 19th worst performing Trust. 122 of these providers had 500 or more first attendances, and of these, HDFT was the 18th worst performing Trust.

Indicator	**5.11 - Cancer - 28 days faster diagnosis standard (suspected cancer referrals)**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Jun-23
Value / RAG rating	70.7%

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 June 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 70.7% (2WW cancer – 76.1%; 2WW Breast Symptoms – 91.5%; Screening – 16.9%).

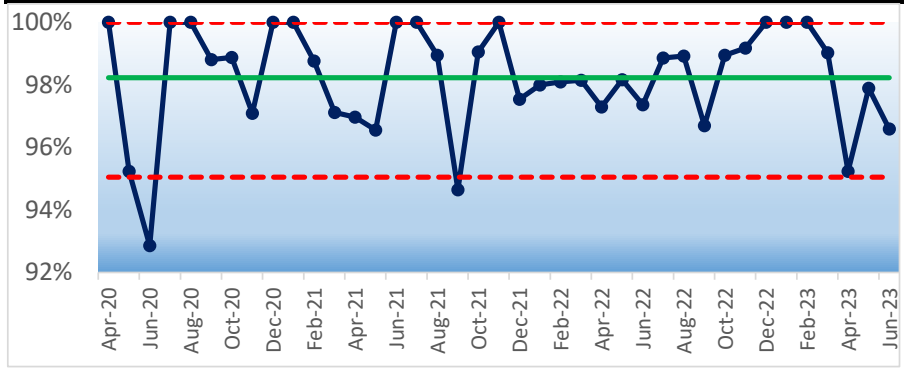
This is at a slight improvement on last month (68.7%) although it should be noted that at this stage in the month data collection for June will not be complete.

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	Jun-23
Value / RAG rating	96.6%

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 88 patients received First Definitive Treatment for cancer at HDFT in June, with 3 patients treated outside 31 days (3 x Colorectal). The delay reasons were as follows:

- Colorectal: 3 x Elective capacity

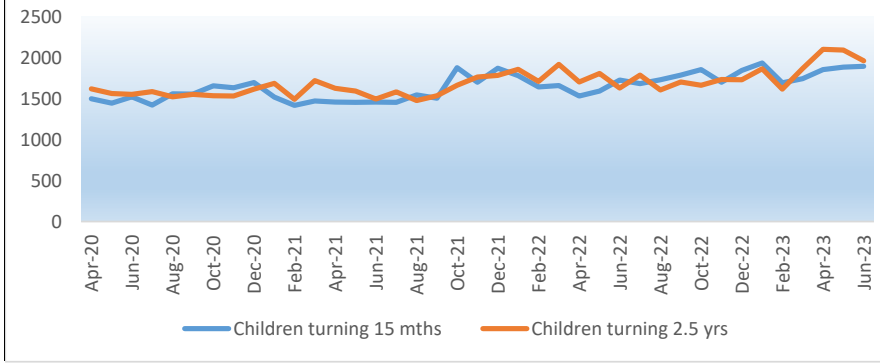
Overall performance was above the expected standard of 96%.

Indicator	**5.13 - Children's Services - 0-12 months and 2-3 years caseload**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Jun-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.

SPC chart



Narrative

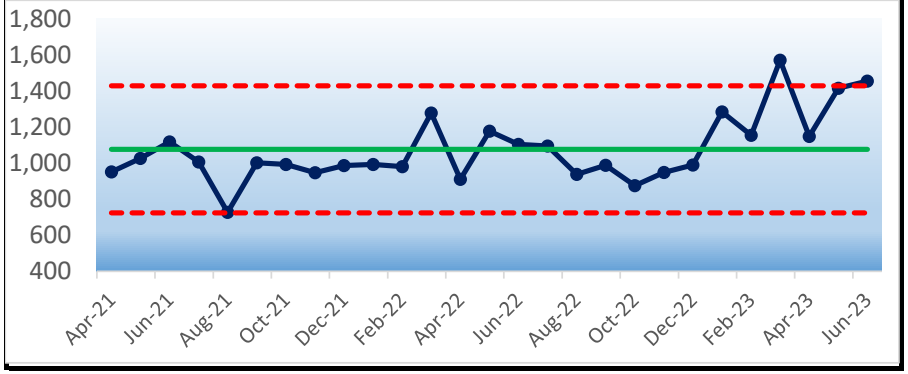
The 0-12 month caseload increased in June, whilst the 2-3 year caseload reduced. Data for Wakefield 0-19 Services is included from Apr-23 onwards.

Indicator	**5.14 - Children's Services - Safeguarding caseload**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Jun-23
Value / RAG rating	1455

Indicator description

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

SPC chart



Narrative

The chart shows the number of Child Protection strategies as an estimate for Safeguarding caseload. Data for Wakefield 0-19 Services is included for Apr-23 onwards.

Indicator	**5.15 - Children's Services - Ante-natal visits**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Jun-23
Value / RAG rating	93.4%

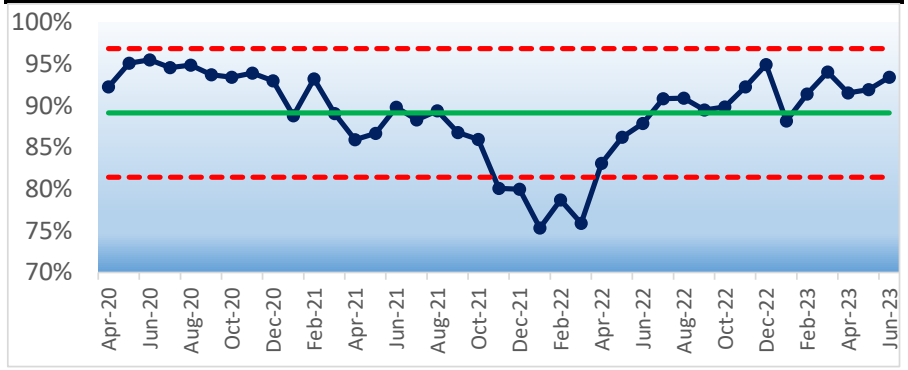
Indicator description

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

Narrative

93% of eligible pregnant women received an initial antenatal visit in June. Data for Wakefield 0-19 Services is included for Apr-23 onwards.

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	Jun-23
Value / RAG rating	93.7%

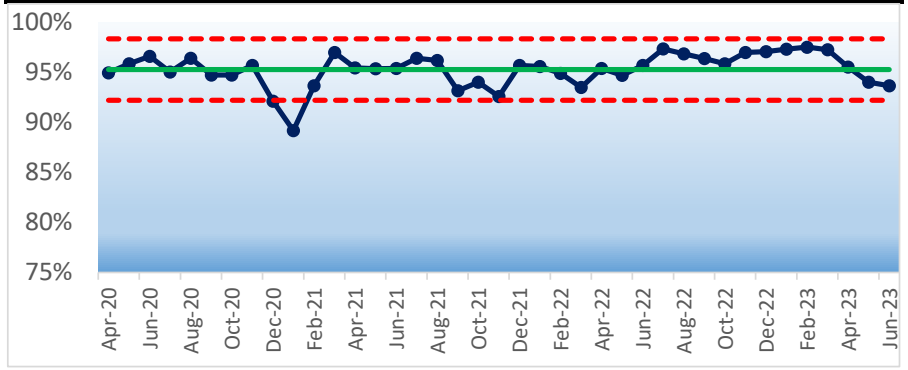
Indicator description

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

Narrative

94% of infants received a new birth visit within 10-14 days of birth during June. Data for Wakefield 0-19 Services is included from Apr-23 onwards.

SPC chart



Indicator	**5.17 - Children's Services - 6-8 week visit**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Jun-23
Value / RAG rating	93.6%

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 June. Data for Wakefield 0-19 Services is included from Apr-23 onwards.

SPC chart

Indicator	**5.18 - Children's Services - 12 month review**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Jun-23
Value / RAG rating	96.6%

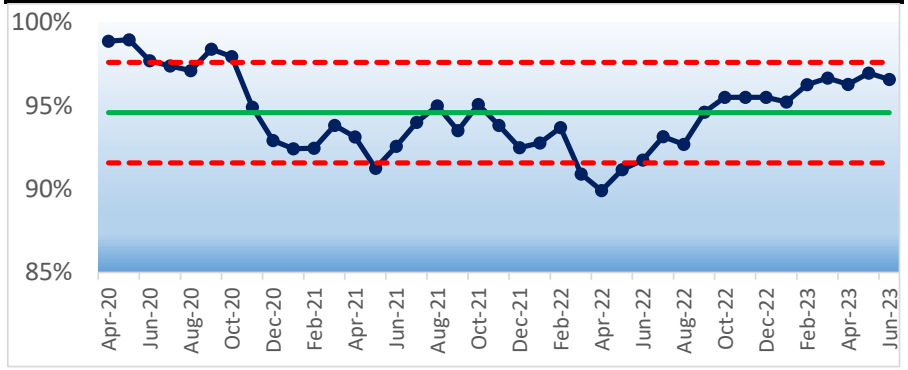
Indicator description

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

Narrative

97% of eligible children received a 12 month review by 15 months of age during June.
Data for Wakefield 0-19 Services is included from Apr-23 onwards.

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	Jun-23
Value / RAG rating	95.5%

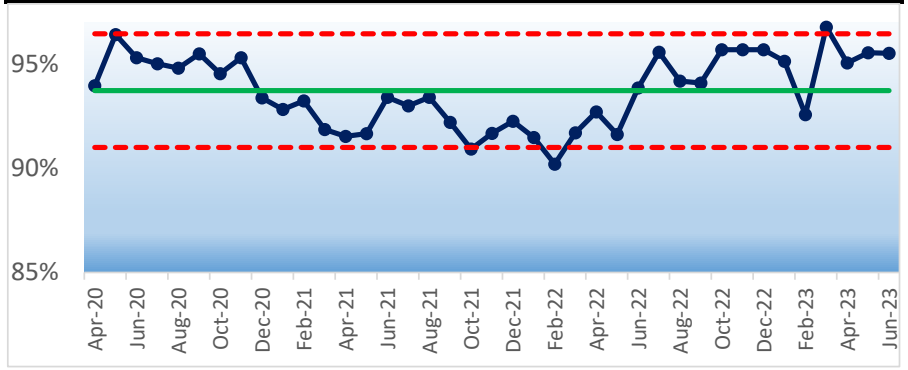
Indicator description

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

Narrative

96% of eligible children received a 2 - 2.5 year review by 2.5 years of age during June. Data for Wakefield 0-19 Services is included from Apr-23 onwards.

SPC chart



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

Indicator description

This indicator is under development.

SPC chart

Narrative

A one-off audit was carried out on North Yorkshire data in 2021 which looked at children born in 2017/18 and how many mandated contacts they had received. This showed that 62% of children had received all mandated contacts. 0.4% of children were recording as not having had any mandated contacts. A list of these children was shared with service managers to follow up.

The intention is to repeat this audit annually and extend to include all localities covered by HDFT's Children's Services.

Indicator	**5.22 - 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 June 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 3
Northumberland - Level 2
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 June 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	4

Indicator description

This indicator is under development.

SPC chart

Narrative

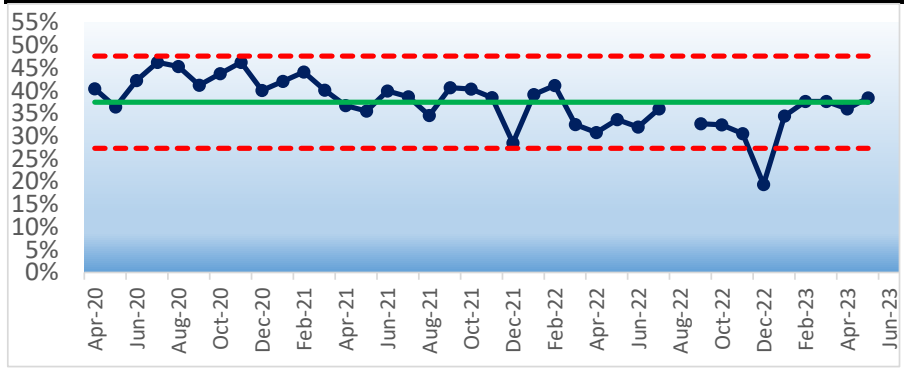
CC Directorate have started to discuss and record OPEL levels for Adult Community Services at their Safety and Governance huddles. The overall position for June increased to Level 4. The Adult Community Services are currently running on a 25% vacancy rate for nursing. As part of the OPEL actions, work is prioritised according to risk and ensuring all available capacity is re-directed to clinical work. Unfortunately during the period in question, the teams experienced additional short term sickness and an increase in referrals and acuity of current caseloads, which meant that the actions taken did not stop the service moving into OPEL 4 for a period. The main action was to reduce referrals to the service for a period. The situation was reviewed daily and are the service is now back at OPEL 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	May-23
Value / RAG rating	38.4%

Indicator description

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

SPC chart



Narrative

The GPOOH service moved clinical systems part way through June - from Adastra to Systmone. As a result, there will be a delay in reporting Jun-23 performance data.

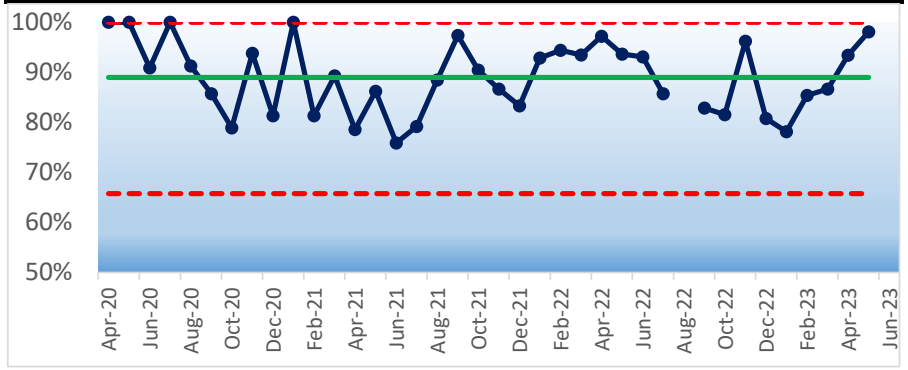
In May, 38% of urgent cases received a telephone clinical assesment within 20 minutes of call prioritisation, an increase on last month.

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	May-23
Value / RAG rating	98.1%

Indicator description

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

SPC chart



Narrative

The GPOOH service moved clinical systems part way through June - from Adastra to Systmone. As a result, there will be a delay in reporting Jun-23 performance data.

In May, 98% of urgent cases received a home visit within 2 hours, an increase on the previous month.

Integrated Board Report - June 2023

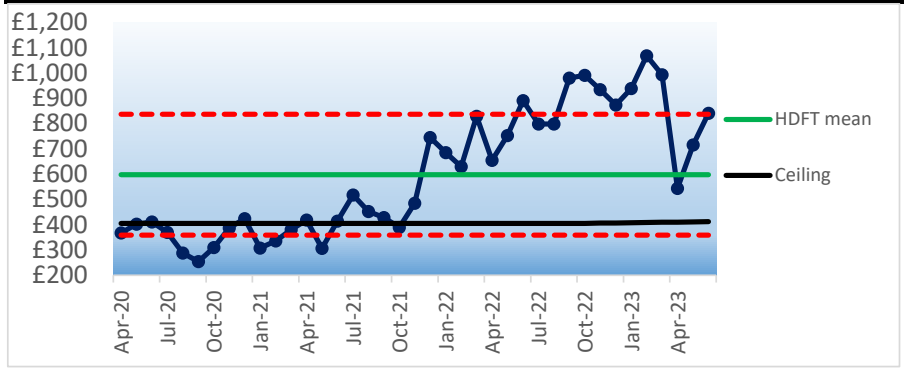
Domain 6 - Efficiency and Finance

Indicator	**6.1 - Agency spend**
Executive lead	Jordan McKie, Finance Director
Board Committee	Resources Committee
Reporting month	Jun-23
Value / RAG rating	£840

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

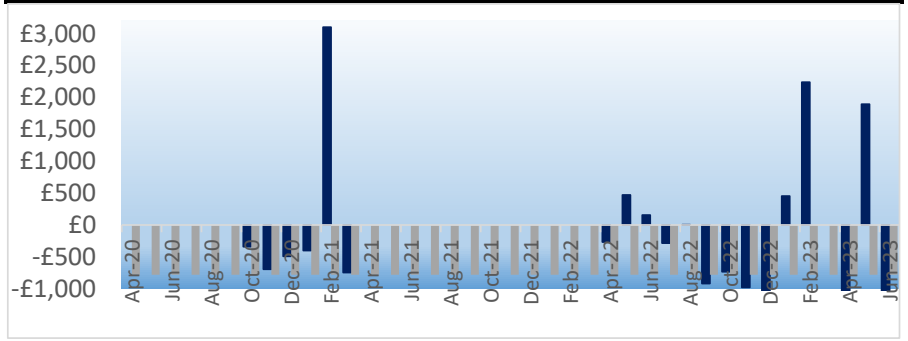
Significant agency costs remain across the organisation and have increased by a further £125k in month. All Directorates are reviewing Agency spends and considering options to reduce current usage.

Indicator	**6.2 - Surplus / deficit and variance to plan**
Executive lead	Jordan McKie, Finance Director
Board Committee	Resources Committee
Reporting month	Jun-23
Value / RAG rating	-£1,886

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 YTD position is currently a £1.4m deficit against the planned surplus, however the underlying position is actually £2.9m deficit (the planned surplus has been adjusted to the second half of the year). Plans are still to be worked through to deliver the £6m surplus.

Indicator	**6.3 - Capital spend**
Executive lead	Jordan McKie, Finance Director
Board Committee	Resources Committee
Reporting month	Jun-23
Value / RAG rating	£1,848

Indicator description

Cumulative Capital Expenditure by month (£'000s)

Trend chart

Narrative

The capital plan has been re-phased to reflect the forecast spend. The PDC schemes are weighted towards the second half of the year. Larger estate schemes are also likely to be completed from September onwards.

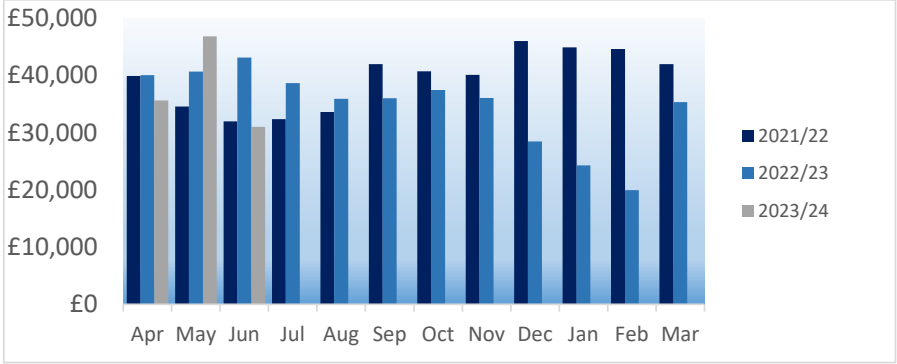
As at June, £1.9m has been spent on capital, CT pressures have emerged which wasn't part of the original plan.

Indicator	**6.4 Cash balance**
Executive lead	Jordan McKie, Finance Director
Board Committee	Resources Committee
Reporting month	Jun-23
Value / RAG rating	£31,006

Indicator description

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

Trend chart



Narrative

There are no current cash concerns. There has been a significant reduction in cash as the payment of the non-consolidated pay award and the backdated recurrent pay award is processed but we have assurance on the reimbursement. Conversations with 0-19 Services are ongoing for their contribution.

Indicator	**6.5.1 - Long stay patients - stranded (>7 days LOS)**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Jun-23
Value / RAG rating	126

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 126 in June, an increase on last month.

Indicator	**6.5.2 - Long stay patients - superstranded (>21 days LOS)**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Jun-23
Value / RAG rating	51

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

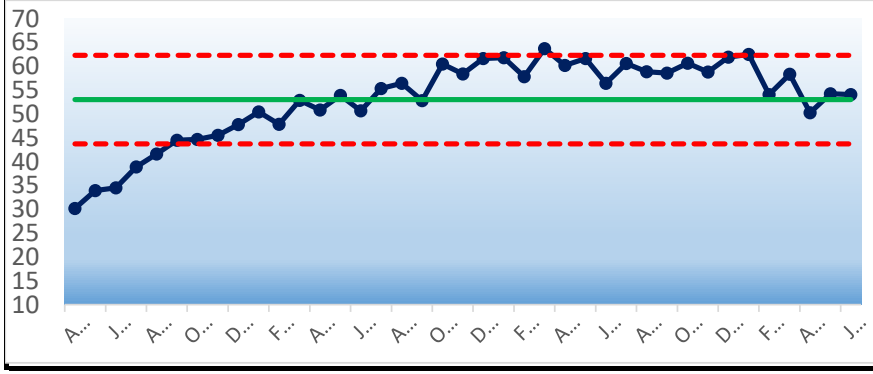
The number of long stay patients (> 21 days) was 51 in June, an increase on last month.

Indicator	**6.6 - Occupied bed days per 1,000 population**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Jun-23
Value / RAG rating	54.1

Indicator description

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

SPC chart



Narrative

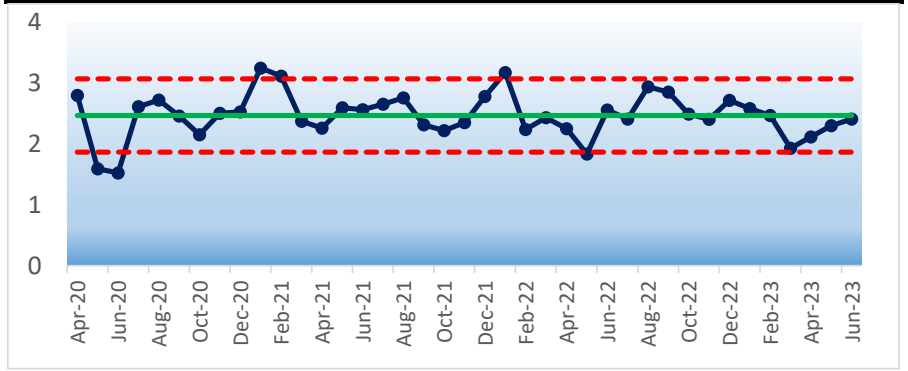
Occupied bed days per 1,000 population were at 54.1 in June, no significant change on last month. In the 2 years prior to the pandemic, occupied bed days per 1,000 population averaged 57.8, above the current level.

Indicator	**6.7.1 Length of stay - elective**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Jun-23
Value / RAG rating	2.41

Indicator description

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

SPC chart



Narrative

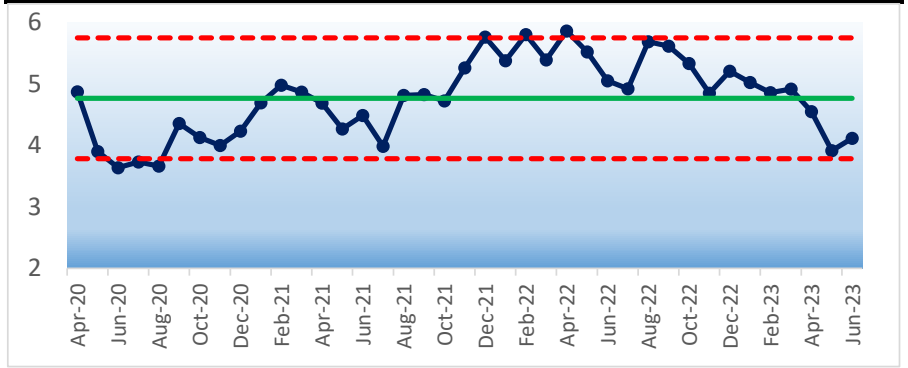
Elective length of stay increased in June but remains below our local stretch target of 2.5 days.

Indicator	**6.7.2 Length of stay - non-elective**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Jun-23
Value / RAG rating	4.11

Indicator description

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

SPC chart



Narrative

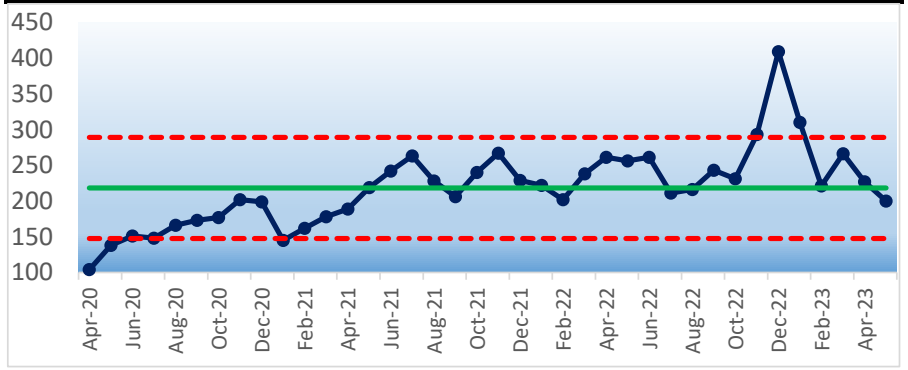
Non-Elective length of stay increased to 4.1 days in June and is above our local stretch target.

Indicator	**6.8 - Avoidable admissions**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	May-23
Value / RAG rating	200

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 200 avoidable admissions in May, within expected levels and a continued reduction on the winter months. The most common diagnoses remain as pneumonia and urinary tract infections. Excluding children and admissions to SDEC, the figure was 134.

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	Jun-23
Value / RAG rating	80.1%

Indicator description

The percentage of time utilised during elective theatre sessions (i.e. those planned in advance for waiting list patients). The utilisation calculation excludes cancelled sessions.

SPC chart

Narrative

Theatre utilisation was at 80.1% in June, a decrease on last month and 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	Jun-23
Value / RAG rating	1.8%

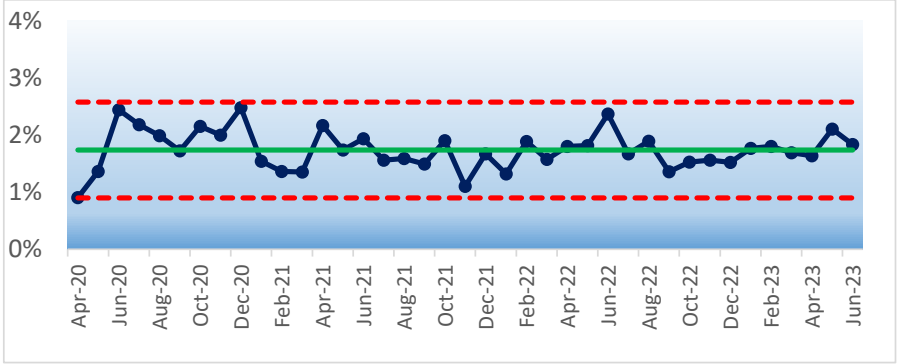
Indicator description

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

Narrative

1.8% (44 patients) of intended day cases stayed overnight or longer in May, a decrease on last month and remaining within the control limits.

SPC chart



Integrated Board Report - June 2023

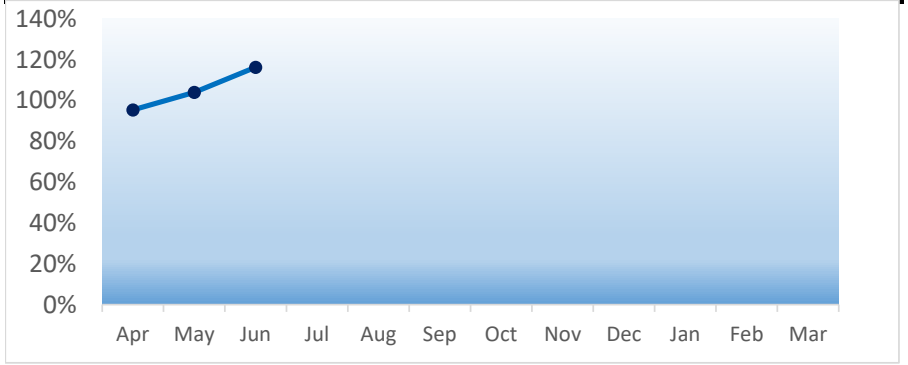
Domain 7 - Activity

Indicator	**7.1 - GP referrals against 2019/20 baseline**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Jun-23
Value / RAG rating	116.3%

Indicator description

GP referrals against 2019/20 baseline.

SPC chart



Narrative

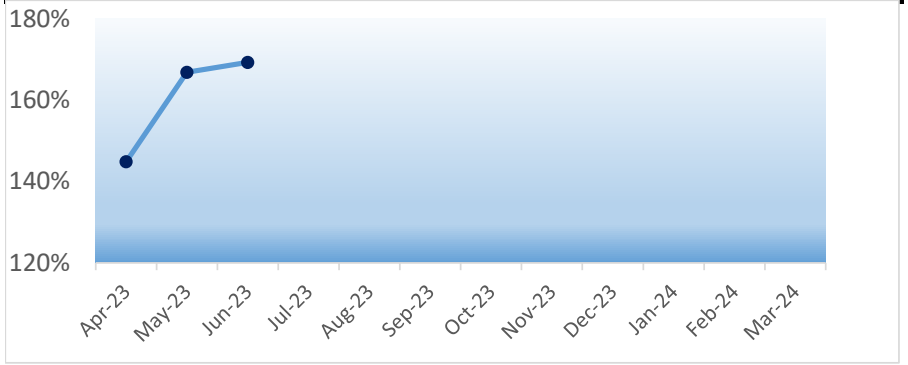
In June, GP referrals were 16% above the equivalent month in 2019/20. On a year to date basis, GP referrals are 5% above 2019/20.

Indicator	**7.2 - Outpatient activity (consultant led) against plan**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Jun-23
Value / RAG rating	169.3%

Indicator description

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

Trend chart



Narrative

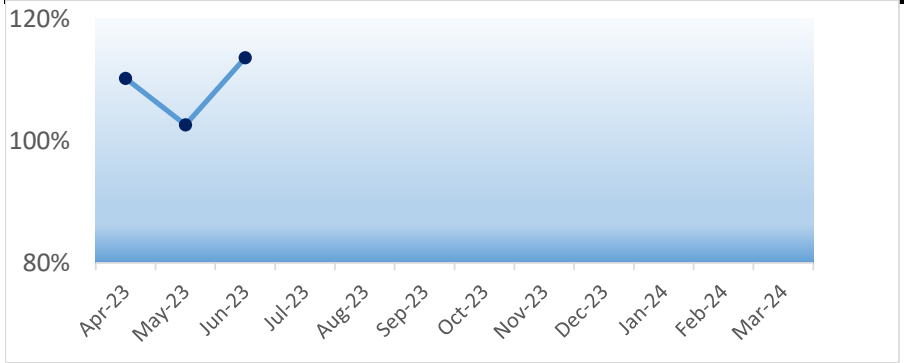
Outpatient activity was 69% above plan in June. New outpatient attendances were 29% above plan and follow up attendances were 98% above plan. Work is underway on how to reduce follow up activity - however HDFT are already achieving significant follow up avoidance through Patient Initiated Follow up (PIFU). Further analysis to understand the breakdown of the additional follow up activity is underway.

Indicator	**7.3 - Elective activity against plan**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Jun-23
Value / RAG rating	113.6%

Indicator description

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

Trend chart



Narrative

Elective admissions were 14% above plan in June. Elective day cases were 13% above plan and elective inpatients were 18% above plan.

Indicator	**7.4 - Non-elective activity against plan**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Jun-23
Value / RAG rating	115.7%

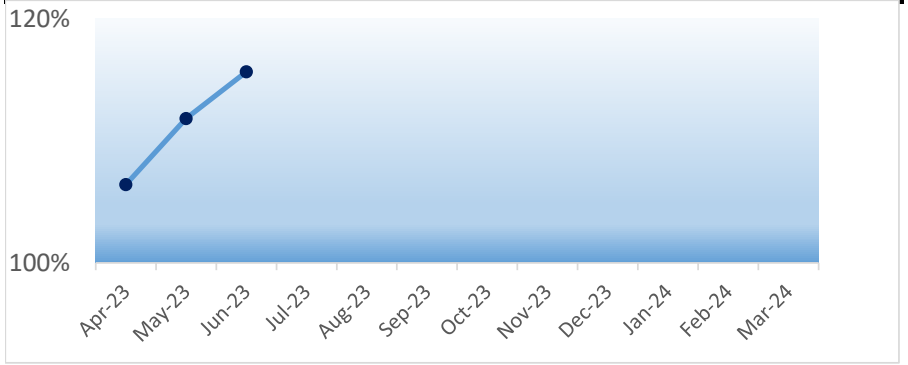
Indicator description

Non-elective activity against plan.

Narrative

Non-elective activity was 16% above plan in June.

Trend chart

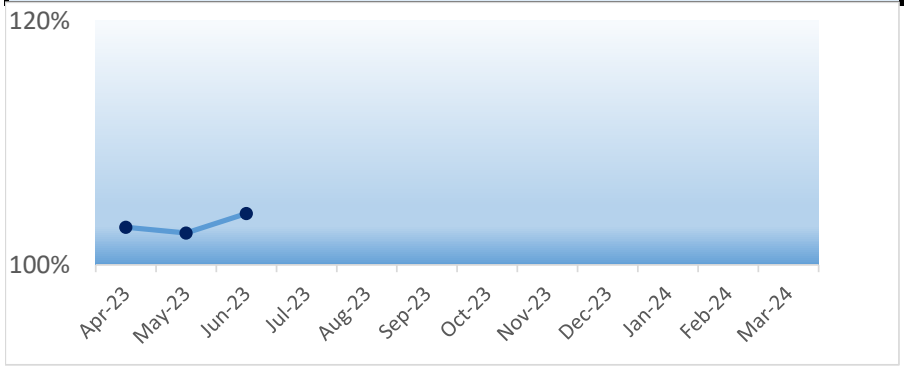


Indicator	**7.5 - Emergency Department attendances against plan**
Executive lead	Russell Nightingale, Chief Operating Officer
Board Committee	Resources Committee
Reporting month	Jun-23
Value / RAG rating	104.2%

Indicator description

Emergency Department attendances against plan.

Trend chart



Narrative

Emergency Department attendances were 4% above plan in June.

Integrated Board Report - June 2023

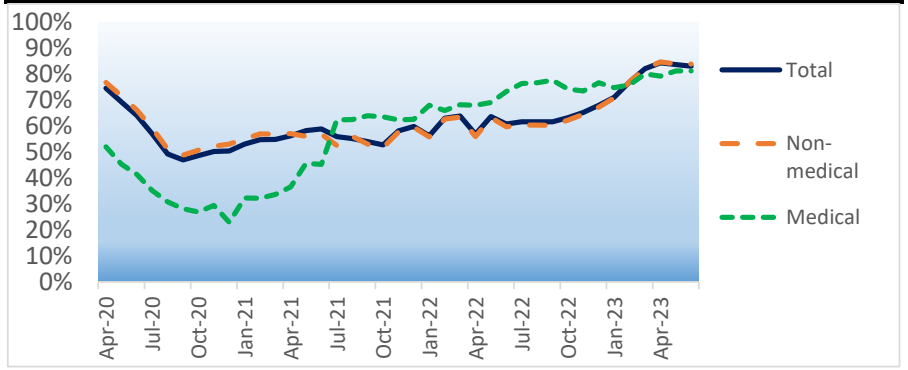
Domain 4 - Workforce

Indicator	**4.1 - Appraisal Rate - Non Medical and Medical Staff**
Executive lead	Angela Wilkinson
Board Committee	People and Culture Committee
Reporting month	Jun-23
Value / RAG rating	83.1%

Indicator description

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

SPC chart



Narrative

The appraisal rate in June is 83.1%, which is a small decrease in comparison to May, which saw an appraisal rate of 83.7%. Corporate Services has the lowest compliance rate of 77.5% in June which is a decrease from 80.2% last month. 651 appraisals are outstanding as at 30th June 2023.

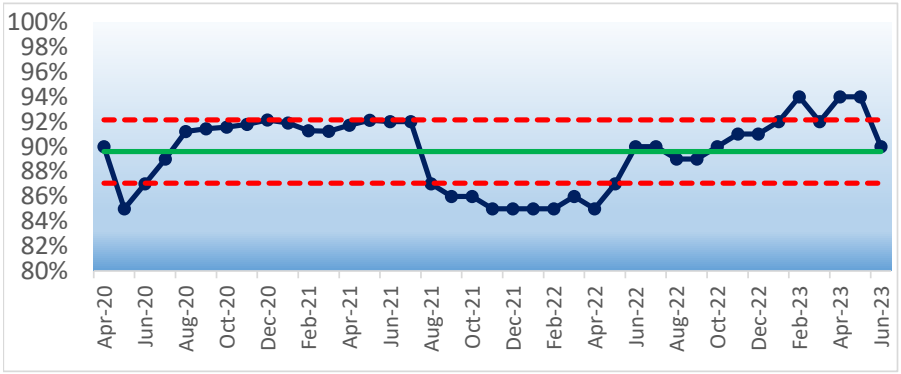
- Non-Medical appraisal % = 83.5% (previous month 83.9%)
- Medical appraisal % = 78.4% (previous month 81.3%)

Indicator	**4.2 - Mandatory and Essential Skills Training rate**
Executive lead	Angela Wilkinson
Board Committee	People and Culture Committee
Reporting month	Jun-23
Value / RAG rating	90.0%

Indicator description

Latest position on the % of substantive staff trained for each mandatory training requirement

SPC chart



Narrative

The data shown is for the Mandatory training compliance for end of June. The overall compliance rate for substantive Trust staff is 90% and has decreased since the previous month, following a review of the mandatory training portfolio and amendments to the definitions of training.

The Mandatory training overall compliance for bank staff is now 76% and has decreased by 10% since the previous month following the same review as mentioned above.

The overall compliance for Role Specific training for Trust substantive is currently 91% and has increased by 1% since the previous month.

Indicator	**4.3 - Staff sickness rate**
Executive lead	Angela Wilkinson
Board Committee	People and Culture Committee
Reporting month	Jun-23
Value / RAG rating	4.4%

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 increased in June from 4.2% to 4.4% . Covid sickness absence remains at a low level this month, seeing a minimal decrease to 0.1% in June. 172.23 FTE days were lost due to Covid related sickness in June. “Anxiety/stress/depression/other psychiatric illnesses” remains the top reason for sickness this month and contributes to nearly a third of the overall sickness. Sickness due to this reason has seen very little change when compared to May sickness and 111 employees were absent in June.

Sickness has increased in both the CC and PSC Directorates, with CC having the greatest sickness rate in June of 6.0%. This is an increase from 5.5% in May. The top 5 areas of greatest sickness are all within the CC Directorate and the top 4 are Children’s Services.

The Gateshead and North Yorkshire localities have the highest rates of 10.5% and 9.0% respectively and both saw an increase in June compared to May.

Short term sickness has seen an increase from 1.6% to 1.8% and is the reason for the increase in sickness rates this month.

Indicator	**4.4 Staff turnover rate**
Executive lead	Angela Wilkinson
Board Committee	People and Culture Committee
Reporting month	Jun-23
Value / RAG rating	14.7%

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 seen a further decrease in June to 14.7% (This incorporates voluntary and involuntary turnover). A decrease in the number of leavers over the last 12 months is the reason for turnover rates decreasing in June.

Turnover has increased in both the Corporate Services and LTUC Directorates, with Corporate Services having the greatest turnover rate in June of 17.0%. The Directorate has seen a general increasing trend since October 2022. The 'Support to Clinical staff' staff group has the greatest turnover rate of 17.3% this month, however this is a decrease from 18.0% in May.

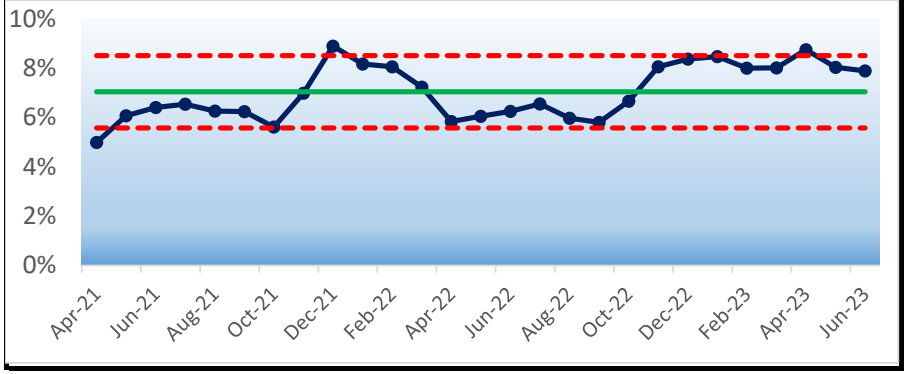
48% of leavers over the last 12 months have less than 2 years' service with the Trust. Work is ongoing to understand reasons for leaving as part of the retention programme and develop short, medium and long term actions to help reduce voluntary leavers.

Indicator	**4.5 - Vacancies**
Executive lead	Angela Wilkinson
Board Committee	People and Culture Committee
Reporting month	Jun-23
Value / RAG rating	7.9%

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 June is 7.9%, which is a decrease from 8.0% in the previous month. This equates to 354.38wte vacancies. The reason for the decrease in vacancies is due to an increase in the staff in post this month by 6.37wte and a reduction in budget of 0.50wte.

LTUC and PSC Directorates have the greatest vacancy rates of 14.4% (193.27wte vacancies) and 10.0% (93.14wte vacancies) respectively. This is a decrease for LTUC from 15.0% last month, however PSC has seen an increase from 9.2%. We continue to review recruitment pipeline and processes to help mitigate vacancy rates

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

Date	**4 May 2023**	**Location**	SJUH
Chair	**Brendan Brown**	**Minutes prepared by**	Lucy Cole
Attendees	Lucy Cole, Len Richards, Brendan Brown, Foluke Ajayi, Jonathan Coulter, Mel Pickup, Phil Wood Sal Uka (items 4 and 5)		
Apologies	None.		

Agenda

Item	Time	Description	Lead	Attachment
Part 1 – Workshop session				
	09:30	WYAAT Strategy • Focal areas • Key priorities • Requirements from ICB Operating Model review	All	Verbal
Part 2 – Formal Programme Executive Meeting				
1	11:15	Attendance & Apologies	Chair	
2	11:20	Minutes & Actions	All	2a, 2b
3	11:25	Collaborative Report and WY HCP Report	LC	3a and 3b
4	11:45	Vascular operating model	LC / SU	4
5	12:00	Haematology update	SU	Verbal
6	12:10	AOB • June meeting	All	Verbal
7	12:20	Close	Chair	

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

<table>
<tr><th>By Agenda Item</th><th>Main Points and Decisions from Discussions</th><th>Agreed Actions</th></tr>
<tr><td>Workshop session: WYAAT Strategy</td><td>Outputs from the Strategy workshop are summarised in the table below.
<table>
<tr><th>What</th><th>How</th><th>Implications</th></tr>
<tr><td>Greater sharing of best practice</td><td>• Establish a collaborative portal to share best practice and enable connections between teams / individuals and organisations
• Establish, enable and support clinical networks and networks of SMEs across WYAAT to enable peer support and shared learning</td><td>• BAU resource required to support and maintain networks and portal / website to ensure most benefit
• Effectively a shared ‘function’ of the operating model
• Resource likely to be administrative
• Consider support from ICB as part of operating model review – could other networks in ICB e.g., cardiac, stroke become part of this?</td></tr>
<tr><td>Focus on quality improvement</td><td>• Cement the ‘WYAAT way’ of conducting service improvement / transformation, supported by standard work
• Embed quality improvement ethos and approach into networks
• Implement greater rigour and clear approach to evaluation</td><td>• Consider our evaluation approach – academic partner?
• Link with NHS IMPACT?
• Strengthen data available to networks to identify variation and good practice to enable improvement</td></tr>
<tr><td>Collaborative R&I</td><td>• Establish a collaborative approach to responding to and proactively seeking opportunities with academic and industry partners</td><td>• BAU resource required to support this work
• Effectively a shared ‘function’ of the operating model</td></tr>
</table></td><td>Review next steps at July meeting</td></tr>
</table>

				• Could this be a different relationship with the AHSN? • Evaluate where we've done this e.g., NPIC		
		Patient safety	• Use collaborative approach to make improvements on patient safety • Review scope and function of learning from incidents group to support improvement approach to patient safety	• Consider appetite and framework to support peer review?		
		Relationship between WYAAT and Place	• Create clearer relationship between WYAAT and Place on pathway developments and transformation projects	• Communication mechanisms • Implications of owning programmes on behalf of ICS • Role in data sharing to demonstrate variation at Place level for local solutions		
		Strengthen comparative data	• Create broader shared data to enable growth of best practice sharing and improvement • Create shared data set to support closer networks	• IG barriers will need to be overcome to share more granular data		
		Workforce	• Understand the pipeline of new workforce coming through vs. the capacity required in the future • Develop new roles and workforce models to support service delivery for the future • Implement structure around 'test, learn and scale' approaches	• Availability of good data on our workforce – current and future (relationship with ICB and NHSE on this)?		

			• Create recruitment approaches for networked services to support sustainability			
		Governance	• Create greater ownership and stronger links between exec peer groups • Collaborative agreement of shared priorities across exec groups with cross-functional working to support this	• Strategic focus of programme exec (each quarter) • Invite chairs of exec groups to this meeting to support implementation of workplan • Focus of CiC to be shaped around strategy and objectives and associated risks – revised risk management approach		
Review previous meeting minutes and action points	The minutes from the previous meeting were accepted as a true record. The action log was reviewed, and the following updates were given: • Actions 99 – in progress. • Actions 101, 104, 105, 106 are complete.					
Collaborative Report and WY HCP report	LC presented the Collaborative Report. LC gave highlights from the Collaborative Report: • Endoscopy – self-assessment process from trusts has now been completed to host the Regional Training Centre (RTC). A letter from HEE directly to trusts has caused some confusion which the programme team is clarifying with HEE/NHSE. It is understood that this relates to the pan-Yorkshire arrangements rather than the model in West Yorkshire. Once clarified, communications will go out to colleagues and the steering group will be convened. • Pathology – risk increasing of a delay to the implementation of the microbiology and blood sciences modules due to capacity of staff to undertake testing. Reviewing options to mitigate. LC will escalate to CEOs if further support is required.					**SU to bring progress on neurology to next meeting.**

WYVaS options	LC presented the WYVaS options paper, noting that the original model described in the options appraisal (single management team, single contract, single commissioning model and financial model) had not been implemented. Given the emergence of other models of networked services, notably the NSO sector model, the WYVaS Board has considered options for the delivery of the vascular network. The preferred option has been identified as Option 3 which ensures operational and clinical leadership is retained as close to service delivery as possible, through the two sectors, led by the arterial centres – BTHFT for WYVaS West and LTHT for WYVaS East. This option continues to maintain a single vascular network, bringing together clinical teams across East and West to undertaken joint clinical governance, pathway development and improvement work. The network will be overseen by a WYAAT-wide governance structure to ensure equity of provision and outcomes across East and West. The group highlighted the need to understand whether the outcomes described at the start of the programme had been achieved. LC noted that the programme was not yet complete. Some indicators such as length of stay have shown improvements in the West, but work was still required to develop the model in WYVaS East. BB queried if changing the model would limit the achievement of the specified outcomes. LC shared her view that the outcomes could still be achieved and there would still be a single vascular network, with a slightly different delivery model (sector rather than single managed service). Additionally, LC commented that the original model was very ambitious and probably related to the maturity of relationships at the time. There is now strong evidence that the network can be delivered through a more collaborative network approach, rather than requiring a single managed service. Programme Executive supported the recommendation of the WYVaS Board as the delivery model for the service, retaining the commitment to a single vascular network and requested that the WYVaS team updates Programme Executive on outcomes in six months' time.	**WYVaS team to bring overview of outcomes to meeting in October 23.**
Haematology	SU updated on haematology noting that there had been two sessions, the first with a smaller number of clinicians specifically to understand the issues in relation to on-call arrangements and the second with a broader group of clinicians to explore a wider range of issues in relation to the sustainability of haematology services. SU confirmed that the engagement and appreciation of the issues from the clinical and operational teams was strong, and this group could and should be supported to develop a local solution, without the need to engage any external support. It was noted that there was a lack of insight from other systems and collaboratives on clinical haematology models, LC commented that a number of systems were concerned about the sustainability of the specialty but had yet to undertake proactive reviews or implement new models. There was also a lack of benchmarking information e.g. GIRFT.	**SU to bring progress update on haematology to meeting in August 2023.**

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

	FA asked that the short-term stability of the service was also prioritised during the long-term design phase of work. The group agreed that progress should be reported to Programme Executive in four months' time.	
AOB	LC noted that the June meeting slot would now be used to hold the rearranged senior leadership programme launch event. It was agreed to hold a short Programme Executive meeting before or after this launch session.	**LC to confirm times of event and agree programme exec session around this.**

OTHER ISSUES TO NOTE
N/A

NEW RISKS/ISSUES RAISED
N/A

Next Meeting	**WYAAT Programme Executive**		
Date	6 June 2023 (Time TBC)	**Location**	Huddersfield Royal Infirmary

Humber and North Yorkshire
Health and Care Partnership

Collaborative of Acute Providers (CAP) Board Meeting
24th April 2023 10.00 – 12.00
Via Teams

Those Present: Jonathan Coulter (JC), Acting CEO, Harrogate
Peter Reading (PR), CEO, NLaG
Ivan McConnell (IMc), Director of Strategic Development, NLaG
Simon Morritt, (SM) CEO Y&STFT
Shauna McMahon (SMc) Chief Information Officer
Kate Wood (KW) Chief Medical Officer (NLaG)
Andy Bertram (SB), Chief Financial Officer, York

In Attendance: Carla Mitchell, (CM) Executive Assistant (Note Taker)
Lynnette Smith (LS) Deputy Managing Director of the Collaborative
Paul Mctague (PM) Community Health and Care Collaborative

1 Apologies:
Wendy Scott (WS), MD CAP
Chris Long (CL), CEO HUTH (Chair)
Shaun Jones (SJ) Locality Director, NHSE,
Shaun Stacey (SS), COO (NLaG),
Matt Graham (MG), Director of Strategy, Harrogate

2 Minutes from last meeting
The Minutes from 27.03.2023 were approved as an accurate record.

KW noted as present however she was on annual leave. KW did not receive the papers and would like these to be shared.

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

4 Community Collaborative - Frontrunner
PM shared the aims and objective overview of the Discharge Integration Frontrunner; *to co-design with system partners a digital dashboard for use in the community that supports faster hospital discharge, significantly reduces NCTR and LOS and prevent avoidable admissions by having visability of overall system capacity and the ability to link this to demand in an intelligent way.* PM advised of the programme key points and gave the detail.

He advised of the proposed roll out timeline/mobilisation plan across the sub systems, commencing in Hull and East Riding. PM shared the delivery stages, noting that this is in the design stage and that challenges are ongoing in bringing local authority data into the single dashboard which has meant that some plans have had to be revisited with the national team. The scoping phase was hoped to conclude at the end of quarter four last year but it is now likely to be June this year before the first site programme goes live.

PM advised of the linked programmes to the D2A Programme and noted that a lot of the work that *public sector commissioning (Consultancy)* are undertaking, is valuable in understanding the pathways process and how this will aid conversations with colleagues in North links and NE Lincs in undertaking a similar piece of work.

Humber and North Yorkshire
Health and Care Partnership

In terms of what the data analysis has demonstrated, he noted that there is a clear case for change and that the current state analysis and pathway has highlighted 2 overarching reasons for change. PM shared the detail

1) Because the current situation is not sustainable
2) To Improve patient experience and outcomes

PM advised of the operational process mapping undertaken to ensure that user needs and data flows are understood. He advised of the qualitative engagement processes that has also identified potential issues with the discharge process and gave the details.

PM advised that Community OPTICA is the system being used to develop the data. PM shared a view of how using Community OPTICA will support the wider system flow. In terms of next steps and progress, PM shared the highlights and concluded that they are positively encouraged by what the system will be able to deliver in terms of outcome measures

IMc offered to work with PM offline looking at the stakeholders and the mapping demand dependencies/interdependencies in order to map some of across as some of the work might already be in place. PM appreciated this suggestion and thanked everybody for their contributions. **IM**

A discussion ensued and JC asked for further info outside of the meeting in respect of how a single workforce plan links together. JC and PM to discuss offline **JC**

CM to share the presentation **CM**

PM advised that this session has been primarily about engagement and awareness. JC concluded that the CAP Board were generally supportive and could see the value that this could bring.

5 CAP Governance

WS had previously circulated the CAP Governance options on the non Executive attendance or membership of the CIC. Feedback from everybody has been received and the consensus is option 2, which was having them participate as a member of the CIC which was in the original documentation. This documentation can now be taken to Trust Boards pending discussions of the workplan that will go along side that to respective Boards. Robert McGough will do a tailored version that reflects each Trust with a view to setting up the first Committee in Common in June.

All confirmed they are happy to take through Boards however should there be any concerns beforehand, this can be discussed at the CEO/Chair OD Timeout next week.

LS confirmed that she will write out to all Board Secretaries to confirm which Boards it will go through and governance groups. **LS**

6 System Financial Plan and Resources

(a) Update on position

AB confirmed that as a group of providers and wider ICS and ICB, the old year position has been balanced and the use of CDEL has been maximised noting that we are where we should be as individuals and as a collective.

Humber and North Yorkshire
Health and Care Partnership

Moving into the new year's plans, there is a £118m deficit as an ICB. He advised that the ask from our ICB from NHSE is centering on getting that £118m down to £60m so a £58m improvement. AB shared the details of where the savings are to come from noting that £28m is to come from places which will take them beyond balance as £26m is the place deficit. He noted that Harrogate in terms of West Yorkshire Elective Recovery Funding, will bring £3m into the patch and improve the position and the balance that takes us to the £58m target improvement with £27m to be shared out by the 3 providers on the patch, £10.3M York, £11.7m Hull and £4.8m in Harrogate. There is no further improvement required for NLAG, Humber is already at balance. Plans are to be submitted on the 4th May. All organisations agreed and accepted the improvement to respective plans and as such plans are being prepared on this basis.

AB briefed that in exchange for getting to the £60m improvement, there is an expectation that two things will happen as an ICB, around £27m is likely to be released into the system which is a combination of funding that most are holding for NHSE and some national inflation settlement which would take the net operating deficit down to £33m. AB added that there is a benefit in that there is no regulatory intervention

(b) Quality, Efficiency and Productivity approach

Acute Collaborative next steps – AB advised that these have been shared with the national team specifically about what it is the collaborative is doing. AB advised of the actions underway and Major collaborative programmes already deployed. He noted there is now an ICB finance efficiency group that is meeting, looking to develop a matrix of opportunity and learning and is also drawing in other groups, looking at efficiency, productivity gains and workforce and how we support each other. This is in the early planning stage and will be taken back to individual organisations in due course.

KW raised that it will be clinical staff within organisations that will help with the productivity and efficiency gains therefore early engagement with key clinical staff is necessary. A discussion ensued that this group is currently just sharing ideas together and that the efficiency leads are working with clinicians within organisations therefore this element is included. AB shared the details. PR raised that the top of the list for efficiency and productivity is HASR as if permission is given by Stephen Eames to go out to public consultation this summer and we accelerate the rationalisation particularly on the south bank of services, we have the prospects of releasing a lot of money.

AB concluded with details of the current CAP challenge (still to deliver operational plan target activity ambition) and difficult choice working models (compromises operational plan target activity ambitions). He highlighted a summary of actions that we are collectively considering of how to get down to the £60m deficit as an ICB. AB shared the details.

IM asked if the CAP should be looking at the wider strategic/clinical change programmes as they take time to deliver and some will require consultation and build that in as a CAP into what we do.

IM asked what other programmes have we got – we have the Humber Clinical Collaborative Programme, are there ways we could link that better to the networks/accelerate the networks? How do we optimise the cash coming in. A discussion ensued around the potential demand on the system in terms of the diagnosing increasing, how do we balance that demand. It was agreed that this would be a useful

piece of work as there may be an opportunity for more funding (item discussed in more detail further in the meeting).

A discussion ensued around the possible delivery of the savings and where the targeted money is coming from. JC concluded that all the costs are being incurred by each organisation and what the collaborative can do is work together and share good practice on productivity.

7 CAP Programme Summary

LS shared the CAP governance structure and the overall 4 programmes of how they feed into the CAP Programme. LS advised of who are the decision maker for the 4 Clinical CAP priorities, what our role is and what the Acute Trusts role is adding that Places role within this needs working through.

She noted that the clinical programme priority is where most time has been spent however there is further work to do in term of making sure Trusts are not being asked to report in multiple different ways etc. Initial conversations have begun with Shaun Jones to work through the differing views and agree some clear roles and responsibilities particularly of the locality team and how they interact with Trusts and with regions.

Other CAP priorities – unwarranted variations ie population health, digital workforce and workforce board. These are all clear ICB committees with support from Primary Care, Acute Care and Mental Health, CAP is part of these committees and contributes to them and they are setting a broad digital agenda and a broad workforce agenda.

Supporting sustainable services through our Corporate programmes
These are Acute Collaborative led, where the CAP set out what is our pattern of provision and what are our opportunities. Planned Care Strategy, Clinical Networks and some Fragile Services that are Trust led and is around the provider collaborative development.

Clinical Programmes
Elective. LS advised that here has been a refocus on some of the programmes in order to get some core pieces of work that we are expecting to deliver on. LS noted that there are still some gaps in terms of SRO's/ clinical leads.

Urgent and Emergency Care - The elective time out has taken place and there has been a lot of work on the UEC Programme. There are still some gaps however as JC is the SRO he is well sighted on this in terms of delivery.

Diagnostics – it was agreed at the Diagnostics Board that this would be reframed to focus on productivity and make sure it is aligned to some of the risks within the operational plan.

LS confirmed that work is now underway to align resources to these programmes, starting this week getting programme teams in to deliver these. She added that we need to ensure that this still aligns with the core pieces of work in light of the big financial plans, if the efficiency group has identified 3 or 4 areas, is that where we deploy resources? LS would welcome AB's thoughts on that.

IM advised that work is underway to re-scope planned care and link in the finance piece as discussed by AB and build in the network element. The outcomes should still be the

same and the plan is to still do this within 4 months but thoughts around how we resource it. **Item to be brought back to the next meeting for a further update**. **IM**

KW raised, Where do the decisions get made that all 'Acute Trusts have to implement something? Where have these discussions taken place with Acute Trusts. LS advised that in terms of decision making, we need to distinguish between decisions and deliverables that acute trusts can get on with and that would be within the mandate of the Board to be able to do through Trust's own internal mechanisms. Where the CAP is holding a programme on behalf of the system and decisions are the acute sector the Programmes Boards have an important role. LS added that it is a continuing discussion with the ICB.

In terms of next steps, LS shared that we need a clear prioritisation framework, as we are not going to be able to do everything we want therefore we need to work through a good prioritisation framework for taking on new programmes as we move forward.

A discussion ensued around the role of CAP in tackling Health inequalities. PR added that this collaborative has a responsibility for ensuring that the organisations within it provide sufficient investment in supporting patients with learning disabilities and autism and to ensure that they don't get unnecessarily adverse outcomes. A discussion ensued around does the ICB/CAP Board have the authority to make the decisions on clinical prioritisation as place has a crucial issue in this decision process also. PR added that we need to be careful about what the CAP can do and what is beyond it's remit.

JC concluded that this is part of the conversation that is happening now re how does place, the ICB and the CAP etc come together under an operating model and this will also form the conversation to be held at the timeout next week. LS added that Trusts can individually make the decisions themselves but there is a broader discussion around doing something as a collective noting that there is significant funding attached to health inequalities for this area that we need to consider. LS confirmed that the programme of work will go to the Programme Exec group on the 16th May for a fuller discussion. Item brought here for awareness only. Exception reports will be brought to the CAP Board in due course.

8 Programme Highlights

78 week position/ UEC Programme

LS shared the waiting list position noting that there are x2 104 week waits, x350 78 week waits, x2564 65 week waits. LS gave the details and advised that Anil's report re 65 week waits will go up and down because of the profile of what's on the waiting list. LS noted that Alex Bell has now picking up the BI Lead for the ICB and is really keen to work with the collaborative to ensure that the data and dashboard on priorities within the programmes work for the collaboratives and has asked if he can work with our CAP first as a benchmark. The CAP Board supported this.

LS shared that the report in the pack gives visability to Board members of the high areas of concern that the ICB flag through their performance report. Alex Bell is keen to make sure that the Board have sight of everything in a more accessible format.
LS noted that we were under the 78 week trajectory for the end of March which should be celebrated.

Other areas to highlight; LS confirmed that the Elective Recovery programme has been refreshed and an Away Day was held in April. She noted that the key element is the

Humber and North Yorkshire
Health and Care Partnership

outpatients and follow ups that have already been discussed. A further timeout is planned for the 11th May where they will be scoping up what the follow up programme looks like. Any further inputs from a finance and efficiency point will be picked up by the respective leads that will attend the meeting. From a diagnostics perspective, the national team are looking at setting a 13 week zero trajectory for diagnostics in the same way they have for 65 weeks for elective care. Implementation is likely to be later this year. LS gave the details that Humber and North Yorks have 17% of patients waiting more than 13 weeks for a diagnostic. We will be asked what we think we are likely to achieve and the BI team will work on what that may look like.

A discussion ensued around ensuring that the CAP manage the messages around diagnostics and that going forward we do so in a consistent way to our Regional and National colleagues. IM shared the details of the CDC funding position and the implications of getting the CDC's up and running, noting that there will be a time lag therefore as a CAP we need to be clear what do we want to ask for as a result of the funding in the CDC's. We need to be clear about the future workforce, and what will be the impact on the waiting list position/trajectories etc.

IM noted that we need to maximize what we can get in terms of the funding available and get the digital element right. IM gave the details of the bid that he has submitted to the ICB as part of the Scunthorpe Hub for licenses, software and implementation of any digital infrastructure. IM is awaiting approval notification. IM suggested a discussion outside of this meeting with LS/WS. **IM/LS/WS**

9 CAP Board Time Out

A programme/agenda outline was shared with the attendees of the timeout of what the day is expecting/hoping to achieve.

A discussion ensued around the HUTH/NLaG Group CEO process and the impact of that on the timeout programme/agenda. It was noted that it should be fed back to Adele Couthard of the concerns raised around the timing of the event however the general position was that the day should go ahead as planned.

10 Any Other Business

There were no further areas of business for discussion

Date and Time of the Next Meeting

22.05.23, 10.00 – 12.00 via teams