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
Executive Committee	Quality Management Group (QGMG)
Initial Date of Assessment	1st July 2022
Last Reviewed	August 2024

Summary:
In alignment with the CQC SAFE Domain, the organisation is addressing critical safety risks across several areas to ensure people are protected from harm, neglect, and abuse, while fostering a culture of learning and continuous improvement. The risks related to the HDH Goods Yard (CHS2) focus on maintaining a secure environment to prevent unauthorized access and ensure the safety of staff, patients, and visitors. Efforts include implementing temporary security measures and planning for permanent improvements, with a target completion by March 2025. In managing fire safety risks (CHS3), the organization has completed comprehensive fire risk assessments and is enhancing infrastructure to prevent injuries and ensure safe transitions and environments, with a goal to reduce the risk rating by September 2024. The risk of violence and aggression against staff (CHS5) is being mitigated through policy updates, enhanced training, and a review of security measures, reflecting the organization's commitment to safeguarding and maintaining a safe and effective workforce. These actions demonstrate the organization's proactive approach to managing safety risks in line with the SAFE Domain's standards for safe systems, environments, and staffing.

Corporate Risk ID	Strategic Ambition	Type	Principle Risk: **CHS2**: HDH Goods yard	Appetite	Initial Rating	July Rating	Aug Rating	Target Rating	Target Date
CRR75: CHS2 Health and Safety	An Environment that promotes wellbeing	Operational; Health & Safety	Unauthorized access and safety hazards in the HDH Goods Yard may result in major injuries, fatalities, or permanent disability due to inadequate security measures, non-compliance with safety regulations, and improper use of the area, posing a risk to the objective of maintaining a safe and secure environment for employees, patients, and others within the hospital premises.	Minimal	16	12	12	8	March 25

Key Risk Indicators

Board level lead for Health and Safety

Annual Audit programme for Health and Safety

Health & Safety Committee

Suitable and sufficient risk assessments in place

Implementation of control measures from assessments

Capital programme to implement permanent physical changes to the area

Control of unauthorised access

Current Position

The organisation has taken several steps to address health and safety risks within the goods yard. Risk assessments have been completed, identifying key areas of concern. In response, temporary measures have been implemented to mitigate these risks:

- **Security Measures**: A security guard is stationed at the goods yard from Monday to Friday, 8 AM to 6 PM.
- **Access Control**: A temporary Heras fenced walkway has been established to safely guide staff and visitors to the Pharmacy lift and stairwell.
- **Staff Communication**: Instructions have been communicated to all Trust staff via email and Team Talk regarding the safety protocols.
- **High-Visibility Clothing**: High-visibility clothing is required for personnel who need routine access to the yard.
- **Contractor Guidelines**: Contractors have been instructed that the yard area is strictly for delivery drop-offs and collections, and not for parking.
- **Security Weakness**: The loading bay entrance remains unsecure 24/7 due to doors that do not close properly, posing a significant security risk, particularly during the night when staff presence is limited, leaving the area open to unauthorized access.
- **Safety Improvements**: New pedestrian crossing markings were added at the entrance to the goods yard and car park in July 2023.

Despite these measures, the ongoing issue of the unsecured loading bay entrance remains a critical security concern that requires further attention.

Controls and Plans

The organization has outlined several key plans and actions aimed at improving safety and security in the goods yard:
Physical Barriers and Controls: for the the protection of the liquid oxygen store, which will be factored into the overall improvement costs for the goods yard.
Waste Management: A newly formed group is tasked with assessing the impact of changes to waste separation and new waste streams on site, with a report due to the Health & Safety Committee in June.
Contractor Management: A new Contractor Management Policy is awaiting approval, with written instructions now issued to all delivery drivers and external users of the goods yard. This policy will guide future management and operations.
Security Review: There will be a review of the current security guard provision in the goods yard to ensure it meets the evolving needs of the area.
Construction Planning: A programme outline is being developed in collaboration with a contractor to ensure that the goods yard remains operational during upcoming construction activities.
Timeline: The target date for completing these improvements is set for March 2025, aligning with the organization's 24/25 backlog programme.

These actions are designed to enhance the safety, security, and operational efficiency of the goods yard while maintaining confidentiality of specific details.

Harrogate and District NHS Foundation Trust Corporate Risk Register

Corporate Risk ID	Strategic Ambition	Type	Principle Risk: CHS3: Managing the risk of injury from fire	Appetite	Initial Rating	July Rating	Aug Rating	Target Rating	Target Date
CRR75: CHS3 Health and Safety	An Environment that promotes wellbeing	Operational ; Health & Safety	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.	Minimal	20	15	15	10	Sept 24

Key Risk Indicators

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

Communication of fire procedures to all employee

Audits and reviews of the above conditions at appropriate intervals.

Current Position

The Trust has made substantial progress in addressing fire safety concerns, with several key actions and improvements:

Fire Risk Assessments: Fire risk assessments, which were initially incomplete, have now been completed for all areas of the HDH site. The process is being carried out by Oakleaf and is monitored by the Fire Safety Group with reports to the Health & Safety Committee. However, Oakleaf has been unable to meet the required level of availability, leading to a backlog in reviewing risk assessments, particularly in areas that have recently changed usage due to Block C moves. Addressing this backlog will be a priority for the new Fire Manager.

Communication Improvements: Communication of fire safety information, which was previously inconsistent, is now regularly disseminated through weekly bulletins by the Fire Manager.

Fire Wardens: The use of Fire Wardens remains inconsistent, highlighting an area requiring further attention.
Fire Manager Recruitment: The position of Fire Manager has been advertised, attracting some interest. The recruitment process is complete, with pre-employment checks currently underway.

Contractor Assessments: The assessment of contractors and construction work is to be integrated more consistently into Trust fire assessments and evacuation procedures. Construction Phase Plans for all CDM work are under review to include fire risk assessments and shared control measures.

Corridor and Exit Safety: There has been a significant improvement in keeping corridors, escape routes, and exits clear, with the HIF waste team prioritizing daily clearing. However, issues with fire doors being wedged open on wards still persist.

Fire Policy and Management: A new Fire Policy and Fire Management Procedures have been established. A Service Level Agreement (SLA) with Leeds Teaching Hospitals NHS Trust (LTHT) has been fully implemented, with regular site attendance to review fire risk assessments, fire strategy in relation to construction work, and provide training.

Ongoing Assessments and Reporting: The Health & Safety Team continues to report on fire safety assurances for the community estate in fortnightly CC Estates meetings. Additional information is being gathered from all community sites to assess resource needs, including risk assessments and training.

Fire Safety Testing: Significant Cause and Effect testing, especially in the main theatres, has been completed.

Evacuation Procedures: Ward changes and the development of updated evacuation procedures are ongoing, with the Fire Safety Manager collaborating with relevant teams. A recent lift failure in the Strayside wing has highlighted limitations in the current evacuation procedures and controls.

SLA Conclusion: The SLA with LTHT has officially ended, although support for some pre-arranged work, including SMT training, the TIF2 project, and online training is on-going.

Fire Safety Group Establishment: The Fire Safety Group has been fully established, with its first meeting held on August 31, 2023. Monthly meetings are now in place, with an action being reviewed by the Fire Safety Group and escalated through the Health & Safety Committee as needed.

Controls and Plans

Ongoing Fire Safety Support: The Fire Safety team continues to receive ad hoc requests for support from both the HDH site and Community sites.

Infrastructure Risk Work: Efforts to separate infrastructure risk items, such as fire alarms, compartmentation, fire doors, and fire dampers, are ongoing and expected to be completed by April 2024. These risks will be added to the Health & Safety Risk Register and escalated where necessary, with updates reported via the Fire Safety Group, Health & Safety Committee, and Environment Board.

Fire Alarm System Costs: An analysis of the costs for a new fire alarm system is being conducted, comparing the total upfront cost of switching providers versus upgrading the existing system over multiple years.

Basement Corridor Improvements: Priority work is being planned to improve the compartmentation and fire stopping in the basement corridor between plant rooms as part of the 2024/25 backlog maintenance budget. New drawings have been produced, and cost estimates are being sought.

Evacuation Risk Management: Remedial actions are being taken to minimize risks associated with the closure of corridors for six weeks. Evacuation aids have been repositioned, and additional training is being provided to both clinical and non-clinical staff, with multiple sessions organized by the Fire Manager.

Monthly Fire Checklist: A new Monthly Acute and Community Fire Checklist is being developed for completion by all teams, departments, and community locations.

Evacuation Procedures and Training: Evacuation procedures are being escalated, with training provided to clinical teams, including a simulated exercise at an extended SMT workshop, which has been completed.

Backlog Maintenance for Fire Safety: A Backlog Maintenance paper for 2024/25 has been submitted to the Environment Board, covering key fire-related works, including basement compartmentation, fire damper remediation, main entrance remedial work, and upgrades to fire doors. The outline proposal has been agreed upon, with detailed costs and a program plan being developed. Costs have now been confirmed, and the work is being scheduled.

Corporate Risk ID	Strategic Ambition	Type	Principle Risk: CHS5: Violence and aggression against staff	Appetite	Initial Rating	July Rating	Aug Rating	Target Rating	Target Date
CRR75: CHS5 Health and Safety	An Environment that promotes wellbeing	Operational ; Health & Safety	Organisational risk to compliance with legislative requirements, with the risk of major injuries, fatality or permanent disability to employees due to the failure to manage the risk of staff being subjected to acts of violence and aggression whilst carrying out normal duties, due to lack of suitable control measures and appropriate training.	Minimal	16	12	12	8	Sept 24

Key Targets	Current Position	Controls and Plans
Suitable and sufficient assessments of risk Trust / HIF activities. Supported by up to date policies that reflect the activities carried out by the Trust and the geographical differences created. Risk assessments, policies and control measures actively monitored and reviewed. Use of available data sources, such Datix, sickness absence as part of the monitoring and review process. Provision of appropriate training and information to all Trust staff clinical and non-clinical.	The organization is facing several challenges related to Violence & Aggression (V&A), Security, and Lone Working: • **Outdated Policies**: Current policies on Violence & Aggression, Security, and Lone Working are outdated and do not reflect the Trust's current structure, services, or resources. • **Generic Risk Assessments**: Available risk assessments are generic and lack clear identification of hazards or control measures. • **Limited Security Presence**: Security coverage is limited, with a security guard in place only in the Emergency Department from 6 PM to 6 AM, and a single Local Security Management Specialist (LSMS) supporting the entire Community footprint. • **Inadequate Training**: Training is limited and not provided on a risk-based approach, with low compliance in Conflict Resolution and Physical Restraint training, particularly before 2024. • **Inconsistent Escalation Procedures**: Procedures for staff response to incidents and patient management are limited and inconsistently applied. • **High Incident Rates**: There are daily reports of violence and aggression against staff, with 20-30 incidents recorded per month, despite the Trust's promotion of a zero-tolerance approach. • **Cultural Issues**: There is an ingrained culture of accepting certain levels of violence and aggression. **Training Updates and Compliance**: • Conflict Resolution Level 1 (mandatory e-learning) was introduced in January 2024, with 83.9% compliance across the Trust and 77.4% compliance in the HIF. • Lone Working training compliance stands at 96.7%. • Pre-2024 compliance for Conflict Resolution Breakaway Skills was 56.2%, with even lower compliance for Physical Restraint training. **Security Review**: • A limited assurance audit on Security has highlighted significant gaps, leading to a decision to separate Security risks from the broader V&A risks. This will include areas such as security policies, physical presence, lockdown procedures, and community support. • **Legislation Impact**: The upcoming Martyn's Law, which is pending due to the election, will likely require significant changes to the Trust's security measures. • **Resource Limitations**: The lack of dedicated security presence, especially at the HDH site, has hindered the ability to reduce the V&A risk score, with notable incidents occurring in hospital corridors and visitor toilets. • **Risk Score**: The risk score remains at 12, reflecting the ongoing challenges and will be reviewed at the August H&S Committee Meeting. The situation is compounded by a recent increase in high-risk incidents, highlighting the insufficient resources available to support both acute and community settings	**Task and Finish Group**: A Task and Finish group, led by the Head of H&S, has been established to review and improve all existing policies and procedures, aligning them with NHSE's Public Health Approach. Monthly meetings will begin in May 2024. **Mental Health Triage and Policy Update**: Changes to mental health triage in the Emergency Department are ongoing and will be incorporated into a new policy for managing patients who may self-harm or have mental health issues. This policy is in the approval process as of April 2024. **Ligature Assessments**: Ligature risk assessments are under review due to ward and therapy area changes. Training provision for ligature risks is also being addressed after delays caused by staffing changes. **Conflict Resolution Training**: A new Conflict Resolution training program is being developed with three levels tailored to staff risk levels. The content will align with the CQC-supported Restraint Reduction Network, with ongoing discussions to ensure appropriate training needs assessments (TNA) across the Trust. A business case is being prepared to expand training provision. **Community Security and Lone Working**: Visits to all community teams and locations are underway to assess current security and lone working procedures. **Domestic Abuse and Sexual Violence**: Meetings are being held to integrate issues of domestic abuse, sexual violence, and workplace sexual safety into the Violence Prevention and Reduction Strategy. A new policy and training package for line managers is in development, with plans for a team talk session by September/October. **Policy Reviews**: The Lockdown Policy and Bomb Alert Policies are under review to ensure they are up-to-date and effective. **New Risk Assessment Process**: A Trust-wide risk assessment has been developed and is now being used to inform team and department-level assessments. This is part of an ongoing effort to implement a new risk assessment process across the Trust.

Corporate Risk ID	Strategic Ambition	Type	Principle Risk: Outsourcing of Hazard Group 3 Microbiology Work Due to CL3 Facility Unavailability	Appetite	Initial Rating	July Rating	Aug Rating	Target Rating	Target Date
CRR98	An Environment that promotes wellbeing	Operational ; Health & Safety	The unavailability of the onsite Containment Level 3 (CL3) laboratory at HDFT, deemed unfit for purpose in November 2022, has led to the outsourcing of Hazard Group 3 microbiology work to external providers. Initially outsourced to NHS Trusts within WYAAT and, since June 2024, to a private laboratory in London, this situation poses risks to quality, safety, and financial sustainability, including potential delays in clinical diagnosis, risk of inappropriate treatment, and significant ongoing cost pressures.	Minimal	9	15	15	6	March 25

Key Targets

1. Minimise delay to patient treatment
2. Zero staff harms resulting from exposure to unexpected hazard group 3 pathogens
3. Zero lost samples
4. Cessation of outsourcing & transport cost pressure

Current Position

Since the unavailability of the CL3 lab at HDFT and the outsourcing of Hazard Group 3 microbiology work to a private laboratory in London, significant risks have emerged related to the logistics provider (DX).

These include:

- **Sample Delays:** Routine delays of one day compared to in-house testing, with an additional four-day delay for Friday samples due to weekend non-delivery.
- **Lost Samples**: In June 2024, a box of 12 samples was lost for nine days without an audit trail, raising concerns about sample integrity, data breaches, and mishandling of potentially hazardous materials.
- **Patient Safety:** Delays in sample processing may lead to inappropriate antibiotic use, missed opportunities for treatment adjustments, and patients needing to repeat invasive procedures.
- **Mitigation Efforts**: Attempts to source alternative NHS suppliers within the region have been unsuccessful, as many facilities are at capacity or under refurbishment, leaving limited options to reduce current risks.

These issues present quality, safety, and financial implications that remain unresolved while awaiting further mitigation strategies.

Controls and Plans

A series of plans and actions are being developed to address the risks associated with the outsourcing of Hazard Group 3 microbiology work, including delays, lost samples, and logistical challenges.

These include:

- **Recommissioning of Onsite CL3 Facility:**
  An outline business case to recommission an onsite CL3 facility was presented to the BCRG on 2 July 2024. A full business case will proceed. This business case will detail the lab specification, costs, and implementation timescale, aiming to restore onsite testing capabilities and reduce reliance on external providers.
- **DX Transport Investigation:**
  DX, the transport provider, is conducting an internal investigation to identify potential errors and establish mitigations to prevent future occurrences of lost or delayed samples. The results of the investigation are awaited, with the aim of improving sample tracking, delivery times, and overall reliability.
- **Sourcing Alternative NHS Suppliers:**
  Despite ongoing efforts to find an alternative NHS supplier for Hazard Group 3 work, no viable options have been found due to capacity and facility issues at other trusts within the region. Attempts to identify a suitable alternative will continue alongside the progression of the onsite CL3 facility business case.
-

These actions are critical to mitigating current risks and ensuring patient safety, sample integrity, and operational continuity.

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: People and Culture (Workforce Risk)
Executive Committee	Quality Management Group (QGMG) (Clinical) Workforce Committee (Workforce)
Initial Date of Assessment	1st July 2022
Last Reviewed	August 2024

Summary in Month:
In alignment with the CQC CARING Domain, which emphasizes treating people with kindness, empathy, and compassion while supporting staff wellbeing, the organisation is addressing significant risks related to patient safety and colleague health due to low staffing levels in the North Yorkshire 0-19 Service (CRR93). The shortage of Band 6 staff has led to delays in delivering the Healthy Child Programme, with Health Visitors managing caseloads far beyond expected levels, impacting their ability to provide individualized care. To mitigate these risks, daily reporting and planning meetings are in place to optimize staffing, and efforts are being made to reduce sickness rates and ensure key performance indicators (KPIs) for mandated contacts are met. Additionally, a Virtual Team is being implemented to help manage workloads, though recruitment delays may affect the timeline. The organization is also focusing on recruitment and retention strategies to support workforce wellbeing and ensure that staff can deliver compassionate, person-centered care while managing their own health and work pressures. These actions reflect a commitment to maintaining high standards of care, respecting patient choices, and supporting the wellbeing of the workforce, in line with the values of the CARING Domain.

Corporate Risk ID	Strategic Ambition	Type	Principle Risk:	Appetite	Initial Rating	July Rating	August Rating	Target Rating	Target Date
CRR93: Health Visitor workload and staffing levels	At Our Best – Making HDFT the Best Place to Work	Workforce; Supply and retention	Risk to patient safety due to low staffing levels Risk to colleague health and wellbeing due to sustained work pressures	Cautious	12	12	12	4	Sept 25

Key Targets

Band 6 Availability to work to increase to 80% each day

• Turnover rate

• Stability index of team

• Long term sickness rate

Short term sickness rate

Current Position

The North Yorkshire 0-19 Service is facing significant challenges due to reduced availability of Band 6 workforce, affecting the delivery of the Healthy Child Programme across a large area of 3,100 square miles. The current staffing issues have led to delays in mandated contacts and targeted support, with Health Visitors handling caseloads far exceeding the expected numbers.

Current Mitigation Efforts:

- **Daily Sitrep Reports**: Band 6 availability is reported daily, showing approximately 67% substantive staff, with the use of Bank staff increasing availability to 80%.
- **Weekly Planning**: Band 6 availability for the following week is shared with the team to aid in planning.
- **Daily Meetings**: Two daily meetings are held—one at 8:30 AM to review staffing and prioritize tasks, and another at 12:00 PM for escalations and advice from practitioners.
- **Sickness Management**: There has been a reduction in both short-term and long-term sickness.
- **Assurance and KPIs**: An assurance process is in place to ensure contacts are delivered according to specifications, with key performance indicators (KPIs) monitored for mandated contacts and breastfeeding data. However, there have been slipped timescales for New Birth Visits.

Future Planning:

- **Virtual Team Implementation**: A staff consultation for a Virtual Team has been completed, with an outcome paper scheduled for the Partnership Forum in June. The Virtual Team is planned to be operational by September 2024. However, delays in recruiting Health Visitors for the Virtual Team due to the approval process may impact this timeline.

These actions and ongoing challenges are part of the service's broader strategy to manage the workforce shortfall and ensure the delivery of critical health services across North Yorkshire.

Controls and Plans to implemented

Ongoing recruitment and retention work as part of the Workforce workstream and recruitment strategy

• Increased number of SCPHN students supported in 24/25

• Consultation for Virtual Team implementation commences 2/4/24

• Review of standards of roster creation and agreed staffing level

Procedure for management of Universal caseloads written, will be presented to 0- 19 Learning and Best Practice Group 10/7/24

Action and recovery plan in place

• Ongoing recruitment and retention work as part of the Workforce workstream and recruitment strategy

• Ongoing transformation re Virtual Delivery Team, mobilisation plan for team implementation 1/9/24 is underway

Consideration of roll out of Optima to whole service for oversight and future planning

	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	**Summary** The organization is facing critical challenges within the CQC Responsive Domain, which emphasizes timely, person-centered care and equitable access to services. The risks include significant delays in autism assessments (CRR34), where waiting times have ballooned to a projected 43 months, preventing children from receiving timely diagnoses and necessary support. Additionally, the Trust is struggling to meet the A&E 4-hour target, with performance dropping below the national standard of 78%, leading to increased 12-hour breaches and ambulance handover delays. These delays compromise patient safety and the quality of care, highlighting the urgent need for improved capacity, streamlined processes, and strategic resource allocation to ensure that care is responsive, accessible, and equitable for all patients.
Executive Committee	Operational Management Group (OMG)	
Initial Date of Assessment	1st July 2022	
Last Reviewed	July 24	

Corporate Risk ID	Strategic Ambition	Type	Principle Risk: **CRR34**: Autism Assessment	Appetite	Initial Rating	June Rating	July Rating	Target Rating	Target Date
CRR34: Autism Assessment	Great Start in Life	Clinical; Patient Safety	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. There is a need to reduce the backlog of referrals back to the NICE standard of three months (reduce the waiting list to approximately 120)	Minimal	12	15	15	8	March 25

Key Targets	Current Position	Controls and Plans to implemented
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 Activity ■ To meet the monthly ICB target for number of assessments ■ Meet the annual planned target for assessments	We have modelled the impact of the funded Waiting List Initiative (WLI) for 2023/24 and it will only slow the growth of the waiting list. The projected wait for assessment by end August 24 is now 43 months; this has increased due to the 6 month average monthly referral rate of 86 and the higher current waiting list numbers. Non-recurrent funding challenges service management due to lead times for capacity acquisition and staff training, exacerbated by national shortages. Loss of a key clinical team member impacts medium-term assessment capacity. Support provided to the team; commissioners informed. ICB-wide autism and ADHD group supersedes previous locality-based group, aiming to standardize referral criteria. No extra funding available for capacity gaps. Stabilizing waiting lists requires increased capacity, costing £490k annually. Modeling shared at CC Resources Review and escalated to place ICB meeting for executive consideration. No agreed plan for long-term resource provision is currently agreed and in place.	The progress with PLACE based work. Mobilisation of WLI and new pathways In order to stabilise the waiting list we would need to increase the service capacity to approx. 90 assessments per month with the additional staffing costing £490k full year effect. The modelling has been shared at the CC Resources Review Meeting and has been escalated to the place ICB meeting with Execs as it was felt HDFT could no longer carry all the risk of these waits and there is currently no agreed plan to provide the resources required to address this longer term.

Corporate Risk ID	Strategic Ambition	Type	Principle Risk: **CRR61** ED 4-hour Standard	Appetite	Initial Rating	July Rating	August Rating	Target Rating	Target Date
CRR61: ED 4-hour Standard	Best Quality, Safest Care	Clinical; Patient Safety	Failure to Meet A&E 4-Hour Target Due to Inadequate Patient Flow, Leading to Increased 12-Hour Breaches and Ambulance Delays, Resulting in Compromised Patient Safety and Regulatory Non-Compliance	Minimal	12	12	12	8	November 24

Key Targets

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

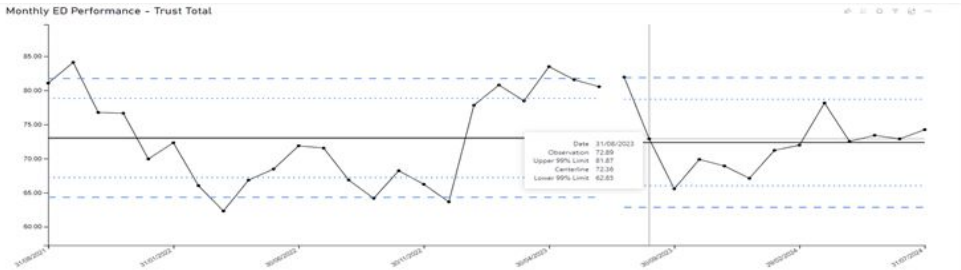
4 hour performance
The new national target for 24-25 is 78%. Whilst we delivered 78% in March, performance deteriorated in April to 72.47% and has sustained that performance level in May and June (with fluctuations of less than 1%)

Current Position

4 hour performance

The new national target for 24-25 is 78%. Whilst we delivered 78% in March, performance deteriorated in April to 72.47% and has sustained that performance level in May and June (with fluctuations of less than 1%)

	Jan 23	Feb 23	Mar 23	Apr 23	May 23	June 23	July 23	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	April 24	May 24	June 24	Jul 24
Type 1 & 3	72%	81%	78%	83%	81%	80%	82%	73%	65%	70%	68.7%	66.9%	71.1%	71.8%	78%	72%	73%	72%	74%



12 hour DTA rates have increased in July. Ambulance handover delays > 30 mins remains consistent despite an increase in overal ambulance arrivals. In Jun 79% were handed over within 30 mins. In Jul 78% handed over within 30 Min.

12 hour waits

	12 Hour DTA	12 Hour total wait
October 23	14	167
November 23	46	226
December 23	71	332
January 24	124	344
February 24	42	202
March 24	35	138
April 24	66	238
May 24	54	282
June 24	31	237
July 24	48	144

We now record ambulance delays using YAS data and ambulance delays are a care group driver metric. The ED Tri management team are measuring the % patients arriving by Ambulance where handover is complete within 30 minutes. The data source is YAS.

Month	Arrivals	30 Min HO	60+ Min HO
March 24	1243	190	54
April 24	1139	208	80
May 24	1262	198	68
June 24	1124	193	49
July 24	1295	211	54

Controls and Plans to implemented

To support the Trust's True North objective of meeting the ED 4-hour standard, several focused actions and plans are being implemented:

- **Focussed Impact Work**: Targeted efforts are being made at the directorate, care group, and ED front line levels to improve performance against the 4-hour standard.
- **Internal Professional Standards**: These are being relaunched, with a draft prepared following a workshop, to enhance escalation processes.
- **Triage Efficiency**: Efforts are underway to ensure all patients receive an initial triage within 15 minutes of arrival, improving patient flow and safety.
- **Effective Streaming**: More focused support is being provided to improve the effectiveness of patient streaming to Same Day Emergency Care (SDEC) and ED2.
- **Non-Headed Beds**: These have been implemented with measurable success, contributing to better patient management and care outcomes.

Harrogate and District NHS Foundation Trust Corporate Risk Register

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
Executive Committee	Operational Management Committee (OMG)
Initial Date of Assessment	1st July 2022
Last Reviewed	August 24

Summary in Month:
The Trust is currently addressing significant financial challenges under the CQC Use of Resources domain, which emphasizes the effective management of resources to maximize patient benefit and ensure sustainable, high-quality care. To deliver the 2024/25 plan, which includes a £5.2 million deficit and a 6% efficiency target, the Trust must reduce its current run rate and successfully implement the Waste Reduction and Productivity (WRAP) programme, despite high-risk schemes and ongoing financial pressures. Additionally, the Trust faces potential cost pressures due to the ability of Local Authorities (LAs) to fund the impact of NHS pay awards, which could further strain resources if funding gaps remain unaddressed. The Trust is engaging in continuous discussions with LAs to secure necessary funding and mitigate these risks. To ensure these financial challenges are managed effectively, the Trust has implemented monthly meetings across directorates, contracting, and finance teams, focusing on corporate efficiency, workforce optimization, and financial stability, all of which are critical to maintaining productivity and delivering high-quality, patient-centered care.

Corporate Risk ID	Strategic Ambition	Type	Principle Risk:	Appetite	Initial Rating	July Rating	August Rating	Target Rating	Target Date
CRR94 Delivery of financial plan	Overarching Finance	Financial	The Trust achieved a breakeven plan in 23/24 however for the Trust to deliver the 24/25 plan, £5.2m deficit, it will require a reduction to current run rate and delivery of the waste reduction and productivity program	**Cautious**	9	12	12	8	**March 25**

Key Targets	Current Position	Plans to Improve Control and Risks to Delivery
1. **Monthly financial reporting** 2. **NHSE productivity analysis** 3. **Agency Expenditure** 4. **Cash position**	The Trust has identified a significant financial pressure of £20.1 million moving into the 2024/25 fiscal year. After thorough review and system-wide discussions, a plan has been established with a £5.2 million deficit, incorporating a 6% efficiency target. However, there are several risks associated with this plan, including ongoing challenges with the ED boundary divert, potential inflation exceeding planned levels, the need for recurrent delivery of the efficiency programme, and the necessity to achieve or exceed ERF funding targets. As of July, the Trust is £0.1 million behind its financial plan, although there has been an improvement in Directorate run rates and recognition of expected income. A key concern is the undelivered WRAP (Waste Reduction and Productivity) programme, which has a shortfall of £2.4 million, with high-risk schemes totaling £12 million. Notably, there was no progress on WRAP in July. Agency spending has improved significantly, now standing at 1.3% compared to the 3.2% target set by NHSE. Despite some positive developments, such as improved agency spending now at 1.3% compared to the 3.2% target set by NHSE, the current run rate is negatively impacting the cash balance. Cash support will be necessary throughout the year if the run rate is not reduced, with the current forecast indicating the need for such support in Q3 (October-December). Mitigations are being reviewed to manage these financial pressures as the Trust works towards its 2024/25 budgetary goals.	1. Continued discussions with ICB. 2. Efficiency becoming a Corporate programme. Targeted Directorate training and support have been delivered to all Directorates. 3. WRAP Champions to be developed across the Trust.

Corporate Risk ID	Strategic Ambition	Type	Principle Risk:	Appetite	Initial Rating	June Rating	July Rating	Target Rating	Target Date
CRR95 NHS Pay awards	Overarching Finance	Financial	Ability of Local Authorities to fund the impact of NHS pay award could result in a cost pressure for HDFT. The Public Health Grant for 2024/25 varies by Local Authority. While NHS national guidance suggests that the Public Health Grant has been uplifted to cover both the ICB non recurrently funded 2.9% from the 2023/24 pay award and the 2.1% proposed pay award for 2024/25 this appears not to be the case for all the Local Authorities we have contract with. Where there is a gap between LA public health grant and the cost of pay award there is a risk HDFT could be left with a financial pressure	**Cautious**	**12**	**12**	**12**	**4**	**March 25**

Key Targets	Current Position	Plans to Improve Control and Risks to Delivery
Written confirmation of funding for pay awards received from LA. Revised workforce model agreed and signed off by LA and HDFT	The Trust has communicated with all Local Authorities (LAs) regarding the need for them to fund the 2.9% pay award and the proposed 2.1% increase for 2024/25. Finance has provided the LAs with the associated costs, and ongoing meetings are being held to discuss funding arrangements, particularly in relation to Public Health Grant allocations and the cost of NHS pay awards. To ensure progress, monthly meetings have been established with the Directorate, Contracting, and Finance teams to track feedback from the LAs and determine the next steps. The situation is being closely monitored as discussions continue.	The Trust is actively engaging with Local Authorities (LAs) to address the funding required for the 2.9% pay award and the proposed 2.1% increase for 2024/25. Finance has provided detailed cost estimates to the LAs, and ongoing meetings are being held to negotiate the funding, particularly concerning Public Health Grant allocations. To manage and monitor progress, the Trust has established monthly meetings with the Directorate, Contracting, and Finance teams to review feedback from LAs and determine the appropriate next steps. These actions are part of a coordinated effort to secure the necessary funding and ensure financial stability for the upcoming fiscal year.

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
Executive Committee	Quality Management Group (QGMG)
Initial Date of Assessment	1st July 2022
Last Reviewed	August 24

Summary in Month:

The CQC Effective Domain is focused on optimizing patient outcomes by addressing their specific needs and continuously improving care quality. Currently, significant risks include prolonged waiting times, which jeopardize patient safety and Trust performance against NHS targets. An additional £1.5 million investment has been secured to extend the Community Dental Services (CDS) contract, with strategic initiatives underway to manage waiting times and enhance service delivery. Despite challenges in funding alignment, IT system replacement, and recruitment, efforts are progressing, including regional discussions on potential funding increases and service adjustments post-election.

Corporate Risk ID	Strategic Ambition	Type	Principle Risk:	Appetite	Initial Rating	July Rating	August Rating	Target Rating	Target Date
CRR87 Community Dental	Provide person centred, integrated services through strong partnerships	Clinical; Patient Safety	Risk to patient safety due to correlation of long waiting times and increased risk of pain and infection, which may affect quality of life and treatment required. Secondary risk to Trust performance standards by failing to meet NHS annual planning target of no RTT waiters beyond 78weeks currently, 65 weeks by end March 2024 and 52wks by end March 2025.	Minimal	12	12	12	6	August 25

Key Targets	Current Position	Controls and Plans to implemented
Numbers on the patients waiting to start treatment over 52weeks, 65weeks and 78weeks **Current position for RTT waiters –3 patients between 52-64 weeks. Current position for Non RTT waiters -– 125 patients over 78 weeks, 199 patients between 65-77 weeks, 366 patients between 52-64 weeks.** No of overdue continuing care patients. **Current position – 2169 patients overdue. Longest waiter - 4 years overdue.**	The ICB has agreed to invest an additional £1.5 million into the CDS service at HDFT, extending the contract by 18 months until March 31, 2025. Regional discussions suggest a potential agreement on a 7+3 contract and amended service specification, with a possible increase in the funding envelope, though formal confirmation is pending post-general election. The current funding does not fully align with the submitted business case, so the operational team and service manager have developed a plan to optimize the use of this investment, focusing on managing waiting times for both RTT and non-RTT patients. Key actions for July include recruiting a new clinical lead, continuing IT procurement, and addressing low staff engagement, which has been identified as a significant risk to service delivery. The CDS team is also being encouraged to participate in the HDFT Impact work as part of phase 4 to further support service improvements.	The key plans and actions for the CDS service include ongoing liaison with the ICB and the implementation of a Waiting List Initiative (WLI) to address patient backlogs, with additional GA and clinic sessions planned for the financial year. The replacement of the SOEL Health dental IT system is underway, although the procurement process has faced delays, and a direct award is being sought to meet the April 2024 deadline. Capital kit replacement, including dental chairs and X-ray equipment, is progressing, with 2023/24 equipment being installed and approvals pending for 2024/25 purchases. Recruitment efforts are ongoing, with successful appointments for dentists and dental nurses from the business case, though challenges remain in filling positions in the East and for paediatric specialists. Recruitment for key leavers is also ongoing, with many new staff expected to start in September 2024.

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	**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.
Executive Committee	Senior Management Committee (SMT)	
Initial Date of Assessment	1st July 2022	
Last Reviewed	March 24	

Corporate Risk ID	Strategic Ambition	Type	Principle Risk:	Appetite	Initial Rating	February Rating	March Rating	Target Rating	Target Date

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

ADULT INPATIENT SAFER NURSING CARE TOOL (SNCT) OUTCOME PAPER: JULY 2024

Data, discussions and recommendations relate to the April 2024 SNCT data collection.

Brenda McKenzie: Workforce Lead

Harrogate and District NHS Foundation Trust

Contents

Harrogate and District NHS Foundation Trust

Safer Nursing Care Tool (SNCT) Adult Inpatient Wards

Date: July 2024

Author: Brenda Mckenzie (Workforce Lead)

Situation

The Board of Directors are required to receive a Nurse Establishment Review twice a year. This requirement is underpinned by the direction of NHS Improvement (2018) who, in conjunction with the National Quality Board (NQB) (2016), provide a guidance framework containing the key components that should be considered as part of safe staffing review and analysis and in turn enable their nationally endorsed expectations to be met.

HDFT undertook its bi annual adult inpatient safer staffing review using the updated licenced SNCT during the month of April 2024.

Background

The NQB guidance framework (2016) is central in supporting us to develop a workforce that is fit for purpose in the context of it being safe, sustainable and productive. It comprises of a principle document which is supplemented by a suite of additional publications that collectively act as improvement resources.

The principle structure of the NQB expectations are illustrated below and together form a framework that facilitates and supports care to be underpinned by;

• delivery of the right care, first time in the right place

• minimising avoidable harm

• maximising the value of available resources

The scope for this Safer Nursing Care Tool (SNCT) data collection encompasses the adult in patient wards. This is the first data that has been collected using the updated SNCT which encompasses the new levels of care for patients with an increased dependency in relation to enhanced care requirements.

Teams are reporting increasing levels of enhanced care requirements on a daily basis. Enhanced care relates to; *patients who require an increased level of care to prevent them harming themselves, others or absconding.* NHSE together with the Shelford Group, have made adaptations to the SNCT tool to incorporate this level of dependency within our patients.

The new levels of care will breakdown the 'Enhanced Care' requirements, which will enable us to better monitor and manage how we care for these patients, in addition to aligning establishments to allow for this level of care. At least two data collections will need to be undertaken before the data can be used to triangulate and apply professional judgment to make changes to the ward establishments.

AIPW AAU SNCT Matrix A4 2023.pdf

Ward budgets were increased to match the outputs of the SNCT in early 2023 and recruitment in to these registered nurse vacancies is almost complete with many wards now recruiting to turnover. This new establishment aligns HDFT to a 60/40 skill mix ratio and has increased our Care Hours Per Patient Day to above the national average.

The April data collection ran for the full month. Prior to these collections, the Workforce Lead facilitated an extensive training programme; an hour training session, that was conducted via MS Teams. All attendees were assessed and were required to pass the inter-rater scoring pass levels. This information is stored on the corporate nursing 'shared drive'. It is essential that all scorers are trained to ensure that high quality, reliable data is collected. All the data was peer reviewed by the Matrons to validate and add assurance that the data was an accurate reflection of the patients on the ward and activity during the time of the audit.

The SNCT was used with a 60:40 ratio Registered Nurse (RN) to Care Support Worker (CSW) for all wards with exception of Farndale, our medical admissions ward. For this ward a ratio of 70:30 was used to take into account the additional registered nurse input required when admitting acutely unwell patients, which is recommended by the tool with regards to assessment areas.

Assessment

All wards have daily safety huddles where all staff, including medical and AHP colleagues come together on the ward at a set time to discuss any patient safety risks; for example patients who are risk of falls and consider preventative measures to be put in place.

A detailed description of each ward and specific staffing, agency and quality indicators were available at the review meetings. As recommended by the SNCT; data collected must be triangulated with quality indicators and professional judgement before any changes to establishments are agreed.

The SNCT recommendation is to review the required staffing establishment for each ward bi annually at differing periods/times of the year.

As part of the SNCT process, the Deputy Director of Nursing, Midwifery and AHP's, Associate Director of Nursing (ADoN) for Planned and Surgical Care and Long Term and Unscheduled Care, Matron and Ward Manager from each ward and the Lead for Workforce Assurance and Compliance met face to face to review the SNCT results, quality data, patient flow information, environmental factors (including PLACE inspection results), and apply professional judgement.

The discussions have been found to be useful in identifying support roles that would enhance patient care and improve the working lives of each team. Mainly, Nutritional Assistant roles and Ward Clerk hours. Complaints and concerns in relation to poor hydration and nutrition have reduced. However, most wards have highlighted the need for their Ward Clerk hours to be reviewed to meet the needs of the patients and staff.

Acuity data was provided via the ward managers and all other supportive data was provided by analytics, sitereps, Tendable, finance, NHSP and ESR

All clinical areas recognised the challenges and understood the results. Where there were perceived anomalies, these were discussed and professional judgement applied. This was pertinent to some smaller wards, wards with more than 50% side rooms, those with assessment areas and those that require non-invasive ventilation (NIV) as not all patients requiring NIV are admitted to a high observation/critical care environment at HDFT.

Headroom for each ward is calculated at an overall 21% with the following breakdown:

- 14.96% Annual leave
- 1.92% Study leave
- 3.9% Sickness.

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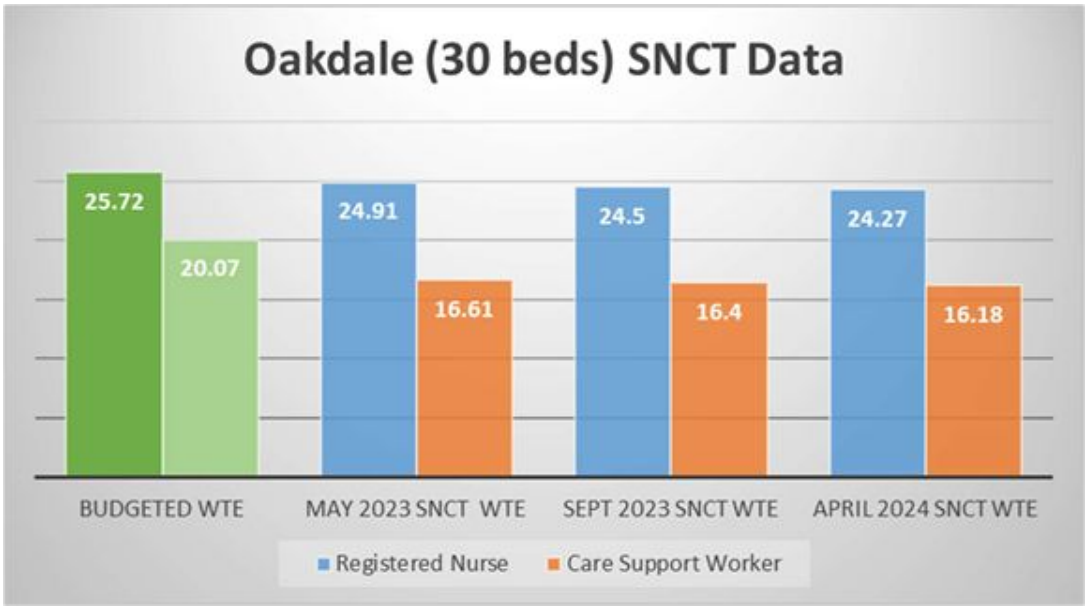
Results by Ward

Oakdale

SNCT Data since establishment uplift in April 2023



Oakdale Data Pack April 2024 v1.pptx

The current staffing template for Oakdale:

	Early	Late	Night
RN	**5**	**5**	**4**
CSW	**4**	**3**	**3**
Nutritional Assistant	**7 days 1.4 WTE**		
MD	**22.5 hours (0.6 WTE)**		

Budgeted Skill Mix

Band	WTE
7	1.0
6	4.0
5	20.72
3	0
2	18.67
2 Nutritional Assistant	1.4
2 Ward Clerk	1.0

Discussion

Oakdale is a 30 bedded General Medical, Oncology, Haematology & Endocrine ward.

The SNCT outputs (data, quality metrics and professional judgement) indicate an accurate nursing establishment.

Oakdale has a new Ward Manager, who is experienced in leading a team of nursing colleagues. There was discussion whether an additional RN would be beneficial in assisting to speed up discharges on a Monday, Thursday and Friday. However, the senior nursing team felt that more evidence base would be required as to whether more WTE was required or that the team still has some junior, inexperienced staff that required development in complex discharge planning.

The enhanced care data and fill rates indicate that there could be a requirement to increase the CSW establishment. However, it was agreed that we would need to embed the new levels of care training to ensure validity, reliability and usability of the data. Therefore, no adjustments are recommended until further data is collected and reviewed.

As part of a national review of Band 2 job profiles, it has been identified that some CSW's have been performing clinical skills which would align them to a Band 3 job profile. During the SNCT review the Band 3 requirements for Oakdale were agreed to ensure clinical skill resilience within the nursing team.

The unregistered WTE will now be split in to Band 3 and Band 2.

Band	WTE
7	1.0
6	4.0
5	20.72
3	11.51
2	7.16
2 Nutritional Assistant	1.4
2 Ward Clerk	1.0

Recommendations

Ensure that the Ward Manager and Matron are re trained and pass the interrater reliability test. Implement an external 'peer review' once a week to provide assurance of validity, reliability and usability of the data.

Any enhanced care requirements or unfilled shifts should be reviewed as part of the new safer staffing meetings using SafeCare. This is a safer staffing tool which measures the actual acuity and dependency of the patients on each ward against the availability of staff to ensure that we are deploying the right staff with the right skills at the right place and time. Once the acuity and dependency levels have been peer reviewed by

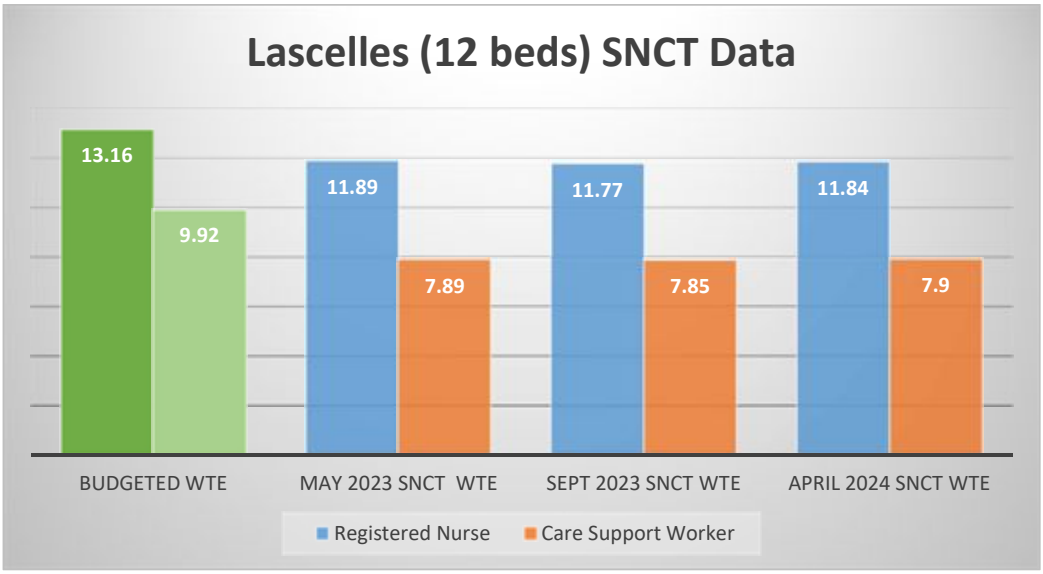
the Matron and professional judgement has been applied to the information within the system, a decision is made as to whether a staff redeployment should be undertaken or additional temporary workforce is required.

Continue to collect twice yearly SNCT data, using the new levels of care SNCT tool. The next data collection will be in July 2024.

To feedback to the Band 2 job profiling review the Oakdale CSW requirements as identified above.

Lascelles

SNCT Data since establishment uplift in April 2023



Lascelles Data Pack April 2024 v1.pptx

The current staffing template for Lascelles:

	Early	Late	Night
RN	**3**	**2**	**2**
CSW	**2**	**2**	**1**
Nutritional Assistant	**5 days 1.0 WTE**		
MD	**22.5 hours (0.6 WTE)**		

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Budgeted Skill Mix

Band	WTE
7	1
6	2
5	10.16
3	0
2	8.92
2 Nutritional Assistant	1.0
2 Ward Clerk	0.53

Discussion

Lascelles is a 12 bedded Rehab ward, that is based off the main HDFT site.

The SNCT outputs (data, quality metrics and professional judgement) indicate an accurate nursing establishment.

Ward Clerk hours were identified as a concern. Additional Ward clerk hours would assist with the administrative tasks that are currently being picked up by clinical staff.

The enhanced care data and fill rates indicate that there could be a requirement to increase the CSW establishment. However, it was agreed that we would need to embed the new levels of care training to ensure validity, reliability and usability of the data. Therefore, no adjustments are recommended until further data is collected and reviewed.

As part of a national review of Band 2 job profiles, it has been identified that some CSW's have been performing clinical skills which would align them to a Band 3 job profile. During the SNCT review the Band 3 requirements for Oakdale were agreed to ensure clinical skill resilience within the nursing team.

The unregistered WTE will now be split in to Band 3 and Band 2.

Band	WTE
7	1
6	2
5	10.16
3	6.10
2	2.82
2 Nutritional Assistant	1.0
2 Ward Clerk	0.53

Recommendations

The directorate should build a business case to encompass all of the wards, Ward Clerk requirements.

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Ensure that the Ward Manager and Matron are re trained and pass the interrater reliability test. Implement an external 'peer review' once a week to provide assurance of validity, reliability and usability of the data.

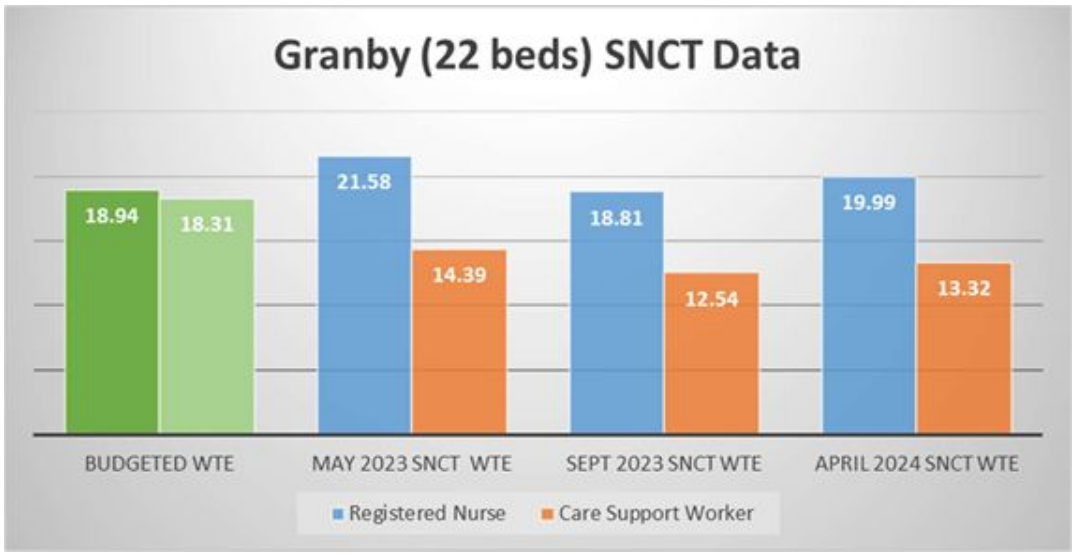
Any enhanced care requirements or unfilled shifts should be reviewed as part of the new safer staffing meetings using SafeCare. This is a safer staffing tool which measures the actual acuity and dependency of the patients on each ward against the availability of staff to ensure that we are deploying the right staff with the right skills at the right place and time. Once the acuity and dependency levels have been peer reviewed by the Matron and professional judgement has been applied to the information within the system, a decision is made as to whether a staff redeployment should be undertaken or additional temporary workforce is required.

Continue to collect twice yearly SNCT data, using the new levels of care SNCT tool. The next data collection will be in July 2024.

To feedback to the Band 2 job profiling review the Lascelles CSW requirements as identified above.

Granby

SNCT Data since establishment uplift in April 2023



Granby Data Pack April 2024 v1.pptx

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The current staffing template for Granby:

	Early	Late	Night
RN	**3**	**3**	**3**
CSW	**3**	**3**	**3**
RN	**Early on Mon Thurs & Fri**		
Nutritional Assistant	**7 days 1.4 WTE**		
MD	**22.5 hours (0.6 WTE)**		

Budgeted Skill Mix

Band	WTE
7	1.0
6	3.70
5	14.24
3	0.0
2	16.91
2 Nutritional Assistant	1.4
4 Ward Clerk	0.73
2 ward Clerk	0.92
7 Specialist Nurse	1.0

Discussion

Granby is a 22 bedded Stroke & Neurology ward.

The SNCT outputs (data, quality metrics and professional judgement) indicate an accurate nursing establishment.

The enhanced care data and fill rates indicate that there could be a requirement to increase the CSW establishment. However, it was agreed that we would need to embed the new levels of care training to ensure validity, reliability and usability of the data. Therefore, no adjustments are recommended until further data is collected and reviewed.

As part of a national review of Band 2 job profiles, it has been identified that some CSW's have been performing clinical skills which would align them to a Band 3 job profile. During the SNCT review the Band 3 requirements for Granby were agreed to ensure clinical skill resilience within the nursing team.

The unregistered WTE will now be split in to Band 3 and Band 2.

Band	WTE
7	1.0
6	3.70

5	14.24
3	6.10
2	10.81
2 Nutritional Assistant	1.4
4 Ward Clerk	0.73
2 ward Clerk	0.92
7 Specialist Nurse	1.0

Recommendations

Ensure that the Ward Manager and Matron are re trained and pass the interrater reliability test. Implement an external 'peer review' once a week to provide assurance of validity, reliability and usability of the data.

Any enhanced care requirements or unfilled shifts should be reviewed as part of the new safer staffing meetings using SafeCare. This is a safer staffing tool which measures the actual acuity and dependency of the patients on each ward against the availability of staff to ensure that we are deploying the right staff with the right skills at the right place and time. Once the acuity and dependency levels have been peer reviewed by the Matron and professional judgement has been applied to the information within the system, a decision is made as to whether a staff redeployment should be undertaken or additional temporary workforce is required.

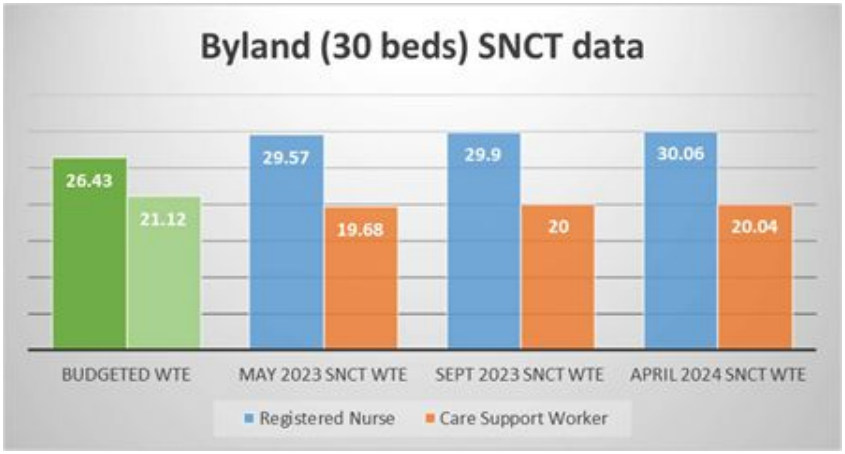
Ensure that all vacancies are filled and concentrate on retention.

Continue to collect twice yearly SNCT data, using the new levels of care SNCT tool. The next data collection will be in July 2024.

To feedback to the Band 2 job profiling review the Granby CSW requirements as identified above.

Byland

SNCT Data since establishment uplift in April 2023



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Byland Data Pack April 2024 v1.pptx

The current staffing template for Byland:

	Early	Late	Night
RN	**5**	**5**	**4**
CSW	**4**	**4**	**3**
Nutritional Assistant	**7 days 1.4 WTE**		
MD	**22.5 hours (0.6 WTE)**		

Budgeted Skill Mix

Band	WTE
7	1.0
6	4.0
5	21.43
3	0.0
2	19.72
2 Nutritional Assistant	1.4
2 Ward Clerk	1.0

Discussion

Byland is a 30 bedded Frailty ward.

The SNCT data and fill rates indicate that there could be a requirement to increase the RN establishment. There were discussions about how this would benefit improve the quality, safety and performance of the ward; with professional judgement strongly considering the recruitment of an enhanced care lead, based on the frailty wards. However, it was agreed that we would need to embed the new levels of care training to ensure validity, reliability and usability of the SNCT data. Therefore, no adjustments are recommended until further data is collected and reviewed.

As part of a national review of Band 2 job profiles, it has been identified that some CSW's have been performing clinical skills which would align them to a Band 3 job profile. During the SNCT review the Band 3 requirements were considered. However, it was agreed that Band 2 care was required for this patient group.

Recommendations

Ensure that the Ward Manager and Matron are re trained and pass the interrater reliability test. Implement an external 'peer review' once a week to provide assurance of validity, reliability and usability of the data.

Any enhanced care requirements or unfilled shifts should be reviewed as part of the new safer staffing meetings using SafeCare. This is a safer staffing tool which measures the actual acuity and dependency of the patients on each ward against the availability of staff to ensure that we are deploying the right staff with the right skills at the right place and time. Once the acuity and dependency levels have been peer reviewed by the Matron and professional judgement has been applied to the information within the system, a decision is made as to whether a staff redeployment should be undertaken or additional temporary workforce is required.

Ensure that all vacancies are filled and concentrate on retention.

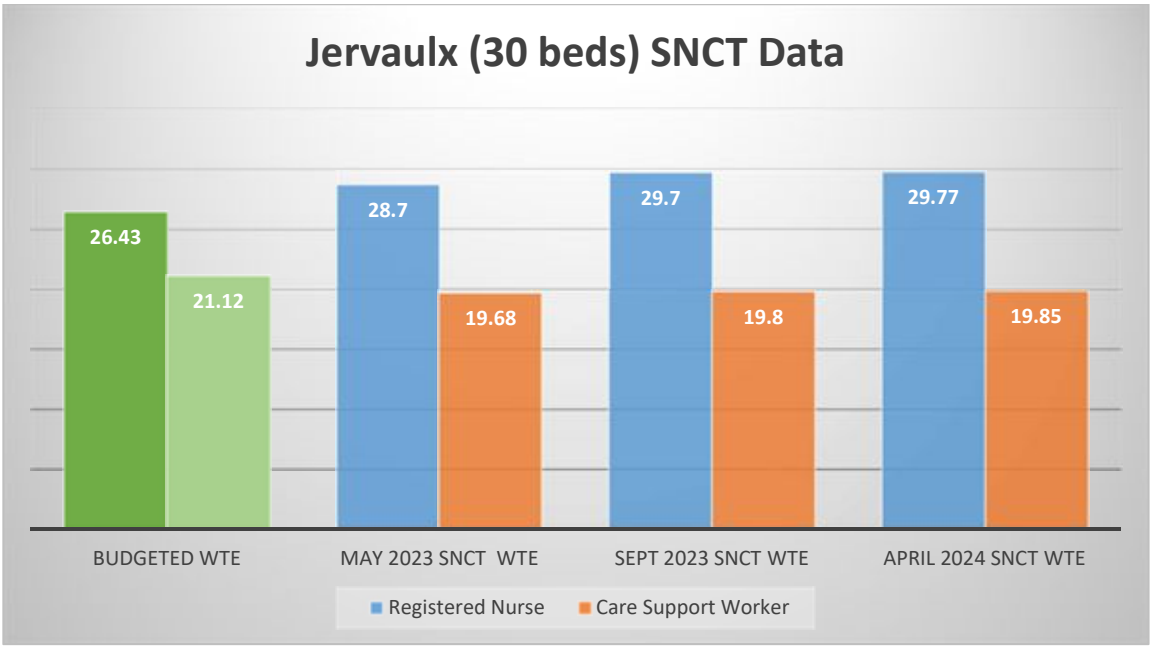
Consider the possibility of introducing an Enhanced Care Lead. To be discussed following the next SNCT data collection.

Continue to collect twice yearly SNCT data, using the new levels of care SNCT tool. The next data collection will be in July 2024.

To feedback to the Band 2 job profiling review that no Band 3 CSW's are required on Byland.

Jervaulx

SNCT Data since establishment uplift in April 2023



Jervaulx Data Pack April 2024 v1.pptx

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The current staffing template for Jervaulx:

	Early	Late	Night
RN	**5**	**5**	**4**
CSW	**4**	**4**	**3**
Nutritional Assistant	**7 days 1.4 WTE**		
MD	**22.5 hours (0.6 WTE)**		

Budgeted Skill Mix

Band	WTE
7	1.0
6	4.0
5	21.43
3	0.0
2	19.72
2 Nutritional Assistant	1.4
2 Ward Clerk	0.6

Discussion

Jervaulx is a 30 bedded Frailty ward.

The SNCT data and fill rates indicate that there could be a requirement to increase the RN establishment. There were discussions about how this would benefit improve the quality, safety and performance of the ward; with professional judgement strongly considering the recruitment of an enhanced care lead, based on the frailty wards. However, it was agreed that we would need to embed the new levels of care training to ensure validity, reliability and usability of the SNCT data. Therefore, no adjustments are recommended until further data is collected and reviewed.

As part of a national review of Band 2 job profiles, it has been identified that some CSW's have been performing clinical skills which would align them to a Band 3 job profile. During the SNCT review the Band 3 requirements were considered. However, it was agreed that Band 2 care was required for this patient group.

Recommendations

Ensure that the Ward Manager and Matron are re trained and pass the interrater reliability test. Implement an external 'peer review' once a week to provide assurance of validity, reliability and usability of the data.

Any enhanced care requirements or unfilled shifts should be reviewed as part of the new safer staffing meetings using SafeCare. This is a safer staffing tool which measures the actual acuity and dependency of the patients on each ward against the availability of staff to ensure that we are deploying the right staff with the right skills at the right

place and time. Once the acuity and dependency levels have been peer reviewed by the Matron and professional judgement has been applied to the information within the system, a decision is made as to whether a staff redeployment should be undertaken or additional temporary workforce is required.

Ensure that all vacancies are filled and concentrate on retention.

Consider the possibility of introducing an Enhanced Care Lead. To be discussed following the next SNCT data collection.

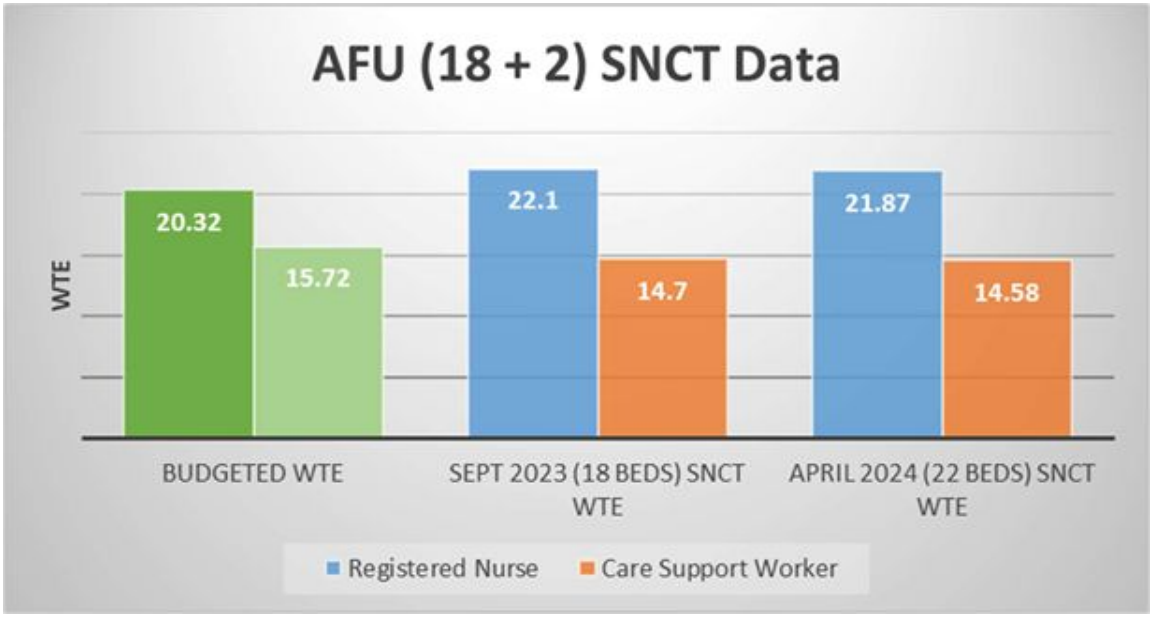
The directorate should build a business case to encompass all of the wards, Ward Clerk requirements.

Continue to collect twice yearly SNCT data, using the new levels of care SNCT tool. The next data collection will be in July 2024.

To feedback to the Band 2 job profiling review that no Band 3 CSW's are required on Jervaulx.

Acute Frailty Unit (AFU)

SNCT Data since establishment uplift in April 2023



AFU Data Pack April 2024 v1.pptx

Harrogate and District NHS Foundation Trust

The current staffing template for AFU (not including the additional 3 beds):

	Early	Late	Night
RN	**4**	**4**	**3**
CSW	**3**	**3**	**2**
Nutritional Assistant	**7 days 1.4 WTE**		
MD	**22.5 hours (0.6 WTE)**		

Budgeted Skill Mix

Band	WTE
7	1.0
6	4.38
5	14.94
3	1.76
2	12.56
2 Nutritional Assistant	1.4
2 Ward Clerk	0.60

Discussion

AFU is an 18 Frailty Admissions Ward with 2 assessment beds. However, due to the demand on Frailty beds the ward has been open at escalation since winter 23/24 at a total of 23 beds.

The SNCT outputs (data, quality metrics and professional judgement) indicate an accurate nursing establishment for the funded baseline beds (18+2). However, when open at 23 beds an additional RN and CSW is required on a night shift.

Ward Clerk hours were identified as a concern. Additional Ward clerk hours would assist with the administrative tasks that are currently being picked up by clinical staff.

The enhanced care data and fill rates indicate that there could be a requirement to increase the CSW establishment. However, it was agreed that we would need to embed the new levels of care training to ensure validity, reliability and usability of the data. Therefore, no adjustments are recommended until further data is collected and reviewed.

As part of a national review of Band 2 job profiles, it has been identified that some CSW's have been performing clinical skills which would align them to a Band 3 job profile. During the SNCT review the Band 3 requirements for Granby were agreed to ensure clinical skill resilience within the nursing team.

The unregistered WTE will now be split in to Band 3 and Band 2.

Band	WTE
7	1.0
6	4.38

5	14.94
3	6.10
2	8.22
2 Nutritional Assistant	1.4
2 Ward Clerk	0.60

Recommendations

The directorate should build a business case to encompass all of the wards, Ward Clerk requirements.

Ensure that the Ward Manager and Matron are re trained and pass the interrater reliability test. Implement an external 'peer review' once a week to provide assurance of validity, reliability and usability of the data.

Any enhanced care requirements or unfilled shifts should be reviewed as part of the new safer staffing meetings using SafeCare. This is a safer staffing tool which measures the actual acuity and dependency of the patients on each ward against the availability of staff to ensure that we are deploying the right staff with the right skills at the right place and time. Once the acuity and dependency levels have been peer reviewed by the Matron and professional judgement has been applied to the information within the system, a decision is made as to whether a staff redeployment should be undertaken or additional temporary workforce is required.

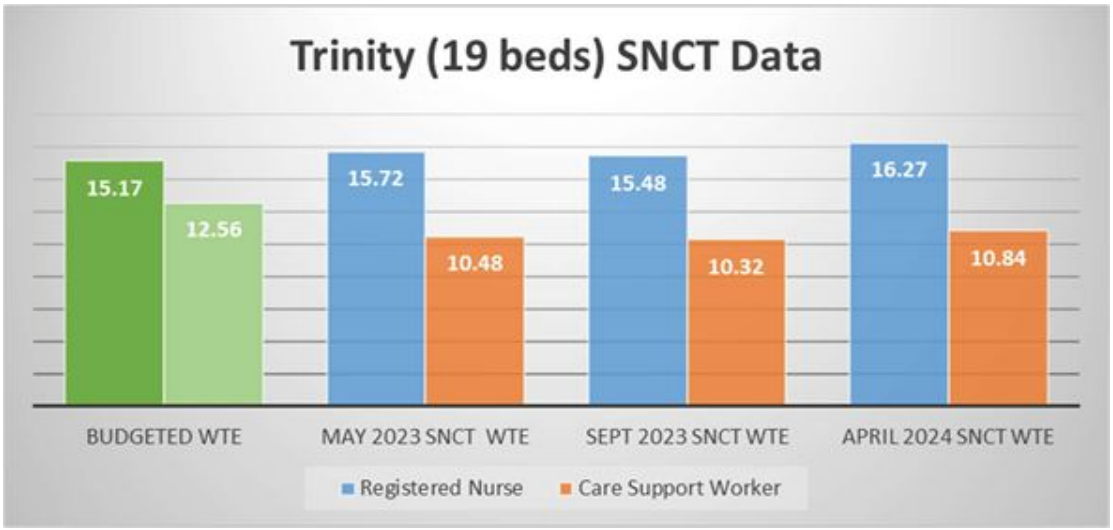
Ensure that all vacancies are filled and concentrate on retention.

Continue to collect twice yearly SNCT data, using the new levels of care SNCT tool. The next data collection will be in July 2024.

To feedback to the Band 2 job profiling review the AFU CSW requirements as identified above.

Trinity

SNCT Data since establishment uplift in April 2023



Harrogate and District NHS Foundation Trust

Trinity Data Pack April 2024 v1.pptx

The current staffing template for Trinity

	Early	Late	Night
RN	3	3	2
CSW	3	2	2
RN	Early RN every Monday (MDT)		
MD	22.5 hours (0.6 WTE)		

Budgeted Skill Mix

Band	WTE
7	1.0
6	2.64
5	11.53
3	0.0
2	12.56
2 Nutritional Assistant	0.0
2 Ward Clerk	1.92

Discussion

Trinity is a 19 bedded Rehab Ward, based within Ripon Hospital (off the main HDFT Hospital site).

The SNCT outputs (data, quality metrics and professional judgement) indicate an accurate nursing establishment.

As part of a national review of Band 2 job profiles, it has been identified that some CSW's have been performing clinical skills which would align them to a Band 3 job profile. During the SNCT review the Band 3 requirements for Trinity were agreed to ensure clinical skill resilience within the nursing team.

The unregistered WTE will now be split in to Band 3 and Band 2.

Band	WTE
7	1.0
6	2.64
5	11.53
3	6.10
2	6.46
2 Nutritional Assistant	0.0
2 Ward Clerk	1.92

Recommendations

Ensure that the Ward Manager and Matron are re trained and pass the interrater reliability test. Implement an external 'peer review' once a week to provide assurance of validity, reliability and usability of the data.

Any unfilled shifts should be reviewed as part of the new safer staffing meetings using SafeCare. This is a safer staffing tool which measures the actual acuity and dependency of the patients on each ward against the availability of staff to ensure that we are deploying the right staff with the right skills at the right place and time. Once the acuity and dependency levels have been peer reviewed by the Matron and professional judgement has been applied to the information within the system, a decision is made as to whether a staff redeployment should be undertaken or additional temporary workforce is required.

Ensure that all vacancies are filled and focus on retention.

Continue to collect twice yearly SNCT data, using the new levels of care SNCT tool. The next data collection will be in July 2024.

To feedback to the Band 2 job profiling review the Trinity CSW requirements as identified above.

Farndale

SNCT Data and Changes in Nursing Establishment

The budget for Farndale was reduced to staff the new Wensleydale ward. The reduction in RN and CSW establishment was to be agreed following SNCT review (once the NIV patients were moved to Wensleydale).

The reduction in staff was 'tested' in a phased approach. Feedback from staff working on and managing this ward highlighted that the reduction was going to affect quality, safety and performance. Therefore, any further reduction in RN staffing was halted until SNCT review. Additionally, Farndale have been receiving NIV patients that have not been able to be placed on Wensleydale.

Furthermore, the updated SNCT now has a new calculation for wards where there are 75% or more side rooms.

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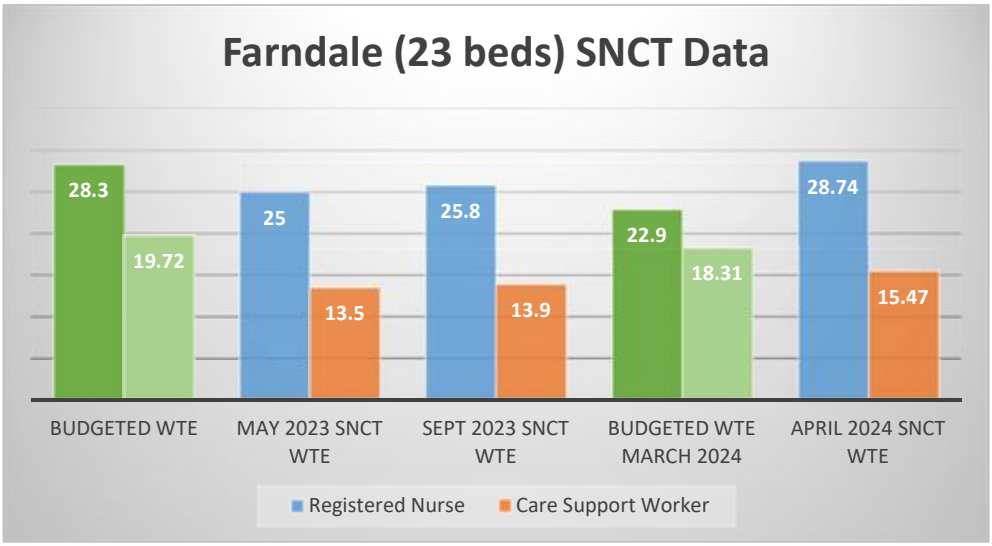


Farndale Data Pack April 2024 v1.pptx

The current staffing template for Farndale:

	Early	Late	Night
RN	**4**	**4**	**4**
CSW	**3**	**3**	**3**
Nutritional Assistant	**7 days 1.4 WTE**		
MD	**22.5 hours (0.6 WTE)**		

Budgeted Skill Mix

Band	WTE
7	1.0
6	6.44
5	15.46
3	0.0
2	16.91
2 Nutritional Assistant	1.4
2 Ward Clerk	2.07

Discussion

Farndale is a 23 bedded Medical Admissions Unit. The SNCT outputs (data, quality metrics and professional judgement) indicate that additional RN resource is required (see below).

The enhanced care data and fill rates indicate that there could be a requirement to increase the CSW establishment. However, it was agreed that we would need to embed the new levels of care training to ensure validity, reliability and usability of the data. Therefore, no adjustments are recommended until further data is collected and reviewed.

As part of a national review of Band 2 job profiles, it has been identified that some CSW's have been performing clinical skills which would align them to a Band 3 job profile. During the SNCT review the Band 3 requirements for Farndale were agreed to ensure clinical skill resilience within the nursing team.

The unregistered WTE will now be split in to Band 3 and Band 2.

Band	WTE
7	1.0
6	6.44
5	15.46
3	11.51
2	5.40
2 Nutritional Assistant	1.4
2 Ward Clerk	2.07

Recommendations

The recommended staffing template for Farndale:

	Early	Late	Night
RN	**5**	**5**	**5**
CSW	**3**	**3**	**3**
Nutritional Assistant	**7 days 1.4 WTE**		
MD	**22.5 hours (0.6 WTE)**		

Any enhanced care requirements or unfilled shifts should be reviewed as part of the new safer staffing meetings using SafeCare. This is a safer staffing tool which measures the actual acuity and dependency of the patients on each ward against the availability of staff to ensure that we are deploying the right staff with the right skills at the right place and time. Once the acuity and dependency levels have been peer reviewed by the Matron and professional judgement has been applied to the information within the system, a decision is made as to whether a staff redeployment should be undertaken or additional temporary workforce is required.

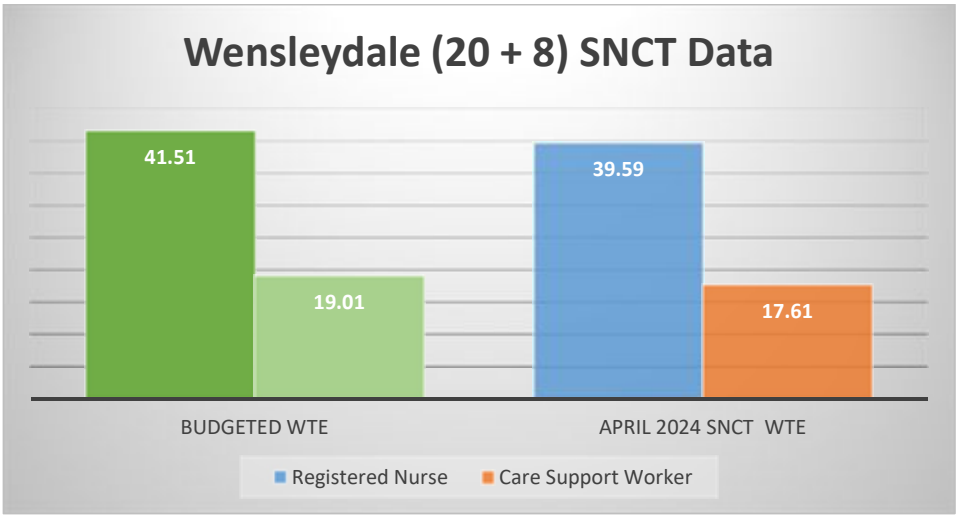
Ensure that the Ward Manager and Matron are re trained and pass the interrater reliability test. Implement an external 'peer review' once a week to provide assurance of validity, reliability and usability of the data.

Continue to collect twice yearly SNCT data, using the new levels of care SNCT tool. The next data collection will be in July 2024.

To feedback to the Band 2 job profiling review the Farndale CSW requirements as identified above.

Wensleydale (was Bolton)

SNCT Data since New Ward Budget Set in April 2023



Wensleydale Data Pack April 2024 v1.pp

The current staffing template for Wensleydale:

	Early	Late	Night
RN	**7**	**7**	**7**
CSW	**3**	**3**	**3**
Nutritional Assistant	**7 days 1.4 WTE**		
MD	**22.5 hours (0.6 WTE)**		

Budgeted Skill Mix

Band	WTE
7	1
6	12.51
5	28.0

3	0.0
2	17.61
2 Nutritional Assistant	1.4
2 Ward Clerk	1.4

Discussion

This is a new Cardio-respiratory ward with MECU beds. This is the first SNCT data collection since the ward opened.

The SNCT outputs (data, quality metrics and professional judgement) indicate an accurate nursing establishment.

As part of a national review of Band 2 job profiles, it has been identified that some CSW's have been performing clinical skills which would align them to a Band 3 job profile. During the SNCT review the Band 3 requirements for Wensleydale were agreed to ensure clinical skill resilience within the nursing team.

The unregistered WTE will now be split in to Band 3 and Band 2.

Band	WTE
7	1
6	12.51
5	28.0
3	11.51
2	6.10
2 Nutritional Assistant	1.4
2 Ward Clerk	1.4

Recommendations

Ensure that the Ward Manager and Matron are re trained and pass the interrater reliability test. Implement an external 'peer review' once a week to provide assurance of validity, reliability and usability of the data.

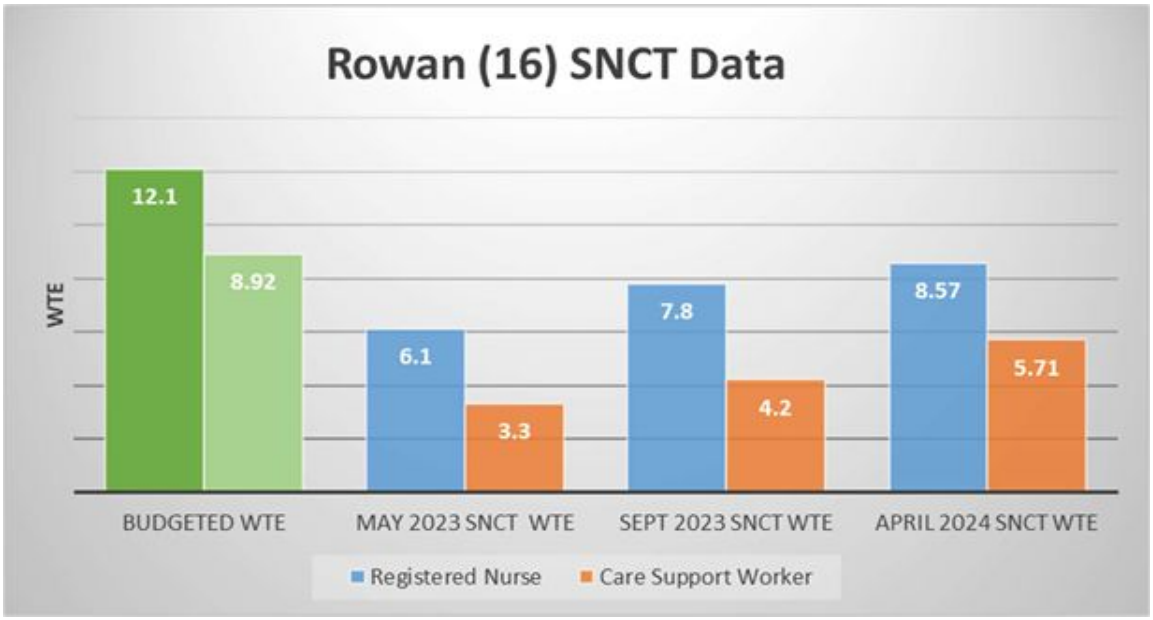
Any unfilled shifts should be reviewed as part of the new safer staffing meetings using SafeCare. This is a safer staffing tool which measures the actual acuity and dependency of the patients on each ward against the availability of staff to ensure that we are deploying the right staff with the right skills at the right place and time. Once the acuity and dependency levels have been peer reviewed by the Matron and professional judgement has been applied to the information within the system, a decision is made as to whether a staff redeployment should be undertaken or additional temporary workforce is required.

Continue to collect twice yearly SNCT data, using the new levels of care SNCT tool. The next data collection will be in July 2024.

To feedback to the Band 2 job profiling review the Wensleydale CSW requirements as identified above.

Rowan

SNCT Data since New Ward Budget Set in April 2023



Rowan Data Pack April 2024 v1.pptx

The current staffing template for Rowan:

	Early	Late	Night
RN	**2**	**2**	**2**
CSW	**2**	**2**	**1**
MD	**22.5 hours (0.6 WTE)**		

Budgeted Skill Mix

Band	WTE
7	1.0
6	3.0
5	8.1
3	0.0

2	8.92
2 Nutritional Assistant	0.0
2 Ward Clerk	1.19

Discussion

Rowan is an Elective Orthopaedic ward with 16 beds. As highlighted by the SNCT results, the full bed capacity is not yet being utilised. However, each data collection indicates greater usage. There is a minimum baseline staffing requirement to maintain quality, safety and performance. Therefore the Budgeted establishment in not able to be changed, but can be flexed, using professional judgement by senior nursing colleagues as part of the daily safer staffing professional judgement redeployment.

As part of a national review of Band 2 job profiles, it has been identified that some CSW's have been performing clinical skills which would align them to a Band 3 job profile. During the SNCT review the Band 3 requirements for Rowan were agreed to ensure clinical skill resilience within the nursing team.

The unregistered WTE will now be split in to Band 3 and Band 2.

Band	WTE
7	1.0
6	3.0
5	8.1
3	6.10
2	2.82
2 Nutritional Assistant	0.0
2 Ward Clerk	1.19

Recommendations

Ensure that the Ward Manager and Matron are re trained and pass the interrater reliability test. Implement an external 'peer review' once a week to provide assurance of validity, reliability and usability of the data.

Any unfilled shifts should be reviewed as part of the new safer staffing meetings using SafeCare. This is a safer staffing tool which measures the actual acuity and dependency of the patients on each ward against the availability of staff to ensure that we are deploying the right staff with the right skills at the right place and time. Once the acuity and dependency levels have been peer reviewed by the Matron and professional judgement has been applied to the information within the system, a decision is made as to whether a staff redeployment should be undertaken or additional temporary workforce is required. It was agreed that Rowan would not recruit in to the remaining 2 WTE care support worker positions until activity increases. However, the budget and staffing template would remain the same.

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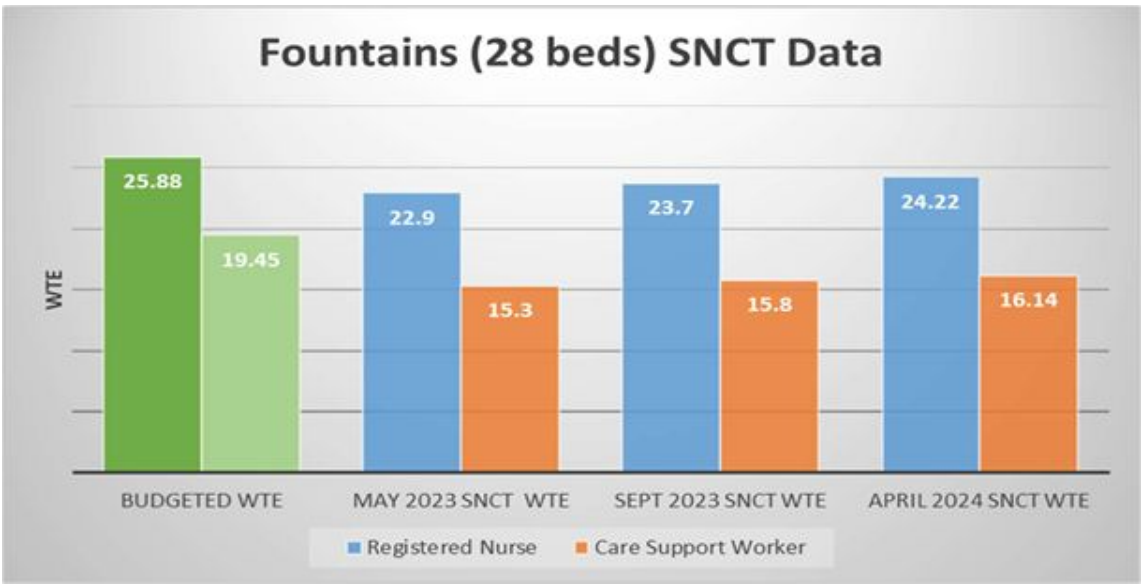
Continue to collect twice yearly SNCT data, using the new levels of care SNCT tool. The next data collection will be in July 2024.

To feedback to the Band 2 job profiling review the Rowan CSW requirements as identified above.

Fountains

SNCT Data since New Ward Budget Set in April 2023



Fountains Data Pack April 2024.pptx

The current staffing template for Fountains:

	Early	Late	Night
RN	**5**	**5**	**4**
CSW	**4**	**¾**	**3**
Nutritional Assistant	**7 days 1.0 WTE**		
MD	**22.5 hours (0.6 WTE)**		

Budgeted Skill Mix

Band	WTE
7	1.0
6	3.0

5	21.88
3 Patient Liaison	1.0
3 CSW	0.0
2	18.45
2 Nutritional Assistant	1.0
2 Ward Clerk	1.0

Discussion

Fountains is a 28 bedded Trauma and Orthopaedics ward (Non elective).

The SNCT data and triangulation supports the current funded nursing establishment and skill mix.

The enhanced care data and fill rates indicate that there could be a requirement to increase the CSW establishment. However, it was agreed that we would need to embed the new levels of care training to ensure validity, reliability and usability of the data. Therefore, no adjustments are recommended until further data is collected and reviewed.

As part of a national review of Band 2 job profiles, it has been identified that some CSW's have been performing clinical skills which would align them to a Band 3 job profile. During the SNCT review the Band 3 requirements for Fountains were agreed, to ensure clinical skill resilience within the nursing team.

The unregistered WTE will now be split in to Band 3 and Band 2.

Band	**WTE**
7	1.0
6	3.0
5	21.88
3 Discharge	1.0
3 CSW	8.92
2	9.53
2 Nutritional Assistant	1.0
2 Ward Clerk	1.0

Recommendations

Ensure that the Ward Manager and Matron are re trained and pass the interrater reliability test. Implement an external 'peer review' once a week to provide assurance of validity, reliability and usability of the data.

Any unfilled shifts should be reviewed as part of the new safer staffing meetings using SafeCare. This is a safer staffing tool which measures the actual acuity and dependency of the patients on each ward against the availability of staff to ensure that we are deploying the right staff with the right skills at the right place and time. Once the acuity and dependency levels have been peer reviewed by the Matron and professional judgement has been applied to the information within the system, a decision is made as

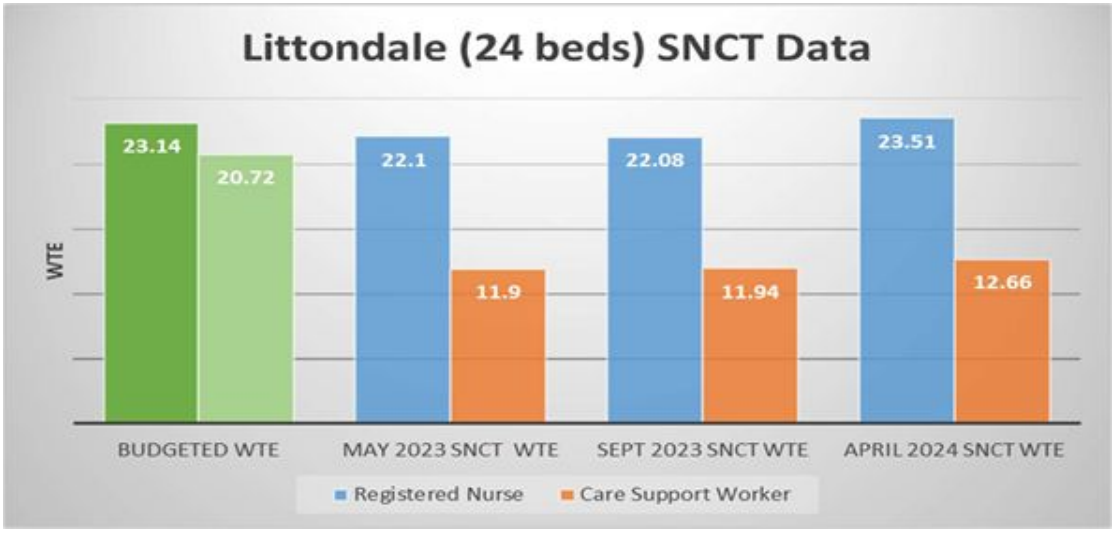
to whether a staff redeployment should be undertaken or additional temporary workforce is required.

Continue to collect bi annual SNCT data, using the new levels of care SNCT tool. The next data collection will be in July 2024.

To feedback to the Band 2 job profiling review the Rowan CSW requirements as identified above.

Littondale

SNCT Data since New Ward Budget Set in April 2023



Littondale Data Pack April 2024.pptx

The current staffing template for Littondale. This staffing model is for the 24 beds and the 8 beds in the Surgical Assessment Unit:

	Early	Late	Night
RN	**5**	**5**	**3**
CSW	**4**	**4**	**3**
Nutritional Assistant	**7 days 1.0 WTE**		
MD	**22.5 hours (0.6 WTE)**		

Budgeted Skill Mix

Band	WTE

7	1.0
6	3.15
5	18.99
3 CSW	8.92
2	10.80
2 Nutritional Assistant	1.0
2 Ward Clerk	1.0

Discussion

Littondale is a 24 bedded, male surgical and gastroenterology ward with a 8 bedded Surgical Assessment Unit.

The SNCT data and triangulation supports the current funded nursing establishment and skill mix.

As part of a national review of Band 2 job profiles, it has been identified that some CSW's have been performing clinical skills which would align them to a Band 3 job profile. During the SNCT review the Band 3 requirements for Fountains were agreed, to ensure clinical skill resilience within the nursing team.

The unregistered WTE will now be split in to Band 3 and Band 2.

Band	**WTE**
7	1.0
6	3.15
5	18.99
3 CSW	8.92
2	9.53
2 Nutritional Assistant	1.0
2 Ward Clerk	1.0

Recommendations

Ensure that the Ward Manager and Matron are re trained and pass the interrater reliability test. Implement an external 'peer review' once a week to provide assurance of validity, reliability and usability of the data.

Any unfilled shifts should be reviewed as part of the new safer staffing meetings using SafeCare. This is a safer staffing tool which measures the actual acuity and dependency of the patients on each ward against the availability of staff to ensure that we are deploying the right staff with the right skills at the right place and time. Once the acuity and dependency levels have been peer reviewed by the Matron and professional judgement has been applied to the information within the system, a decision is made as to whether a staff redeployment should be undertaken or additional temporary workforce is required.

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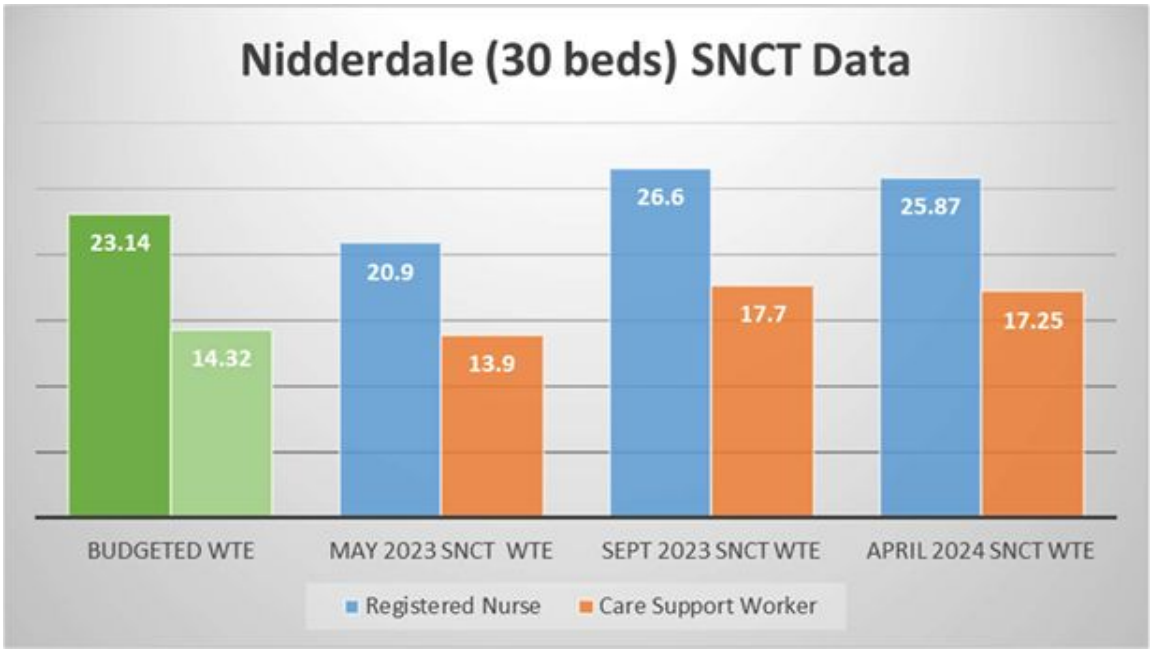
Continue to collect bi annual SNCT data, using the new levels of care SNCT tool. The next data collection will be in July 2024.

To feedback to the Band 2 job profiling review the Littondale CSW requirements as identified above.

Nidderdale

SNCT Data since New Ward Budget Set in April 2023



Nidderdale Data Pack April 2024 v1.pdf

The current staffing template for Nidderdale:

	Early	Late	Night
RN	**5**	**5**	**3**
CSW	**3**	**3**	**2**
Nutritional Assistant	**7 days 1.0 WTE**		
MD	**22.5 hours (0.6 WTE)**		

Budgeted Skill Mix

Band	WTE
7	1.0
6	4.0

5	18.14
3	0.0
2	14.32
2 Nutritional Assistant	1.0
2 Ward Clerk	1.0

Discussion

Nidderdale is a 30 bedded female, multi specialist surgical ward.

The SNCT data over the last three data collections consistently shows a deficit in registered nurse and care support worker WTE. This data has been triangulated with quality and performance data and professional judgement added. The outputs of these discussions have highlighted that there is a requirement to increase the RN and CSW establishment on a night shift.

The enhanced care data and fill rates indicate that there could be a requirement to increase the CSW establishment further. However, it was agreed that we would need to embed the new levels of care training to ensure validity, reliability and usability of the data. Therefore, no adjustments are recommended until further data is collected and reviewed.

As part of a national review of Band 2 job profiles, it has been identified that some CSW's have been performing clinical skills which would align them to a Band 3 job profile. During the SNCT review the Band 3 requirements for Nidderdale were agreed, to ensure clinical skill resilience within the nursing team.

The unregistered WTE will now be split in to Band 3 and Band 2.

Band	**WTE**
7	1.0
6	4.0
5	18.14
3 CSW	8.92
2	5.4
2 Nutritional Assistant	1.0
2 Ward Clerk	1.0

Recommendations

Ensure that the Ward Manager and Matron are re trained and pass the interrater reliability test. Implement an external 'peer review' once a week to provide assurance of validity, reliability and usability of the data.

Any enhanced care requirements or unfilled shifts should be reviewed as part of the new safer staffing meetings using SafeCare. This is a safer staffing tool which measures the actual acuity and dependency of the patients on each ward against the availability of staff to ensure that we are deploying the right staff with the right skills at the right

place and time. Once the acuity and dependency levels have been peer reviewed by the Matron and professional judgement has been applied to the information within the system, a decision is made as to whether a staff redeployment should be undertaken or additional temporary workforce is required.

Continue to collect bi annual SNCT data, using the new levels of care SNCT tool. The next data collection will be in July 2024.

To feedback to the Band 2 job profiling review the Nidderdale CSW requirements as identified above.

The recommended staffing template for Nidderdale:

	Early	Late	Night
RN	**5**	**5**	**4**
CSW	**3**	**3**	**3**
Nutritional Assistant	**7 days 1.0 WTE**		
MD	**22.5 hours (0.6 WTE)**		

Overall Recommendations from April 2024 SNCT Data Collection

1. To support establishment changes to ensure the correct skill mix on each inpatient ward. This will be presented to Establishment Review Panel on Friday 19th July.

2. Directorates to support the business case for review of Ward Clerk hours.

3. Recommendations in relation to enhanced care use will be made once two reliable data collections have been validated and deemed usable at the review meeting. Until this has been achieved, temporary workforce and Safecare redeployment will be used to maintain patient safety.

4. Consider the possibility of introducing an Enhanced Care Lead following the next SNCT data collection and review process.

5. All Matrons and ward managers to be retrained in the Adult Inpatient SNCT; new levels of care and pass the interrater reliability.

SNCT cascade training slides HDFT J

MASTER Inter Rater Reliability Results Nev

6. Weekly ‘peer review’ SNCT data validity, reliability and usability checks to be completed during the data collection period.

7. To continue to support the Matrons with the use of SafeCare to inform redeployment decision making at the Daily Safer Staffing meetings.

8. To work collaboratively with the Band 2 Job Profile review to ensure that the appropriate skill mix of unregistered staff are assigned to each area, as outlined in this paper.

9. Future bi-annual data collections are to be aligned to financial planning process and governance structures.

10. To ensure that the findings within this report are shared through the agreed governance streams.

Safer Staffing Governance Process.p

Harrogate and District NHS Foundation Trust

CHILDRENS & YOUNG PEOPLE

Safer Nursing Care Tool (SNCT)

June 2024

Emma Anderson (Associate Director of Nursing)
Victoria Lister (Matron)
Brenda Mckenzie (Workforce Lead)

Table of Contents

Children and Young People Safer Nursing Care Tool (SNCT)

Background

Following a National Institute of Clinical Excellence (NICE) endorsed Safer Nursing Care Tool (SNCT) (2021) review, undertaken biannually; this report is seeking additional funding to support the recommendations to improve nursing quality, safety and performance within Children's and Young People inpatient services and pathways with the Emergency Department (ED). Specifically in relation to delivering "the right staff, with the right skills, in the right place at the right time" The National Quality Board (NQB) (2018).

Ward Description

Woodlands ward is a 16 bedded general paediatric ward admitting acute and elective medical and surgical patients. A Children's Assessment Unit (CAU) is situated within the ward which can flex the ward to a 22 bedded unit. The ward admits children and young people (CYP) from birth to 17 years old from various referral routes, general practice, emergency department, health visitors, outpatients, midwifes etc. The ward has 3 bays of 4 beds but one is the CAU and 10 side rooms, one of which acts as a high dependency unit (HDU).

The central ward base for nursing and medical staff is in the centre of the ward opposite the HDU. The ward has a good size playroom and outdoor play area both recently refurbished. The store room, kitchen, dirty utility and treatment room are all situated near the central ward base. With linen store, seminar room, staff room, doctors, safeguarding, ward and Matron Office all based around the ward. The ward is linked to the Special Care Baby Unit (SCBU) by a swipe access door next to the central base. Entrance and exit from the ward is swipe card only and all patients, families and some HDFT colleagues have to be swiped in and out of the ward.

The ward is led by a paediatric Ward Manager, there is an establishment which aims to provide collaborative band 6 ward sister cover 24/7 across the paediatric unit and SCBU. As part of their working week the ward manager has four management days per week, the role of the ward manager includes manager responsibilities for SCBU as well as Woodlands ward.

Children and families can attend at any time with varying health needs from simple reviews requested by GP's to very unwell patients requiring immediate resuscitation and stabilisation. Elective surgical lists and emergency surgical procedures can run side by side, however we do also staff two days per month of paediatric day surgery which requires two registered paediatric nurses, a clinical support worker and a play specialist, this is included within our substantive budget. Ward attenders are booked into the ward for procedures or preparation for procedures, such as cannulation prior to radiology tests which are time specific, sedation prior to hearing tests etc. Escorting children to various locations around the hospital for procedures and treatment does impact on nursing time. Urgent reviews by the medical team; previous inpatients at times are also required to attend the ward for review of their illness.

We have a Ward Clerk Monday to Friday 08.30- 16.30, who is complemented by the care support workers, who support with admin where possible during the night and at weekends.

'Oral challenges' and specialty bloods are undertaken on a Tuesday and Wednesday using CAU or a bed space, colleagues from Children's Outpatients care for these patients with limited support from the ward staff.

Patient allocation is decided at handover, it is reliant on the nurse in charge to allocate the patients based on acuity and the skill mix on shift with the nurse in charge taking an allocated workload. Whilst staffing on SCBU and Woodlands is separate, there are close working relationships with the two units cross covering and supporting each other as the work demand requires. Resilience has been developed between the two units, for example if SCBU has an emergency requiring their two nurses at a resuscitation on delivery suite the Woodlands nurse can assist with looking after the remaining babies on the unit.

The Woodlands paediatric nurses will also attend the emergency department resuscitation room to assist with any sick child if the ward acuity allows. Due to the limitation of just one paediatric ward in the hospital we need sufficient colleagues on duty to cover all eventualities, we are generally not able to use resources from other areas of the hospital.

Woodlands ward is a combined inpatient general paediatric ward and a children's assessment unit with quick turnaround, the bed occupancy is unpredictable each day and we flex the bed state by using CAU as our escalation.

In addition to the band 7 Ward Manager, an experienced band 6 nurse is required throughout the 24-hour period to provide necessary support to the nursing team. This will provide an experienced nurse to advise on clinical nursing issues relating to children across the organisation, 24-hours a day.

The shift establishment in June 2024 for 16 beds

Day		Night	
RN	CSW	RN	CSW
M-F 4	1	3	1
S-S 3	1	3	1

The budget establishment is 19.2 RNs and 6.6 CSW this also includes staffing for the two days of DSU work per month, at the time of data collection contracted in post was 19 RNs and 3.1 CSW (the ward clerk hours come out of the clinical band 2 establishment). The budget and staffing template reduces slightly over the summer period as historically the demand on C&YP services is lower in the summer months.

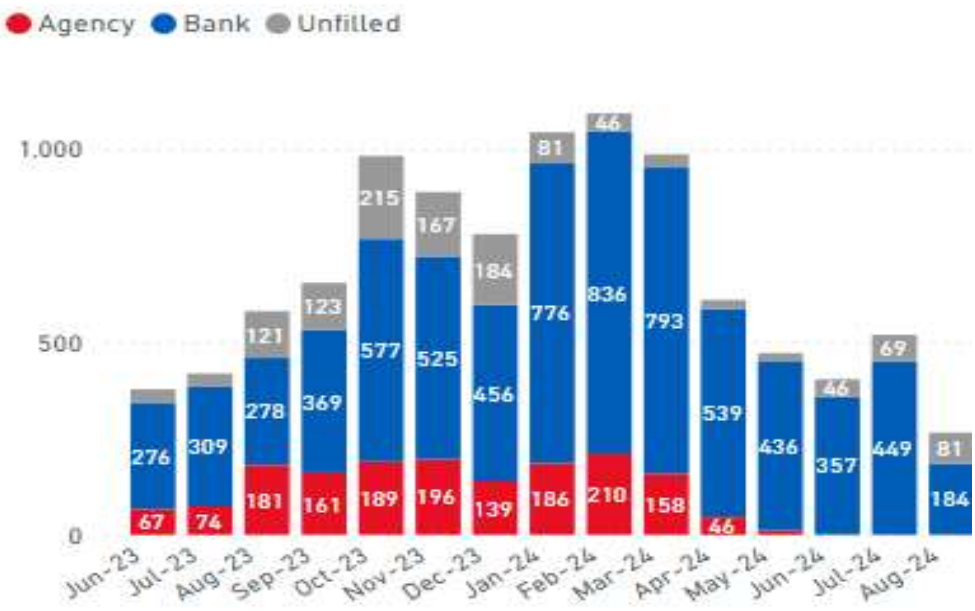
Shift Fill Rates

Shift fill rates are excellent for registered and unregistered nurses. During April 2024 the CHPPD was a pleasing 12.8, with 9.5 being attributed to registered nurse time.

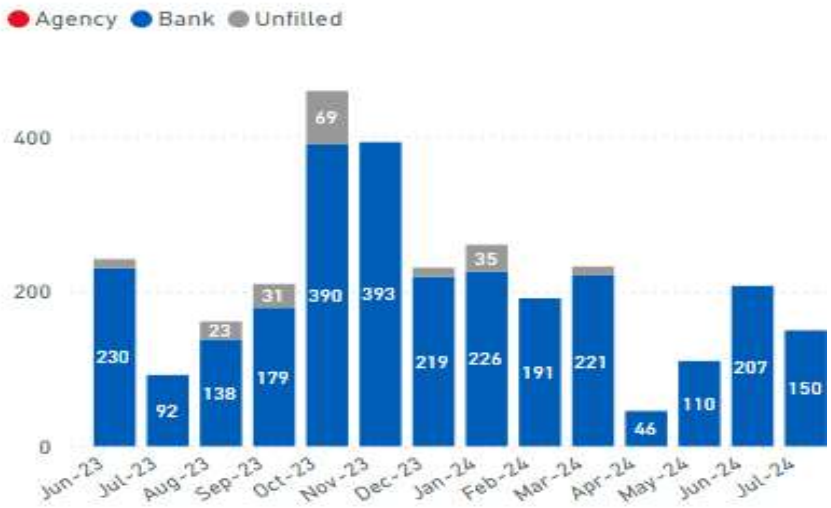
	April						
	Day		Night		CHPPD		
	RN	CSW	RN	CSW	RN	CSW	Overall
Ward	Fill (%)	Fill (%)	Fill (%)	Fill (%)			
Woodlands	94%	106%	100%	103%	9.5	3.3	12.8

NHSP and Agency Demand and Fill

Registered Nurse demand and fill in hours.



Unregistered demand and fill in hours.



Turnover and Sickness Rates

Sickness rates are reducing over the summer months as would be expected. Currently 2.77% for registered nurses and 0% for CSW's.

Registered nurse sickness rate

Directorate	Department	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24
Community and Childrens	Woodlands Ward	0.59%	2.65%	1.67%	5.35%	6.30%	14.77%	17.13%	14.85%	17.72%	15.27%	9.01%	2.77%

CSW sickness rate

Directorate	Department	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24
Community and Childrens	Woodlands Ward	17.61%	2.07%	6.63%	0.86%	1.17%	10.85%	17.22%	1.92%	9.12%	4.69%	0.53%	0.00%

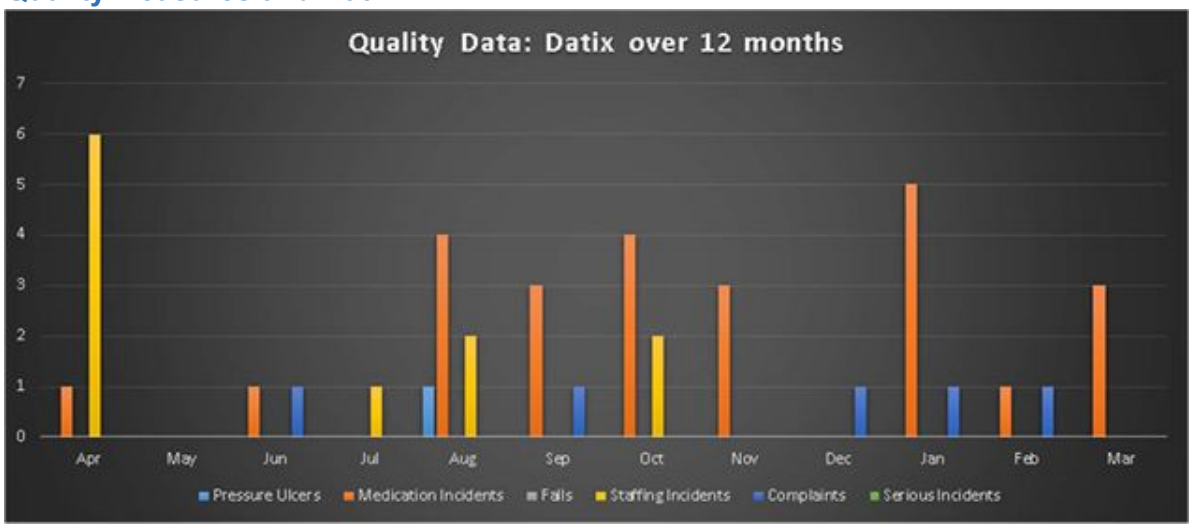
Registered nurse turnover rate

Currently our turnover rate is 12.83% which is within the HDFT acceptable level of 13%.

CSW turnover rate

Due to a small establishment of CSW, when 1WTE CSW leaves the data is markedly impacted.

Quality Measures and Datix



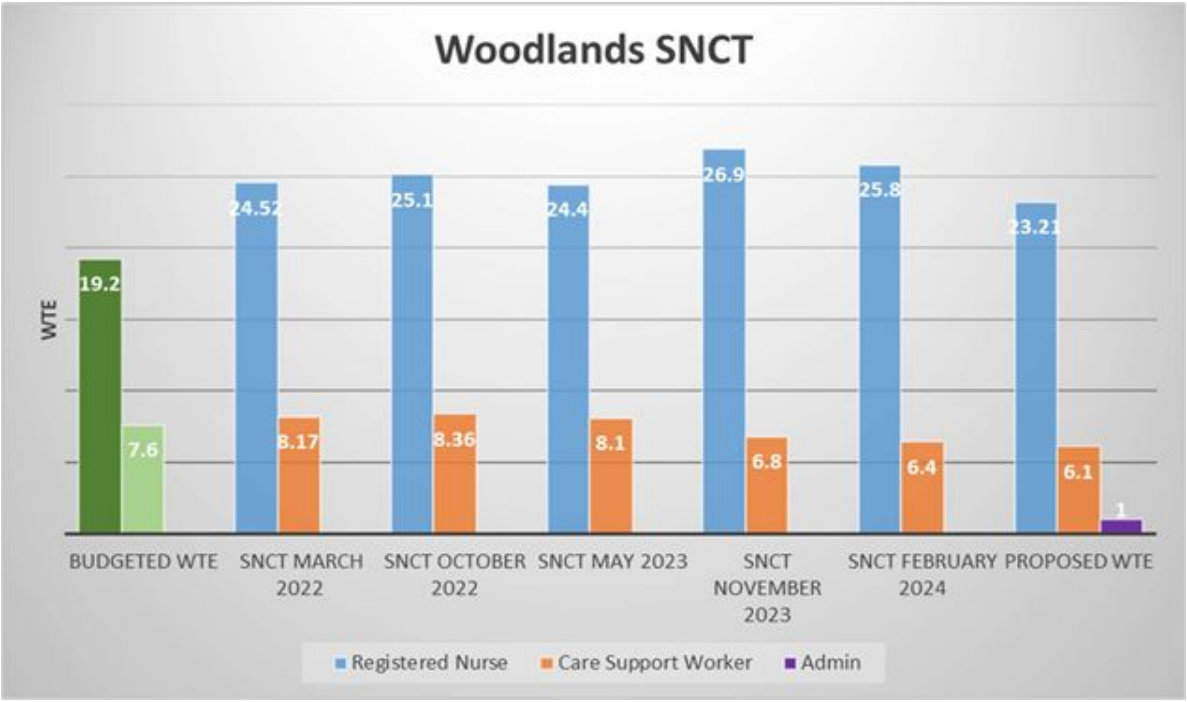
Ward Activity

	Admissions	Discharges	Transfers In	Transfers Out	Deaths	Ward Attenders
January	371	386	9	2	0	26
February	297	310	5	0	0	20
March	328	339	8	0	0	24
April	288	295	4	1	0	25

Summary of SNCT data

The table below illustrates the proposed establishments against the last 5 SNCT data collections at 100% bed capacity. The last columns illustrate the proposed establishment for 16 beds. The SNCT data consistently identifies an increase in RN establishment.

To note: the RN establishment includes the Band 4 Play Specialist and the Practice Educator.



Results

Standards for Bedside, Deliverable Hands-on Care

(Guidance on Safe Staffing Levels in the UK, RCN 2010)

Children < 2 years of age 1:3 registered nurse/child day and night.

Children > 2 years of age 1:4 registered nurse / child day

Children > 2 years of age 1:5 registered nurse/child night

Level 1 (high dependency) 0.5: 1 (1:1 in cubicles)

The results from the SNCT data collections have been calculated on 16 beds. The table below illustrates the budgeted WTE against the SNCT results at 100% bed occupancy and the SNCT proposal. The table below describes the financial impact of the SNCT recommendations for the ward establishment.

To improve the service that can be provided within CAU; to include, pulling through from ED, reducing complaints, improving quality, safety and performance, investment would be

required to fund a Paediatric Nurse Practitioner service. The details of this are not included within this paper as this is separate to the SNCT review. A separate group has been set up to work through the workforce requirements for this service.

To note, there is no budget for Ward Clerk provision, historically this role has been funded from the Band 2 CSW budget. Woodlands currently use 37.5 hours of admin time per week (Monday to Friday) to manage the day to day administration needs of the unit. Therefore, this role has been added to the requirements and costings as part of this review.

Shift Pattern for proposed Establishment

Following the SNCT review meeting (triangulation of nurse sensitive indicators, activity and raw data); professional judgement from senior nursing staff have agreed a safer staffing establishment for Woodlands Ward. The table below describes the proposed establishment for 16 beds.

	Early	Late	Night
RN	**4**	**4**	**3**
CSW	**1**	**1**	**1**
MD	**30 hours (0.8WTE) – this covers Woodlands and SCBU**		
Practice Educator	**37.5 (1.0 WTE)**		
Play Specialist	**37.5 (1.0 WTE)**		
Ward Clerk	**37.5 (1.0WTE)**		

Proposed Establishment Staffing Template by Band

Band 2	Shift Hours	No. of staff	WTE	Annual Leave	Study Leave	Sickness	Total WTE
Early	7.5	1	1.4	0.24	0.03	0.08	1.76
Late	7.5	1	1.4	0.24	0.03	0.08	1.76
Long day	12	0					
Night	11	1	2.05	0.36	0.05	0.12	2.58
			4.85	0.83	0.11	0.29	6.10

Play Specialist	Shift Hours	No. of staff	WTE	Annual Leave	Study Leave	Sickness	Total WTE
B4	7.5	1	1.00	No Headroom			1

Band 5	Shift Hours	No. of staff	WTE	Annual Leave	Study Leave	Sickness	Total WTE
Early	7.5	1	1.4	0.24	0.03	0.08	1.76
Late	7.5	1	1.4	0.24	0.03	0.08	1.76
Long day	12	2	4.48	0.79	0.10	0.27	5.64
Night	11	2	4.11	0.72	0.09	0.24	5.17
				2.12	0.26	0.68	14.13

Band 6	Shift Hours	No. of staff	WTE	Annual Leave	Study Leave	Sickness	Total WTE
Early	7.5	1	1.4	0.24	0.03	0.08	1.75
Late	7.5	1	1.4	0.24	0.03	0.08	1.75
Long day	12	0					
Night	11	1	2.05	0.36	0.05	0.12	2.58
			4.85	0.84	0.11	0.28	6.08

Practice Educator	Shift Hours	No. of staff	WTE	Annual Leave	Study Leave	Sickness	Total WTE
B6	7.5	1	1.00	No Headroom			1

Ward Manager	Shift Hours	No. of staff	WTE	Annual Leave	Study Leave	Sickness	Total WTE
B7	7.5	1	1.0				1.0

Ward Clerk	Shift Hours	No. of staff	WTE	Annual Leave	Study Leave	Sickness	Total WTE
b2	7.5	1	1.00	No Headroom			1

Costings for Proposed Establishment

The financial ask, to fully support the Woodlands roster would be £173,882 in addition to the current Woodlands budget.

The difference from the current establishment:

Additional 1.99 WTE Band 5 Registered Nurse

Additional 0.95 WTE Band 6 Registered Nurse (Practice Educator)

Additional 0.45 WTE Band 2 Admin (increase funding to 1 WTE)

To Note: The Band 2 CSW's have been identified as holding and requiring Band 3 CSW clinical skills. They are currently within the scope of the Band 2 to Band 3 Job profiling that is being undertaken trust wide.

Recommendations

The SNCT raw data does not account for the extra activity as described in this report (escorts, supporting ED in resuscitation, safeguarding skeletal surveys, cannulation prior to procedures, short stay admissions and day surgery support). Therefore, senior nurse leaders have undergone a number of professional judgement review meetings to ensure that the nursing establishment meets the daily service demand, whilst maintaining quality, safety and performance.

Woodlands next C&YP SNCT data collection will be for the month of July 2024. It will include a data capture of the extra activity to enable us to demonstrate in more detail the time spent completing these additional duties. This further data collection will provide assurance around our predicted, future safer staffing levels for Woodlands and align to the planning cycle for 25/26. As in accordance with the National Quality Board standards, Woodlands will continue to collect SNCT data biannually.

As described earlier, a separate business case is being worked up for CAU requirements.

The SNCT review strongly supports the increase of Practice Educator hours, from 0.2WTE to 1.0WTE (included in the RN proposed establishment). This would bring Children's services 'in line' with best practice for supporting, developing and mentoring CYP nurses. Please refer to the embedded document about the requirement for this role.

Paediatric Practice Educator.docx

Finally, this report and recommendations should be shared with the Deputy and Director of Nursing, Midwifery and AHP's, Head of Nursing and Workforce for Children's to consider the outputs and agree next steps.

Establishment Review Panel Outcome

The recommendations within this report were presented at Establishment Review Panel on Friday 19th July 2024.

There was acknowledgement that the SNCT demonstrates a slight establishment change for the Woodlands Ward. However, the Children's Assessment Unit (CAU) service review

and redesign may influence additional changes. Therefore, no changes to be made until the **CAU service review** and establishment modelling has been completed. This should then come back through Establishment review panel in September.

The panel would like to see a breakdown of data collected, on a continuous basis, for:

- Number of attendances per day,
- Age of child,
- Presenting concern,
- Referral pathway,
- Professions seen by (Nurse, Doctor, Reg etc)
- Length of visit
- Outcome (admitted/discharged).

To repeat the SNCT (July).

Complete CAU Service Review.

Present to Establishment Review Panel.

Woodlands - Establishment Review

Embedded document 1 :

Scoping for Paediatric Practice Educator Hours on Woodlands Ward

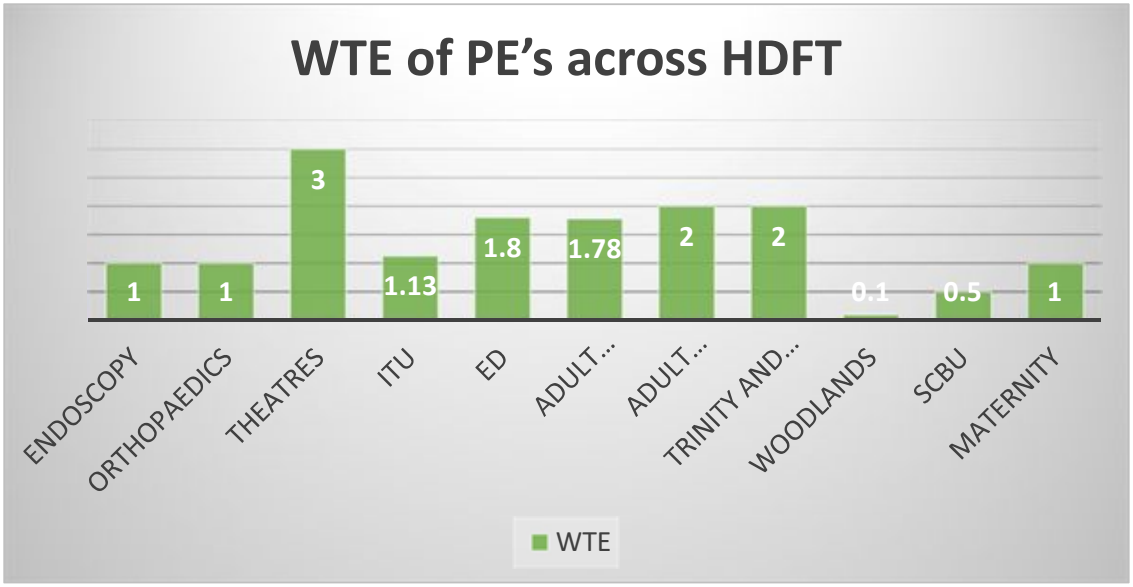
Following a review of the Paediatric Educator post on Woodlands Ward (currently allocated 0.2 WTE) the following data and supporting evidence has been collated in the interest of increasing the post to 1 WTE.

The Woodlands PE post came into place in 2017/2018 at 0.2 WTE at a Band 6. Whilst the role has resulted in many successes, feedback from all professionals who have been in post reflects the responsibilities of the role aren't achievable in 7.5 hours a week. Historically, we have had 6 professionals in this post over the past 6 years, each leaving the position within a year of starting, showing a recruitment and retention concern. Compared to previous years, Woodlands now have a higher proportion of junior to senior staff, therefore an increased need for education support and opportunities.

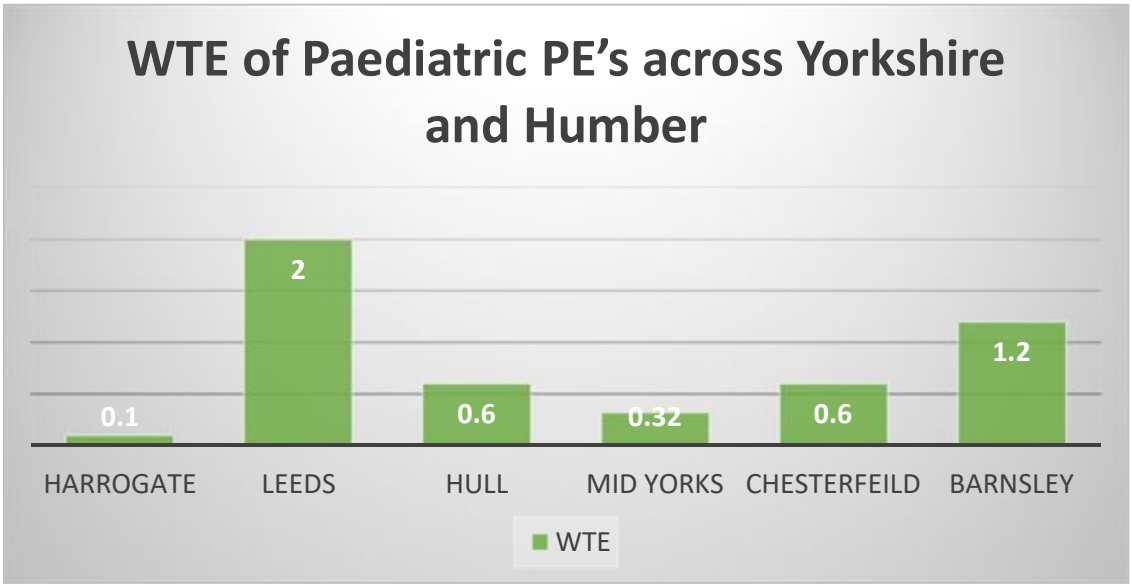
At present the practice educator responsibilities include, but are not limited to, organising, coordinating and teaching on quarterly in house study days, attending local and regional PE meetings, liaising with student nurses and universities around placement allocation, supporting staff nurses and the wider MDT with on the spot paediatric skills training, developing paediatric competencies and preceptorship, education based audits, and supporting the wider hospital with paediatric based training, including simulation training in the emergency department and support for paediatric outpatients.

In comparison to the local and regional allocated WTE for paediatric educators, the following data was collected in May 2024:

HDFT data:

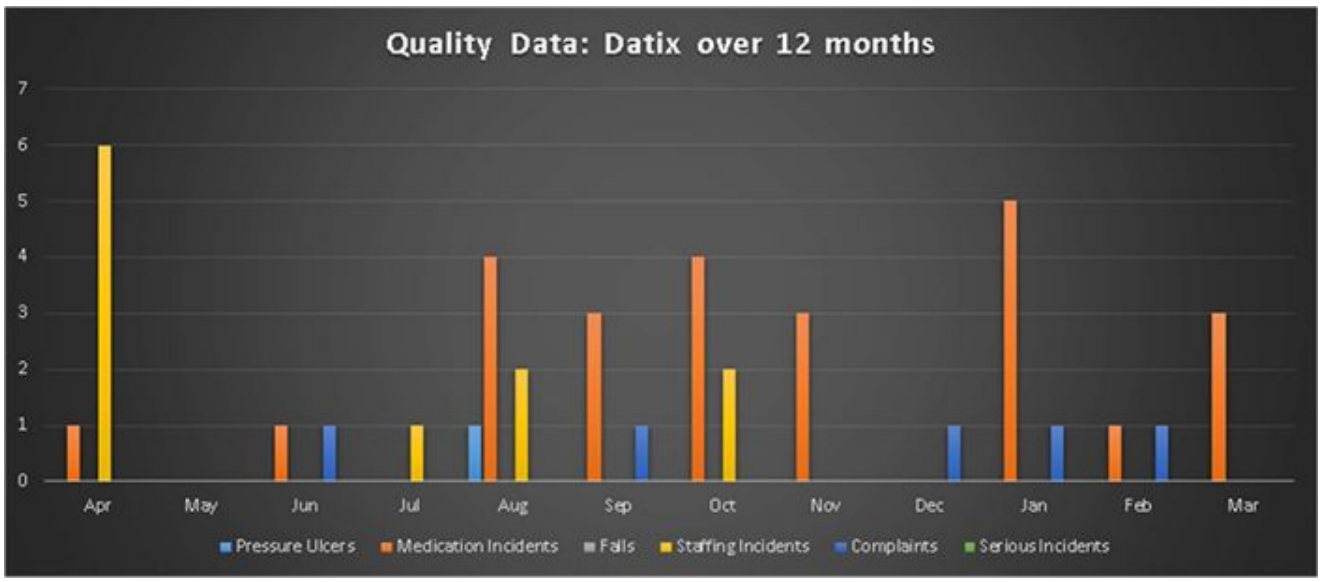


Regional data:

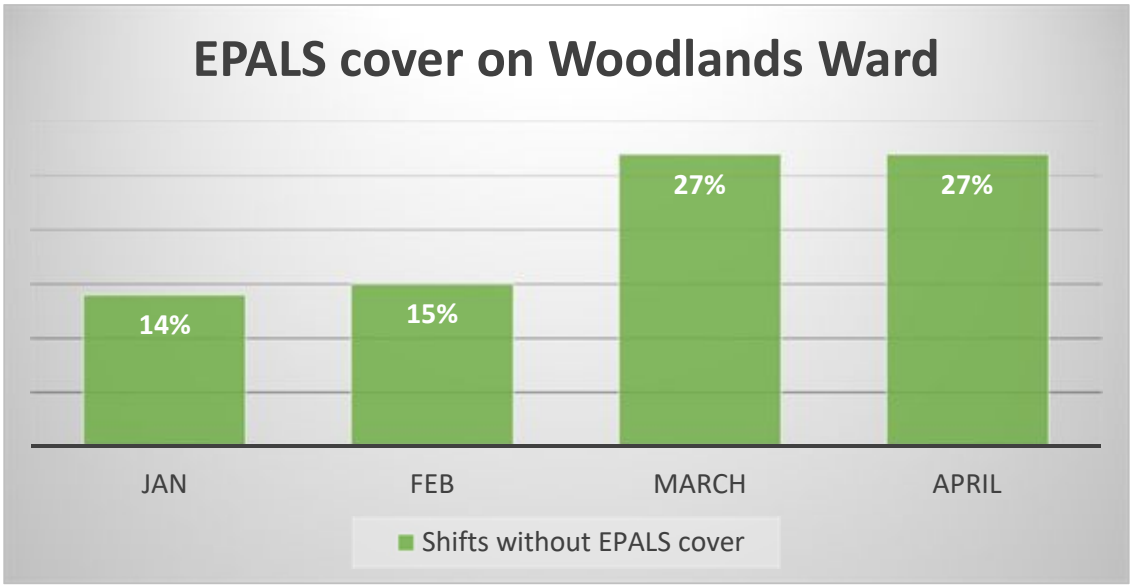


This data shows us that from both a local and regional perspective, the HDFT paediatric educator WTE allocation is an outlier. Mid York's commented that whilst they have a temporary 0.32 WTE at present, their trust is in the process of recruiting for another Band 6 post and a Band 7 paediatric educator Lead. It is also of note that locally, the SCBU Band 7 educator post is externally funded.

Having an increased WTE for the PE would allow for an increased presence and incidence driven education and teaching for the staff on Woodlands ward and the wider trust. This would contribute significantly to reducing the number of DATIX's and incidences, and support reducing active risks on the risk register relating to education gaps. The following data was collated from 2023-2024 which reflects the DATIX themes on Woodlands ward, many of which would be addressed and reduced by having a more established education presence on the ward (in particular medication errors which is our most prevalent theme):



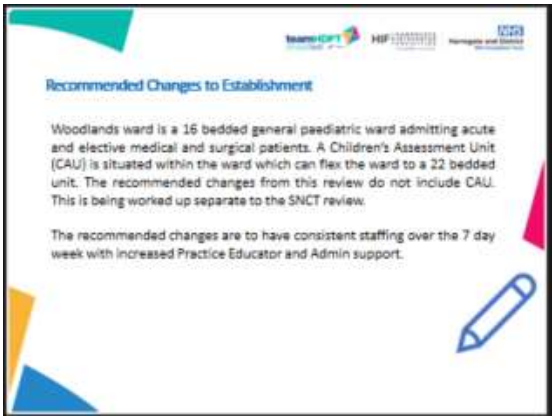
In regards to the risk register, there are multiple risks revolving around staff training and compliance, namely the lack of tracheostomy trained staff and lack of compliance with European paediatric advanced life support qualified nurses (ODN recommendations indicate there should be one nurse per shift trained). At present no nurses on Woodlands are tracheostomy competent and the figures from the 2024 EPALS audit are as follows:

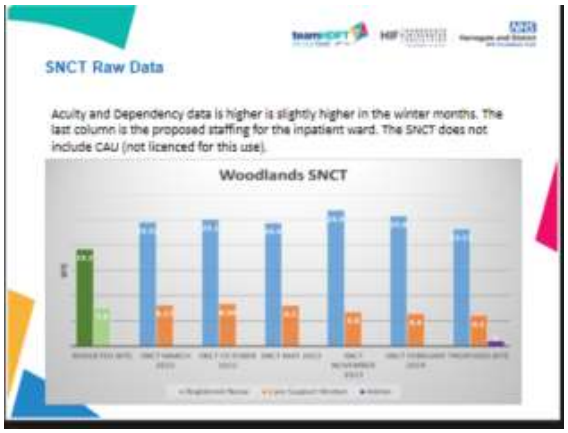


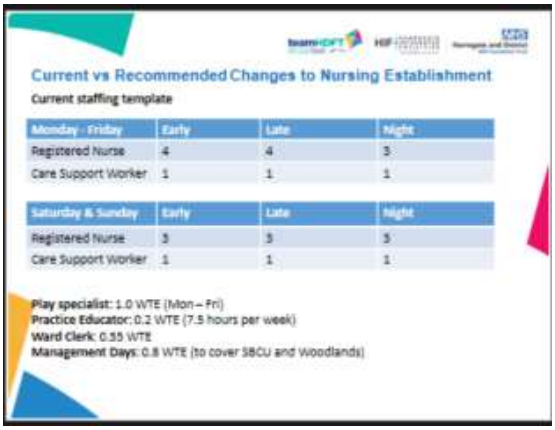
The presence of an educator would allow for the facilitation of tracheostomy training opportunities, as well as linking with local centres to explore options for EPALS training and preparation.

Overall the increase in WTE for the paediatric educator post would have a positive impact on staff confidence, retention and education, it would also reduce the number of DATIXs, incidences and clinical risk on Woodlands ward, and overall have a huge impact on the safety and wellbeing of the patients.

Embedded document 2:







4

Board of Directors
25th September 2024

Title:	Safeguarding Annual Report
Responsible Director:	Emma Nunez, Executive Director of Nursing, Midwifery and AHP
Author:	Alison Smith / Emma Anderson – Deputy Directors Nursing CYP Safeguarding

Purpose of the report and summary of key issues:	The purpose of this report is to provide assurance to the Board of Directors with an overview of Safeguarding activity within Harrogate and District NHS Foundation Trust (HDFT) and identify how this meets our statutory safeguarding responsibilities under the Children Act 1989/2004; the Care Act 2014 and the Mental Capacity Act 2005. The report is aligned to the six safeguarding principles and Section 11 of the Children Act (2004). As part of our multi-agency commitment to Safeguarding Adults and Children; HDFT is represented on North Yorkshire Safeguarding Executive and Adult Board arrangements and is represented by Executive Director of Nursing or Deputy Director of Nursing, CYP and Safeguarding. HDFT are represented in North Yorkshire adult and children`s partnership arrangements by Named Professionals. Named Nurses working across 0-19 localities represent HDFT in respective safeguarding children`s partnership arrangements. Through newly established Governance arrangements The Trust Safeguarding Governance Forum reports to and links directly into the Quality Governance Management Group (QGMG). Our revised Safeguarding Committee, with external partners, reports directly into Quality Committee on behalf of the Trust Board	
	The Patient and Child First Improving the health and wellbeing of our patients, children and communities	x
	Best Quality, Safest Care	x
	Person Centred, Integrated Care; Strong Partnerships	x
	Great Start in Life	x
	At Our Best: Making HDFT the best place to work	x
	An environment that promotes wellbeing	x
	Healthcare innovation to improve quality	x
Corporate Risks		
Report History:	Safeguarding SMT – 5th September 2024 Safeguarding Governance Forum – 10th September 2024 QGMG – 10th September 2024	
Recommendation:	The Board are asked to receive this report and note the content, activity and progress in safeguarding delivery, governance and leadership improvements over the last 12 months	

INTRODUCTION

This report is the Safeguarding Annual Report for the Quality Committee, for the reporting period July 2023 – July 2024.

The report provides an overview of activity and outlines key achievements and developments on our safeguarding priorities. It has been structured around the key principles of safeguarding, which are central within our *All-Age Safeguarding Strategy* currently being finalised for 2024-2027, this will underpin all our safeguarding work. It also aligns to our progress and compliance with Section 11 of the Children Act (2004). Our Safeguarding Strategy will align with the Safeguarding Adults Boards and Safeguarding Children's Partnerships` priorities.

The Executive Director of Nursing Midwifery and AHPs is the Executive Board Lead for Safeguarding, Children in Care and Learning Disability and Autism.

The NHS England Safeguarding Accountability and Assurance Framework (SAAF, 2024) states the following in relation to provider leadership responsibilities aligned to Safeguarding:

- Health providers are required under statute and regulation to have effective arrangements in place to safeguard and promote the welfare of children and adults at risk of harm and abuse in every service that they deliver.
- Providers must demonstrate safeguarding is embedded at every level in their organisation with effective governance processes evident.
- Providers must assure themselves, the regulators, and their commissioners that safeguarding arrangements are robust and are working.

<u>Safeguarding Diagnostic</u>

Shortly following the appointment to the role of Deputy Director Children and Young People (CYP) / Safeguarding in July 2023 a safeguarding diagnostic was undertaken by the newly appointed Deputy. The safeguarding diagnostic was completed over a period of 4 months and used the following methods to undertake a Trust wide benchmark position:

- A benchmark against the NHS England SAAF
- Mapping against the Intercollegiate Guidance (Working Together to Safeguarding Children, 2023)
- Stakeholder engagement feedback internally and externally
- 1:1s with all Named Professionals across HDFT footprint

The key themes identified within the safeguarding diagnostic were as follows:

- Strong focus on safeguarding across 0-19 services with safeguarding embedded across and within locality teams.
- Strong partnership working across most localities within general management and partnership teams.
- Skill mixing and new roles seen as a positive impact across 0-19 locality teams.
- Responsive team
- Good progress in focus on adult safeguarding over the last 12 months
- Good information sharing and communication from most areas.
- Voice of children very strong
- North Yorkshire Children in Care team excellent with great leadership
- Good engagement with statutory reviews

- Very good safeguarding leadership in locality teams
- Very focused on doing the right thing for service users.

Having acknowledged a significant number of areas where positive feedback was shared from both internal and external partners and from the completion of benchmarking activities there are a number of areas which needed to be addressed and strengthened as follows:

- Strengthened safeguarding strategic leadership to provide, oversight and strategic direction with increased visibility within acute services.
- Strategic leadership underpinned by a safeguarding strategy – very operational focus.
- Trust wide Safeguarding processes
- Increased focus on safeguarding within the acute setting – child and adults
- Clarity of roles / responsibilities across safeguarding teams / functions
- Increased focus on LD and Autism
- Development of a Strategic Safeguarding Risk Register
- Clear escalation / communication processes
- Consistency in processes and reporting of mandatory training figures being reported.
- Increased engagement and involvement with the safeguarding adult's team in the wider safeguarding strategy and relevant Trust strategies
- Strengthened team working in acute safeguarding function.
- Strengthened support / communication and engagement with acute clinical teams to improve relationships, increase ownership and accountability.
- A focused safeguarding annual audit plan
- Identification of clear outcomes and impact
- Consistency in representation at CYP partnership meetings – North Yorkshire
- Robust governance processes to provide assurance.
- Clear line of accountability within the organisation for work on safeguarding and promoting the welfare of children and adults
- Revision of Safeguarding Strategic Governance Committee
- Robust processes in Tees Children in Care contracts

HDFT safeguarding leadership roles were previously spread across the organisation with some of the leadership resource sitting within the Director of Nursing budget / team, some of the resource sitting within the Community and Children's Directorate and one post sitting within the Planned and Surgical Care Directorate. There was previously no identified corporate safeguarding function or structure. At the time of writing this report a corporate safeguarding structure is now in place. (Appendix)

SECTION A: Principles of Safeguarding

There are 6 main principles of safeguarding as outlined in the Care Act (2014) empowerment, prevention, protection, proportionality, partnerships and accountability.

1. PARTNERSHIP – *collaboration with partner agencies and communities.*

As part of our multi-agency responsibilities to safeguarding adults/children and children looked after, HDFT is represented at North Yorkshire Safeguarding Adults Board (NYSAB), ICB Safeguarding and Executive arrangements. The Named Nurses/ Professionals represent the Trust on the sub-groups of Adults Boards/Partnerships and across all Children`s Boards/Partnerships across HDFT footprint.

Work across partnerships 2023/4

Maternity

Quarterly meetings are now held with primary care to share information and ensure processes are aligned and robust to enable effective information sharing. It should be noted from feedback through these meetings that HDFT is cited nationally for best practice due to liaison with GP after booking to enquire re safeguarding concerns. High Risk Case review meetings take place weekly with health visiting teams to ensure oversight and handover from acute maternity cases.

Representation from maternity services through Named Midwife role at North Yorkshire Children Safeguarding Children Partnership quarterly meetings. Our Named Midwife works closely with other Named Midwives in region.

Development of guidance for Hold on Pain Eases (HOPE) boxes and birth response plans with social care has been taken forward in 2024, supporting women separated from their baby close to birth due to safeguarding concerns.

Children (acute)

Children`s acute safeguarding team continue to work collaboratively with partners with increased and strengthened engagement in 2024 and are now actively involved in a number of key North Yorkshire partnership meetings identified below:

Multi-Agency Child Exploitation (MACE) level 2 meetings, MACE operational group, Practice and Learning Sub Group, Working Together Progression Task and Finish Group, Child Death Overview Panel, development days, Safeguarding Children Health Professionals Network meeting, Mock Joint Targeted Area Inspection (JTAI) meetings, Learning Themed Audit, subject specific meetings (e.g. protected addresses, notification of death of care leavers), High Risk case meetings. Safeguarding colleagues attend and sharing information for Multi-Agency Risk Assessment Conferences (MARAC) and attend meetings when appropriate.

Community

Safeguarding colleagues embedded within 0-19 locality team's work closely with multiagency stakeholders across all footprints. Quality assurance reports to commissioners across all localities from Named Nurses continue to be shared to outline the findings of the safeguarding children team activity undertaken and any changes in practice that impact and/or improve quality of practice within the 0-19 Service and safeguarding children team. The reports outline any learning from Inspections/Child Safeguarding Practice Reviews and/or Learning Lesson Reviews and also highlight evidence of good practice. Reports are provided to assure commissioners that key performance indicators are being achieved which will include safeguarding supervision and training compliance.

A number of inspections / reviews of children`s services have taken place within the previous 12 months which safeguarding teams have engaged with and provided evidence for, those with direct quotes related to HDFT team inputs are provided for information;

> **Inspection of Northumberland County Council local authority children's services**:
> The experiences and progress of children who need help and protection: **Outstanding.**

Children in Northumberland receive a highly effective response when they are referred into the 'front door'/multi-agency safeguarding hub (MASH). Partnership working is consistently strong, and children are appropriately referred into the front door by partner agencies. All contacts are thoroughly considered by social workers. Social workers are rigorous in gaining parental consent to gather further information which is proportionate and relevant to the areas of need and risk being presented.

Focused visit to Sunderland children's services: arrangements for children in need or subject to a child protection plan.

"Children in need or those subject to a child protection plan in Sunderland typically receive timely and effective support when they need it. Their needs and risks are assessed by highly skilled and committed workers who, in partnership with children's family networks and professionals, develop clear plans to make children safer."

Focused visit to Darlington children's services: arrangements for children in need and children subject to a protection plan

"Relationships with partners are a particular strength. This is enabling professionals to engage in effective multi-agency information-sharing which informs decision-making and sound planning for children. The principles of family group conferences are strongly evidenced in this practice area. This is helping parents and their wider family network to safely take responsibility for decision-making where appropriate."

Inspection of Hartlepool local authority children's services
The experiences and progress of children in care: outstanding

"*There are a very small number of children in private fostering arrangements. When children live in these arrangements, appropriate assessments and checks are undertaken, and regular oversight is in place. Visits to this group of children are carried out regularly and their views about their living arrangements sought."*

Inspection of North Yorkshire local authority children's services
The experiences and progress of children who need help and protection: outstanding

"Children in need of help and protection are safeguarded well. Children come into care when it is appropriate to do so. Every effort is made to support children's connections to family and their communities and for them to return home safely. Those children who need to remain in care are supported well and helped to make progress. Leaders take their responsibility towards care leavers seriously and this is exemplified by the 'always here' approach to support care leavers at any age."

Adults

The Named Professional (Safeguarding Adults) represents HDFT on the three North Yorkshire Safeguarding Adults Board (SAB) sub-groups. At each Performance and Quality Improvement sub-group, data is shared from all providers in relation to safeguarding adult activity and audit updates, to identify themes, trends and areas of concern. This allows HDFT activity to be benchmarked against other acute Trusts, which supports prioritisation of focused activity. At the Learning and Review (LAR) Sub-Group shared learning from Safeguarding Adult Reviews (SARs) and non-statutory reviews is identified, with resulting action plans for relevant partners. During 2023/24 the Named Professional led a task and finish group in relation to improving information sharing between HDFT's Emergency Department and Primary Care in relation to

a recent SAR, the outcomes of which were shared at the LAR group, who were assured by the new processes. Within the Policies, Practice, Development and Legislation Subgroup, the Named Professional presented the HDFT 2023 Deprivation of Liberty Standards (DoLS) audit and action plan, which was positively received, and contributed to the development of SAB Organisational Safeguarding Procedures

2. PROTECTION – *keeping people safe by help, support and stopping abuse.*

Domestic Abuse

A domestic abuse action plan has been developed and initiated, which centres on the support staff require to be able to effectively identify and respond to disclosures of domestic abuse, including disclosures from colleagues. A network of domestic abuse champions has been identified and the first meeting will be held in September. A domestic abuse steering group will be in place from October, which will feed into safeguarding governance reporting structures. During North Yorkshire safeguarding week in June, HDFT held a study day for staff on domestic abuse, with external speakers from the police and from survivor organisations.

Domestic abuse was the subject for L3 Safeguarding Children refresher Training in 2023. Bespoke domestic abuse training was also provided for Emergency Department (ED) doctors on their weekly training.

Staff have supported patients and colleagues who have disclosed domestic abuse through Domestic Abuse Staking Harassment and Honour Based Violence Assessment (DASH) and MARAC process and with safety planning and accessing support.

Summary Case Studies are shared within Appendix of this report to provide further detail and information

Sexual Safety Charter

On 4 September 2023, NHS England launched its first ever sexual safety charter in collaboration with key partners across the healthcare system. Signatories to this charter commit to taking and enforcing a zero-tolerance approach to any unwanted, inappropriate and/or harmful sexual behaviours within the workplace, and to ten core principles and actions to help achieve this. HDFT as an organisation has signed up to the Charter. The Commitments are as follows;

1. We will actively work to eradicate sexual harassment and abuse in the workplace.
2. We will promote a culture that fosters openness and transparency, and does not tolerate unwanted, harmful and/or inappropriate sexual behaviours.
3. We will take an intersectional approach to the sexual safety of our workforce, recognising certain groups will experience sexual harassment and abuse at a disproportionate rate.
4. We will provide appropriate support for those in our workforce who experience unwanted inappropriate and/or harmful sexual behaviours.
5. We will clearly communicate standards of behaviour. This includes expected action for those who witness inappropriate, unwanted and/or harmful sexual behaviour.
6. We will ensure appropriate, specific, and clear policies are in place. They will include appropriate and timely action against alleged perpetrators.
7. We will ensure appropriate, specific, and clear training is in place.
8. We will ensure appropriate reporting mechanisms are in place for those experiencing these behaviours.
9. We will take all reports seriously and appropriate and timely action will be taken in all cases.
10. We will capture and share data on prevalence and staff experience transparently

We have carried out an initial self-assessment with actions to address any gaps, to ensure we are in line with the ten core principles. Work being led by Medical Director and team will be added to the initial self-assessment and the combined document will inform the development of a delivery plan which will be take forward. Our current actions being taken forward over the next 12 months broadly fall into the following work streams:

Supporting Staff Disclosures
Development of an operating model and support mechanisms for staff who report incidences of sexual misconduct. This will include the creation of a generic sexual safety mailbox and signposting of staff to the Vivup counselling service, external specialists for support with sexual safety concerns. Part of this work will also explore other potential reporting routes for staff to make disclosures as accessible for staff as possible.

Communication & Engagement
Implementation of a communication and engagement plan to promote the launch of work of the sexual safety task and finish group, including CEO video message, posters, manager briefing document for team meetings, staff network engagement, all staff webinar and 'let's talk about sexual safety' animation to be published on the HUB. We will be asking senior managers to proactively raise and talk about the Charter.

Launch Workshops
We will be accessing specialist support from the Survivors Network for leaders (Execs, Directors, Directorate triumvirates) and key influencers (e.g. Freedom to Speak Up Guardians, Staff side, Employee Support & Resolution team) to be better prepared lead and handle issues in this sensitive space.

Training
Sexual safety training will be rolled out. It is intended that this can be accessed by any member of staff. It is proposed that this will also be built into all new manager and leadership training and will be complemented by wider rollout of the existing bystander intervention training.

Policy and Guidance
To complement current policies guidance is being developed around sexual harassment and sexual assault as well as how to handle disclosures. All documents look to enable a trauma informed approach.

Reporting
Work with the Datix team is starting to ensure matters reported via Datix can be categorised to sexual safety. The executive team should expect that we will see an increase in reporting once launch HDFT`s Sexual Safety Charter, which would be a positive in the current context.

The Named Professional is a member of the North Yorkshire and Humber ICS Domestic Abuse and Sexual Violence strategic group. One area of focus of the group is on non-fatal strangulation and embedding an overarching clinical pathway for organisations to adapt to their own needs. Once the pathway has been developed, this will be shared with ED. In the interim, the latest guidelines from the Institute for Addressing Strangulation for the management of non-fatal strangulation have been shared with ED, with an agreement from the lead clinician to add to the ED app.

White Ribbon Accreditation Programme
As part of this work HDFT as an organisation plan to sign up to the White Ribbon Accreditation which is a nationally recognised programme to end violence against women and girls in the workplace, providing organisations with a framework to achieve transformational change in their staff culture, systems and communities.

Female Genital Mutilation (FGM)

Following a benchmark with other acute and community health providers we have identified a gap in our policy and processes for management of FGM. A Trust wide FGM policy is now in draft and will be ratified in October 2024 prior to implementation.

Prevent

The Counterterrorism and Security Act (2015) places a duty on HDFT to have; 'due regard to the need to prevent people from being drawn into terrorism.' HDFTs Safeguarding Team continue to respond to information requests and share these with partner agencies. Over the reporting period there have been 51 requests for information from North Yorkshire Police.

Prevent training has now moved to a three yearly requirement from October 2023. Compliance is 95.6% for Basic Prevent Awareness and 93.9% for Awareness of Prevent – level 3. The Prevent Policy was reviewed in July 2024 and will be ratified in Safeguarding Governance Forum in September.

Trauma Informed Care

We continue to deliver ED Bespoke Safeguarding sessions to staff across our departments and embedded within these sessions the principles of Trauma Informed Practice.

The Named Professional Adults will be a member of the panel for the North Yorkshire 'Right Care, Right Person multi- agency meeting chaired by North Yorkshire Police and TEWV with representatives across health and social care. This is Trauma Informed Initiative to share experience and learning between agencies around vulnerable adults and the appropriateness of the care provided in these cases. HDFT is already represented in this group by the ED matron.

Emergency Department

The acute safeguarding team have jointly developed an action plan with ED, based on the Facing the Future urgent care standards, adapted to include adults. Key lines of enquiry include: supporting ED to meet safeguarding training and supervision compliance; appropriate escalation; and ensuring access to safeguarding policies, procedures and guidelines. The action plan forms the basis of discussion in monthly meetings with the ED matron where progress can be tracked.

The safeguarding team attend the daily ED safety huddle, giving key messages to staff and ensuring visibility into the department.

3. ACCOUNTABILITY – *safeguarding is everyone's responsibility. Everyone in contact with a vulnerable patient should be responsible for identifying and acting on any risks.*

Mental Capacity Act (MCA) / Deprivation of Liberty Safeguards (DoLS)

There continues to be a focus on MCA and DoLS, including considering the importance of the executive functioning of our patients from the Safeguarding Team. During this reporting period the team have processed:

- 258 urgent referrals
- 7 applications have been cancelled due to no longer being required.
- Of these, 0 applications have resulted in a Best Interest Assessor attending the ward to approve a standard DoLS authorisation.

Over the last year no DoLS applications have been rejected by North Yorkshire or any other Supervisory Body giving the Trust good assurance that all applications made have been appropriate for our patients. Bi-weekly meetings are now in place between the Named Professional and North Yorkshire DoLS team to support the prioritisation of applications to reduce the risk of patients being unlawfully deprived of their liberty.

An internal audit was undertaken and review of all DoLS applications was undertaken in Q1, with the objective of determining whether: the applications met the acid test; capacity assessments had been documented; least restrictive options had been considered; the patient's nearest relative had been consulted; restrictions were reviewed and patients were being unlawfully deprived of their liberty due to the urgent authorisation expiring without a standard authorisation having been approved.

There were areas of good practice identified with the vast majority of cases meeting the acid test; most applications had a capacity assessment documented contemporaneously to the DoLS application being made. Areas identified for improvement were around reviewing capacity; reviewing restrictions; limited evidence of nearest relatives being consulted. An action plan was developed, which focused on the requirement to offer training to wards; a recommendation for the Trust to recruit to a lead practitioner role; consultation with the Trust's legal service in relation to patients remaining in hospital after the urgent DoLS expires; and consideration on prompting.

Our Future Plan:

One of the recommendation from the DoLS audit was for Trust to recruit to an MCA lead practitioner post, which is in line with the SAAF requirements. Due to internal promotion, recruitment to the role of Named Professional Safeguarding Adults is currently in process and this role will include the role of MCA Lead combined with the Named Professional role. This will help to drive forward a programme of MCA improvement across HDFT, including building on the current MCA training offer; extending the current ability of the team to support practitioners with implementing the MCA; developing an audit programme and ensuring a more timely and robust process in the delivery of HDFT's statutory responsibilities as a Managing Authority under the DoLS framework through the transfer of responsibility of the DoLS administration system to the safeguarding adults team.

Safeguarding Training.

The Safeguarding Children's/Adults/MCA/DoLS training packages for level 2 and level 3 continue with good feedback from staff and include a hybrid approach of e-learning and face to face sessions. This ensures compliance with the Safeguarding Children and Young Peoples: Roles and Competencies for Healthcare Staff (2019), the Looked After Children: Roles and Competencies for Healthcare Staff (2020) and the Safeguarding Adults: Roles and Competencies for Healthcare Staff (2018).

Safeguarding Training Compliance

Safeguarding training compliance - end August report 2024

- Category	Certification Name	Required	Not Achieved	Compliance %	Increased/Decreased since previous month
Mandatory Training	Safeguarding Adults Level 1	1060	40	96%	Decreased 1%
Mandatory Training	Safeguarding Adults Level 2	2637	251	91%	Increased 1%
Mandatory Training	Safeguarding Adults Level 3	1115	200	82%	Increased 9%
Mandatory Training	Safeguarding Adults Level 4	1	0	100%	Same

Category	Certification Name	Required	Not Achieved	Compliance %	Increased/Decreased since previous month
Mandatory Training	Safeguarding Children Level 1	1152	73	94%	Decreased 1%
Mandatory Training	Safeguarding Children Level 2	1893	120	94%	Increased 1%
Mandatory Training	Safeguarding Children Level 3	1752	335	81%	Increased 3%
Mandatory Training	Safeguarding Children Level 4	16	1	94%	Increased 6%

Following review of guidance HDFT have, in 2004, increased the numbers of staff now requiring Level 3 Safeguarding Adults training which has resulted in a dip in our compliance figures, but we remain confident that this will continue to increase with more training being arranged, provided and attended,

The Safeguarding Training Steering Group has been revised and is currently focused on the following 5 key priorities:

1. Undertaking a Trust wide Training Needs Analysis
2. Development of a Safeguarding Training Plan
3. Review of all training packages to ensure compliance with Intercollegiate Guidance
4. Oversight and assurance of compliance with safeguarding mandatory training compliance
5. Strengthening governance into Trust wide Training Group

Safeguarding supervision

The requirement for all staff to have access to safeguarding supervision and support when required is a key principle for safe practice, which has the potential to make life different for the children and adults within our care.

The managerial oversight and monitoring of attendance at safeguarding supervision has previously been inconsistent with a lack of clear guidance in relation to frequency of attendance, which is proportionate to clinical roles and responsibilities, and is parallel to the safeguarding training requirement of individuals.

In 2024 a task and finish group for both training and supervision has been established to address the integrated operational changes to centralise a whole system reporting.

Further work was identified from this group which forms the basis of the next steps:

- Current model of peer safeguarding supervision
- Training provided for safeguarding peer supervisors as an establish process.
- Scoping of Current practice was undertaken to identify gaps and challenges.

The primary model to deliver Safeguarding Supervision across HDFT is the Tony Morrison 4x4x4 Model. (Morrison T, 2005)

This model has been used effectively across the Children and Community Directorate and within maternity services for several years and maintained through the training and recruitment of peer supervisors. The number of peer supervisors is proportionate to the total number of 0-19 staff within a contract area as it is an inclusive model for all staff who are in receipt of level 3 safeguarding training.

The training of new supervisors is delivered by a Safeguarding Specialist Nurse as a two-day course which has two main learning outcomes of safeguarding supervision skills and the Morrison's supervision model. This is delivered on a demand and capacity basis and feeds forward to continuing to develop a network of safeguarding supervisors.

Once the bespoke training is completed the supervisors all attend supervisor's supervision within their clinical areas on a minimum six-monthly basis and currently attendance at supervisor's supervision is not part of the compliance report.

A recently completed scoping exercise indicated a strong network of peers, and it is hoped to expand this network of champions over the next 12 months to other key areas.

The two Named Nurses who hold the thematic lead in supervision and have several areas for development which will be taken forward over the coming 12 months:

- Develop a system of central compliance reporting together with Learning & Development and consider resource to support.
- Undertake a review and update the existing trust wide 'Supervision Policy' to reflect both Adult and Children's arrangements while joining acute and community arrangements into one policy.
- Review the findings of the scoping exercise to inform the development work within this thematic work stream, and lead on a wider inclusive consultation to support the network of peer champions for all clinical areas.

Maternity

Acute staff are invited to attend bi-annual supervision. Case-loading midwives attend quarterly supervision. Recently developed supervision groups for managers with a focus on role specific safeguarding supervision have been established. Recording of safeguarding supervision is now live on learning lab for maternity staff which has recently been established as a pilot and where compliance reports are now available. This will be further rolled out across the whole organisation through the work of the supervision task and finish group.

Children`s (Acute)

Case holders, such as Paediatric Nurse Specialist, Community children's Nurses, Paediatric physios/OTs, Paediatric SLT, Paediatric Dieticians and the Autism assessment team, receive

quarterly group supervision in set groups. Nurses and Clinical Support Worker's in ED, SCBU, Woodlands and Paediatric Outpatients have supervision six monthly. All supervision sessions are facilitated by the acute safeguarding children team. There are multiple sessions offered on a monthly basis and sessions are either face to face or via MS Teams In response to feedback from staff and key area managers more sessions will be provided face to face in 2025.

Adults

Safeguarding adults' supervision will be rolled out from October 2024. Mandatory group supervision will be offered to matrons, ward managers and to safeguarding link workers and departmental leads on a biannual basis. There will be optional group supervision offered to medical staff. The model for supervision will again be Morrison's 4x4x4. Supervisor training will also be delivered internally to increase access to safeguarding supervision training for prospective supervisors. Once facilitators are trained this will increase the availability of safeguarding supervision across the HDFT footprint.

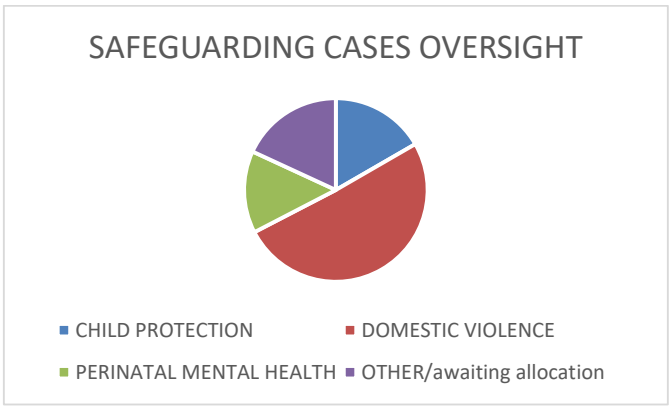
We continue to develop our safeguarding champion's network as this is instrumental in supporting our staff. The Named Nurse for Safeguarding Children has worked closely with the Safeguarding Administrators and in consultation with the Champions to review and improve the Safeguarding Champions role. The network now meets on a quarterly basis offering bespoke safeguarding training, steered by the needs of the Champions. It is hoped to expand this model over the next 12 months and apply to other key areas.

Audit

A number of safeguarding audits have taken place across the Trust over the last 12 months. Some examples are shared below;

<u>Maternity</u>

Audit of cases from past year underway. A summary of the key themes are shown in the following diagram.



<u>0-19 services</u>

Local area Safeguarding 5-19 Impact Audit, reviewing school nursing outcomes with safeguarding families, continues to identify areas of improvement and maximise support for families where we can have the most impact and work with the wider health economy to ensure appropriate representation in child protection processes.

Adult Services

A nurse in charge (safeguarding adults) knowledge audit was completed in October 2023. Areas identified for improvement (domestic abuse processes and an understanding of when safeguarding concerns can be sent without consent) were highlighted through amendments to level 3 training.

An analysis of all ED attendances over a 24-hour period was completed in May 2024, to establish if any potential safeguarding concerns had been missed. There were no concerns identified. This audit will be repeated quarterly.

A Making Safeguarding Personal audit was completed in October 2023. The results showed an improvement in establishing capacity and obtaining consent to the referrals when compared to the previous audit. It also showed there was still work to do in ensuring that people's desired outcomes were being captured.

4. EMPOWERMENT – ***people being supported and encouraged to make their own decisions which are supported by informed consent.***

The voice of the child and the lived experience is a golden thread that runs through the work undertaken across the Trust. Throughout the year, County Durham Children in care (CiC) team have worked tirelessly in supporting care experienced young people within County Durham.

HDFT have also considered care leavers in their own right and have ratified a policy to aid practitioners in their support of young people up to the age of 25 years. This policy will also provide each contract area with oversight of how many care experienced young people are making up their population.

Making Safeguarding Personal (MSP) is now a core theme that runs through our safeguarding training. There has been a focus on the effects of poor discharge on making safeguarding personal and how we can better improve outcomes for our patients and families in relation to this. The safeguarding response template for safeguarding adult enquiries has been redeveloped and includes making safeguarding personal in our responses to both the Local Authority and families. This work stream also aligns to the principle of empowerment, given the focus on making safeguarding personal and the impact this has on supporting safe discharge.

The Working Together to Safeguard Children Guidance was published in December 2023. The implementation period is extended to December 2024 to ensure any changes are reflected in operational policy. The Safeguarding Children Policy has been reviewed following publication of the revised guidance and will be ratified through safeguarding governance processes in September.

5. PREVENTION – ***it is better to take action before harm occurs.***

Throughout 2024 HDFT has initiated targeted work regarding discharge within the Trust, focusing on poor discharge and safeguarding implications with regards to this. This is an opportunity to look at poor discharge from a safeguarding perspective and the themes and trends that surround these cases. There is a safer discharge working group which the

Safeguarding Team attend, and safe discharge now forms part of the Level 3 Safeguarding Adult training. Discharge remains a high priority within the safeguarding adult's agenda, and further multi-agency work to improve discharge is planned in collaboration with Local Authorities within the next year. Patient Discharge is also a HDFT Impact Corporate Project.

The principle of early help remains embedded in the Level 3 safeguarding package and promoted as part of the Safeguarding Team's commitment in strategy meetings and MDT's. This continues to be promoted within Paediatric, and Midwifery services and within the risk assessments in the Specialist Midwifery Panel Meeting, and relevant risk assessment meetings.

Following Serious Adult Reviews where hoarding and/or self-neglect was a key theme, the learning from these reviews' forms part of the tailored training packages, supervision sessions and learning briefings that are disseminated to staff, to support understanding of this complex and multi-faceted issue.

Children in Care (CiC) / Care Leavers

Area	Number of CiC	Performance
North Yorkshire	1100	Over the last 12 months our Review Health Assessment (RHA) compliance has been consistently high despite the staffing pressures in North Yorkshire. 0-5 compliance YTD was 97% 5-19 compliance YTD was 96%.
Tees Valley (Darlington, Stockton, Hartlepool, Middlesbrough & Redcar)	2,418	Initial Health Assessment (IHA) compliance averaged 45.2% across the year. Q1 2024/25 this had increased to 71%. RHA compliance averaged 89% across the year.
Durham	1,188	IHA performance unknown as completed by CDDFT. RHA compliance for the 0-25 service was 91% across the year.
Gateshead	72	RHA compliance for the 0-19 service was 92% across the year.

Developments / Improvements

Over the last year there has been a number of developments such as development and implementation of new provider for Initial Health Assessments for our Unaccompanied Asylum-Seeking Children and York and Scarborough children.

A robust system is in place in relation to Quality Assurance of Review Health Assessments.

Named Nurse Children in Care completed Options Appraisal with the support of general manager in relation to ensuring adequate funding and expertise for the Children in Care team, this was successful in recruitment of a 12-month fixed term post for Specialist Nurse Children in Care in North Yorkshire.

Significant intensive partnership working has taken place to improve IHA compliance in Tees Valley which is evident by the increased performance in Q1 2024. Commissioners have also extended the current contract, due to end 2024, by another 2 years due to the increased quality and performance within Tees Valley.

2024/2025 HDFT Children in Care priorities have been set and plans set and are being taken forward.

Key successes

In September 2023 the North Yorkshire Children in Care team were nominated for a North Yorkshire Safeguarding Children Partnership Achievement Award to celebrate and showcase the great work undertaken by the team that resulted in providing an outstanding service to support children in care with their health needs.

Care Leavers

A Care Leaver is a young person who has been “looked after” for at least 13 weeks since the age of 14 years and who was in care on their 16th birthday. Local Authorities are expected to stay in touch with care leavers and provide statutory support to help their transition to independent living. Health passports are a national initiative which provide a health record for the young person. During this reporting period 55 North Yorkshire young people and 1004 North East / Wakefield young people reached their 18th birthday and became care leavers. As part of their final health assessment young people are offered, by HDFT Children in Care team, copies of their health summaries report / assessment. In this reporting period all young people have received their assessment and copies of their health summaries report. Some case studies have been shared within the appendix of this report.

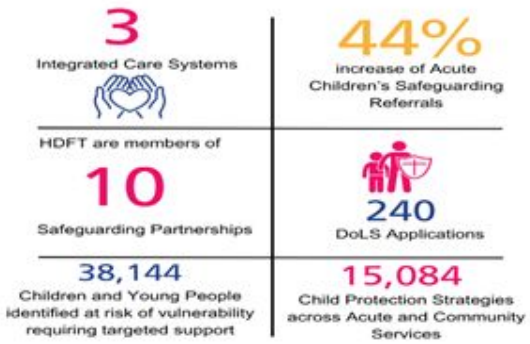
6. PROPORTIONALITY – *the least intrusive response appropriate to the risk presented.*

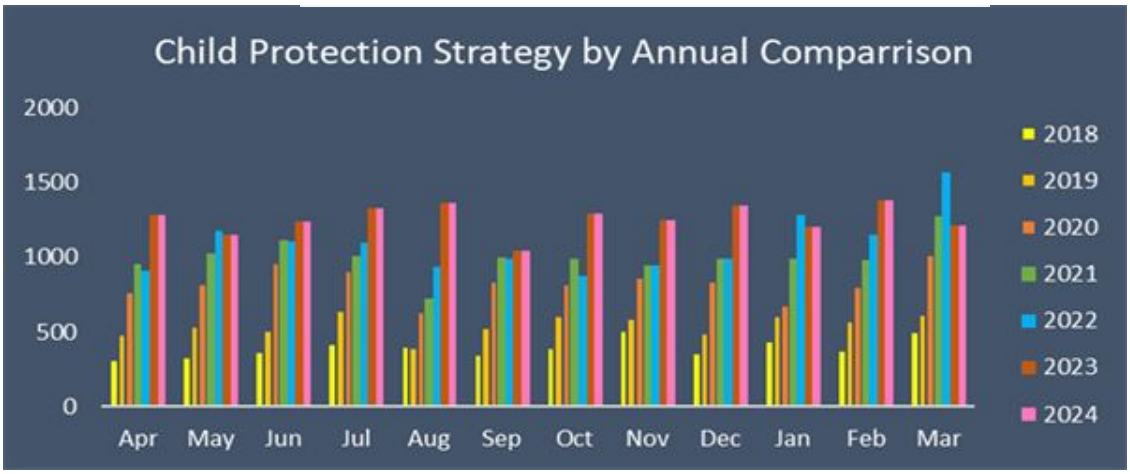
A briefing session on PiPoT/LADO was delivered to HR in July 2024 and the Named Professional has inputted into the revision of the HR Disciplinary Policy.

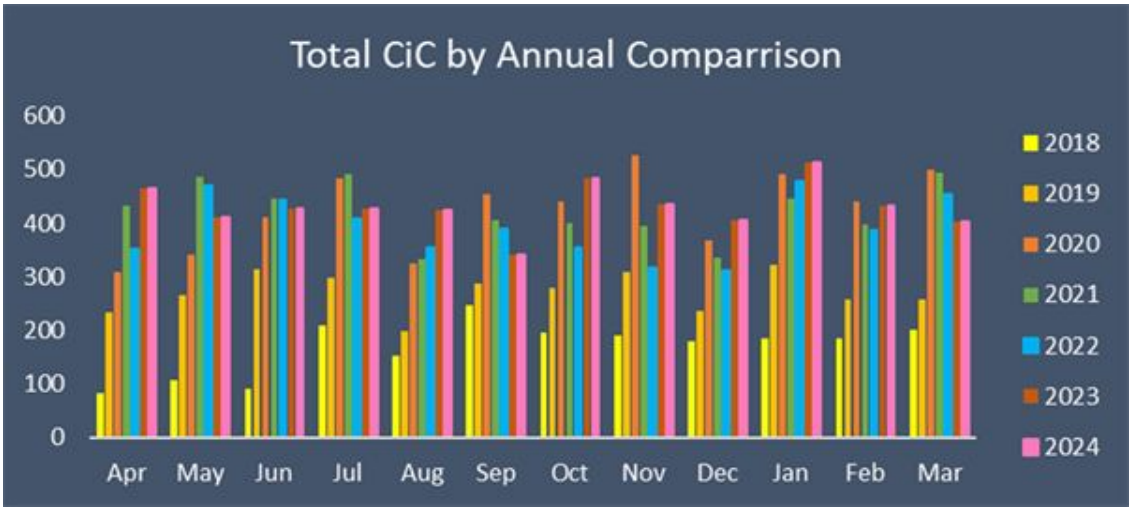
The Child Protection – Information Sharing System is well embedded and identifies to staff children and young people with a Child Protection flag/Looked after Children flag as part of gold standard information sharing practices.

Section B: Data

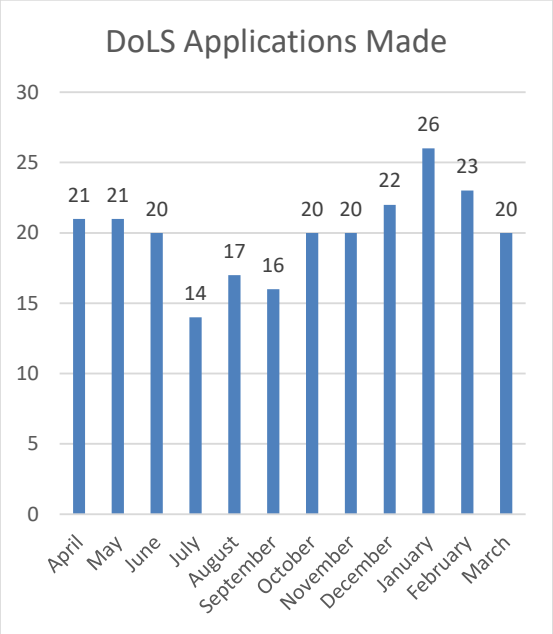
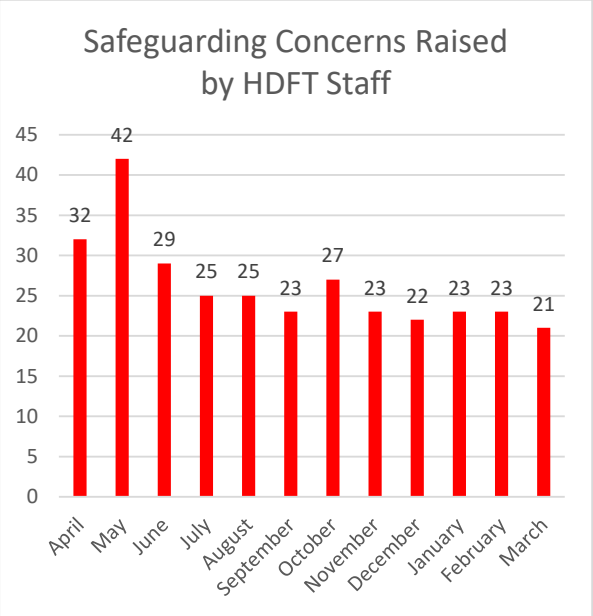
The following section provides an overview of high-level summary of HDFT annual performance. HDFT will be working with NENC ICB Safeguarding leads on the development of a Safeguarding Dashboard in 2024/25 and it is intended that the outputs of the dashboard will form a key part of the Safeguarding Annual report for 2025.



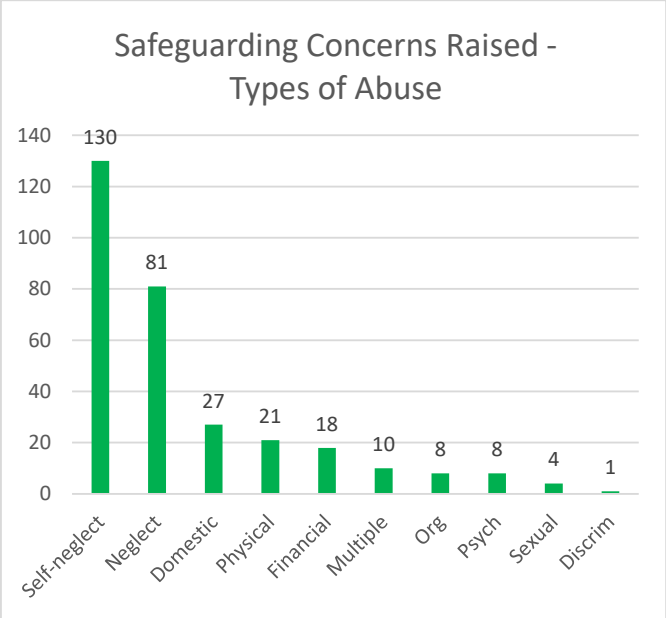
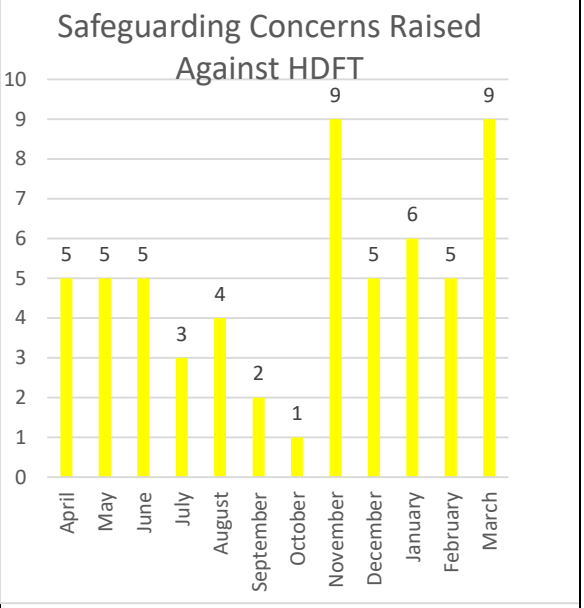



Total CiC by Annual Comparrison
600
500
400
300
200
100
0
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
2018
2019
2020
2021
2022
2023
2024

Safeguarding Adults data

DoLS Applications Made	Safeguarding Concerns Raised by HDFT Staff
	
Type of data – quality & outcomes To monitor compliance against the Mental Capacity Act 2005	**Type of data** – quality & outcomes To monitor the numbers of safeguarding referrals submitted by HDFT.
Commentary: A total of 240 DoLS applications were made during 23/24. There was a roughly even spread across wards. **Highlights: Actions/Outcomes**: • HDFT are now using the DoLS portal for all applications to NYC • Bi- weekly meeting in place between Named Professional and NYC DoLS administration team to support prioritisation of cases • Safeguarding adult team to take over the DoLS administration process from August 2024	**Commentary:** Referral numbers over 23/24 remained relatively consistent, other than a spike of referrals in April and May. ED continue to be the highest source of referrals, raising between 60-65% of all referrals, followed by community teams. Referral numbers are significantly up on 22/23 (approximately 40% higher), possibly due to increased resource in the safeguarding adult's team which has allowed more presence and more focused work with wards and departments. The actual number of referrals made will be higher than these numbers suggest (approximately 10% higher) due to the fact that the safeguarding adult's team are not always sent copies of referrals made. This risk has been added on the risk register and is flagged through governance meetings. **Highlights: Actions/Outcomes**: • The Safeguarding Adults policy was updated in February. A sweep of all wards and departments was undertaken to support communications around the policy. • Bespoke level 3 training was delivered to ED in February, with further sessions planned for community teams in Q1 24/25 • Communications with wards and departments around the importance of ensuring the

	safeguarding team are sent copies of referrals continues. • Safeguarding adults is being added in to the existing safeguarding children's handbook, a copy of which is on all wards • Safeguarding adults' supervision will be delivered from September 2024

Breakdown of referrals raised by Trust staff	Safeguarding Concerns Raised Against HDFT
	
Type of data – quality & outcomes This demonstrates that neglect and self-neglect remain the highest types of abuse reported by HDFT. The Adult Safeguarding Team attend the emergency department frequent attenders meeting to ensure safeguarding referrals are submitted where appropriate	**Type of data** – quality & outcomes To investigate and provide assurance following safeguarding referrals raised against HDFT. Safeguarding referrals against HDFT enable shared learning of outcomes and monitoring of any themes.
Commentary: This data shows that self-neglect was the highest category of abuse reported by HDFT staff during 23/24, which was a significant increase from 22/23 when the number of referrals was 62. This is likely to be reflective of the significant work that has gone in to supporting all wards and departments, but particularly ED, to identify, and appropriately respond to, self-neglect concerns following learning from SARs and non-statutory reviews. Neglect is the next most common reason for referrals. One of the key operational priorities for the adult safeguarding team for 2024 is to strengthen the Trust's response to concerns/disclosures around domestic abuse. **Highlights: Actions/Outcomes**: • Self-neglect action plan has been implemented • Domestic abuse action plan in place – domestic abuse steering group to be established from September	**Commentary:** There were 59 safeguarding concerns raised against HDFT in 23/24. The majority of concerns raised are in relation to neglect/acts of omission; and many of these are either pressure ulcers or falls. The rise in the number of concerns towards the end of 23/24 could be reflective of the fact that the safeguarding adult's team are more involved in 48-hour reviews when compared to the beginning of 23/24 and therefore can advise when a safeguarding concern should be raised. **Highlights: Actions/Outcomes**: • The safeguarding team will be working with the Quality Team during 24/25 to ensure that safeguarding are fully embedded in the PSIRF process

Section C: Section 11

Improving the way key people and bodies safeguard and promote the welfare of children is crucial to improving outcomes for children and young people. Section 11 (s11) of the Children Act 2004 places a statutory duty on key organisations to make arrangements to ensure that in discharging their functions they have regard to the need to safeguard and promote the welfare of children. HDFT have undertaken a baseline self-assessment and progress update over this reporting period which has provided the key lines of enquiry, alongside the recommendations from the safeguarding diagnostic for our All-Age Safeguarding Delivery Plan for 2024/5.

Objectives 2024/25

The Section 11 Themed Lead is now taking forward monthly meetings to undertake a review self-assessment and RAG rate the 10 key themes items. Updates will be provided to the Safeguarding Management Team meetings. A portfolio of evidence will be compiled for HDFT Section 11 self-assessment. Thus, this will ensure that HDFT has a rolling contemporaneous portfolio of evidence for any Section 11 requests from any of the local authorities that HDFT provides 0-19 public health services.

This report provides further detail of the initial S11 baseline assessment within the Appendix.

Section D: Supporting service users with a Learning Disability / Autism

HDFT has a Specialist Nurse for Learning Disability adult service users. The post is 0.9 wte. The post holder sits within the corporate safeguarding team and provides specialist advice and guidance across adult services in addition to providing direct care to service users. HDFT also has specialist roles within children`s services providing care and support to children with a learning disability. HDFT does not currently have a dedicated specialist nurse / role for service users with Autism. Clinical teams work collaboratively to meet the needs of our service users with a diagnosis of autism and are supported by corporate colleagues within our Patient Experience team as required. HDFT aims to recruit to an Autism specialist role in 2025 and will form part of business planning priority processes.

A learning disability dashboard has been further developed to enable the Acute Liaison Nurse to identify and monitor patients on waiting list. This has been designed to reinforce the prioritisation of patients with learning disabilities that was set out through the updated access policy. This has also been strengthened through the design and implementation of an outpatient's pathway for patients with learning disabilities and an automated weekly list of planned outpatient contacts.

An automated notification has been established, to alert the Acute Liaison nurse to an ED attendance, this also allows for review of ED records where a patient has not been admitted to identify any follow-up actions.

HDFT continue to participate in the Learning Disability Improvement Standards benchmarking exercise. The report for year 6 has highlighted some areas where the Trust is performing well, these include, training, seeking feedback using the principles of 'Ask, Listen, Do' and the provision of reasonable adjustments. Areas for improvement include workforce planning, the availability of acute LD liaison, auditing deprivation of liberty and board level engagement with patients with learning disabilities and those who support them.

Section E: Priorities and Next Steps

Following initial benchmarking and diagnostic work completed December 2023 subsequent recommendations were integrated into a 2-year work plan for 2024/2025 which is progressing successfully in all areas:

Governance

1) Implementation of corporate safeguarding structure to support delivery of improvements and drive ambition of safeguarding excellence.
2) Put in place a robust internal and external assurance process with regard to ensuring effective systems, processes, policies, procedures and training are in place to help ensure children and adults who use services are safeguarded from the risk of or actual abuse and neglect meeting all the requirements of the relevant safeguarding regulatory framework for the service we provide
3) Develop and implement HDFT Safeguarding Strategy to achieve our ambition to deliver safeguarding excellence.
4) Establish a robust safeguarding learning and improvement framework aligned to HDFT Safeguarding Strategy to strengthen learning and application of learning from any safeguarding incident across the whole organisation.
5) Review the updates to Working Together (published December 2023) and implementing relevant recommendations.
6) Review HDFTs input to Child Death Review processes.
7) Review of / implementation of clear robust safeguarding audit programme
8) Review current partnership working arrangements to ensure full compliance with all partnership meetings.
9) Consistency in quality and service provision across pathways for Children in Care
10) Self-assessment against CQC safeguarding standards and expectations working closely with Quality team.
11) Delivery of outcomes of Section 11 Audits / Internal Audit report and other key audits / recommendations for HDFT
12) Successful delivery of Safeguarding work plan across 2024 / 2025 – delivered through Safeguarding Governance arrangements.
13) Development and delivery of a robust safeguarding supervision plan
14) Development and delivery of a robust safeguarding training plan
15) Develop corporate compliance evidence file working with quality and safety team.
16) Develop and deliver robust ED Safeguarding Delivery Plan
17) Develop and implement safeguarding dashboard to evidence impact and outcomes.

Leadership

1) Benchmark current safeguarding leadership capacity to ensure sufficient capacity is in place for colleagues to fulfil their statutory duties.
2) Undertake review of capacity in Adult Safeguarding Team / benchmark with other organisations
3) Recruit to Named Professional Adult Safeguarding / MCA Lead role.
4) Recruit to specialist Autism lead role.
5) Develop safeguarding leadership programme for safeguarding colleagues – individual and team level.

6) Review of / evaluation of current workforce models in line with Safe Staffing leadership arrangements
7) Establish focused work to deliver improvements for service users with learning disabilities and autism.
8) Strengthen current safeguarding supervision arrangements across organisation.
9) Review and provide assurance re compliance with accepted national guidance on staff training, skills and competencies in line with their role.
10) Review of induction / preceptorship programmes for all staff working in safeguarding roles
11) Review effectiveness of current arrangements of integrated professional supervision / operational management for Named Nurses

Impact

Revised structures and governance arrangements are shared for information within the appendix of the report (Appendix)

Following changes to safeguarding governance and structure arrangements from January 2024 an initial sample review of impact with internal and external stakeholders was undertaken in July 2024.

The results are as included within the appendix of this report. (Appendix)

Summary and Conclusion

This report has provided detailed activity and information with regard to HDFTs focused improvement work across 2023/24 following a diagnostic exercise undertaken in Q3 of 2023. The report has highlighted areas of good practice and also provided an overview of the key findings and challenges identified from the diagnostic. The report has provided an overview of work ongoing in line with the recommendations, which will continue with increasing focused strengthened leadership and robust governance throughout the remainder of 2024 and throughout 2025 to achieve safeguarding excellence across HDFT services.

Appendix

Section 11 overview

Leadership and Accountability

HDFT is fully compliant in the following standards:

- HDFT has a named strategic lead for safeguarding with commitment to the importance of safeguarding babies' children and adults. The Executive Director of Nursing Midwifery and AHPs is supported by the Deputy Director of Nursing CYP and Safeguarding in providing strategic leadership and oversight to the Safeguarding portfolio.
- HDFT has recently recruited to a Head of Safeguarding role for the organisation. The post holder commences in September 2024.
- Named professional roles are part of the safeguarding corporate structure with staff in the following mandated roles:
    - Named Nurse Children`s Safeguarding.
    - Named Doctor
    - Named Midwife
    - Named Professional Adult Safeguarding
- The organisation has a clear written accountability framework. All staff understand to whom they are accountable and what level of accountability they have. All staff are aware of their own roles & responsibilities and those of the organisation for safeguarding and protecting children. Business/Service plans and reports incorporate staff responsibilities for safeguarding and promoting the welfare of children including objectives, where appropriate, for staff members
- There is a safer working practice for all contractors to the organisation who work with children and are delivering statutory services. Contracts require the organisation to achieve Safeguarding Standards, which are the same as those for Section 11.
- The representative(s) understand their role and how to communicate messages from/to the organisation. The safeguarding diagnostic identified a lack of clarity with regard to roles and responsibilities within the acute safeguarding children`s team. Work has taken place with team members to rectify this. Revised leadership arrangements are now in place. Recruitment to a full time Named Nurse for Safeguarding Children within acute setting is currently taking place.
- There are named / designated person(s) with a clearly defined role and responsibilities to champion safeguarding and child protection. Work continues to strengthen working relationships within the acute setting.

HDFT is partially complaint with the following standards with work ongoing to achieve full compliance by April 2025

- The organisation is linked into the Local Safeguarding Children Board, including contributing to the work of the Board and sub-groups. A mapping exercise across the full geographical footprint to identify where HDFT is required as core membership has taken place. This has identified some key gaps particularly in engagement from acute safeguarding children's team within North Yorkshire arrangements and HDFT

are working together with key partners to strengthen collaboration and engagement from acute colleagues. This will be further strengthened by the recent recruitment to Head of Safeguarding post which will commence in this new role in September 2024.

HDFT is not compliant with the following standard:

- MCA / DOLs lead for the organisation – though HDFT does not have a dedicated role to deliver this function there is support available to staff from the Designated Professional for Safeguarding Adults and team. HDFT are recruiting at the time of writing this report to a new Named Professional for Safeguarding Adults / MCA Lead, due to the current post holder being recruited to the Head of Safeguarding role. The Job Description has been revised and will identify MCA skill and competence as an essential criteria for the post holder which will then enable HDFT to be competent with this standard.

Work Ongoing

- Through revised and strengthened safeguarding governance arrangements, increased on site visible senior leadership, with a particular focus on the acute setting, will be strengthened over the next 12 months.
- Continue to develop our new Leadership roles through new robust Safeguarding preceptorship packages which have been developed since our last Section 11 audit, with a particular focus on acute setting.
- Strengthening and embedding of PiPoT and LADO responsibilities within acute setting.
- Review of the Safeguarding Adult Level 3 training is taking place to ensure all relevant staff are compliant with this essential training, including review of medical staff requirements and compliance.
- Strengthen safeguarding leadership arrangements via newly appointed and revised roles.
- Review of induction training to ensure aligned to NYSAB / NYSCP policies and processes.

Safeguarding Policies, Strategies and Procedures

HDFT is fully compliant with the following standards:

- The organisation has written policies, and where applicable a procedure, for safeguarding and protecting vulnerable people that is accessible to all staff. All policies have been reviewed and updated as required. A nominated Policy owner has been identified for all policies and a Named Nurse Themed Lead supports the Head of Safeguarding / Deputy Director Nursing with oversight. All policies are now ratified through new safeguarding governance arrangements.
- Policies and procedures are in line with and make reference to the relevant multi-agency policies.
- The policy and procedures are reviewed on a regular basis to maintain compliance with new national and local legislation and guidance, and service and personnel changes.
- There are clear procedures for recording and reporting concerns or suspicions of abuse which all staff are aware of

- There is clear guidance on how to respond to a disclosure of abuse from children, which includes a confidentiality policy and procedure.
- Staff working with children, parents or carers are aware of additional vulnerability of some children and the impact of issues such as substance misuse, mental health issues, domestic abuse and learning disabilities on parenting capacity and always give consideration to the needs of the children and where necessary ensure that these are assessed and appropriate referrals made. Audits or referrals take place and safeguarding teams work closely with ED colleagues to ensure that this standard is achieved.
- Relevant staff are aware of the importance of appropriate challenge in case conferences and reviews. Staff understand how to escalate concerns as appropriate, both internally to their own agency and externally to the Safeguarding Unit. A new Escalation SOP has been ratified which supports safeguarding professionals in this matter.

HDFT are partially compliant in the following standards:

- HDFT clearly communicates any changes to policy and procedures to all relevant staff and ensures they are implementing current practice. Work is ongoing to strengthen the communication, collaboration and engagement re policies, through new governance arrangements.
- HDFT can demonstrate a commitment to equality and diversity within its policies and procedures. All staff understand the value of the equality and diversity policy in contributing to improved outcomes for ALL children including, for example, those with disabilities, who do not have English as a first language, who are Looked After or who are young carers – whilst there are many examples of achievements in this standard work is taking place with the Trust equality and diversity lead as part of our developing Safeguarding Strategy.

<u>Work Ongoing</u>

- Development of joint safeguarding all age safeguarding strategy and embedding of all elements across whole organisation
- Review of current patient safety and complaints processes and training needs / provision to be able to provide links with safeguarding practices.
- Review of current Safeguarding sections on HDFT intranet and external internet access to ensure accurate / up to date and inform of Safeguarding Leadership arrangements.
- LADO policy to be updated and ratified to incorporate PiPoT. Training is being developed by Named Professional Safeguarding Adults for HR and line management colleagues.
- Continue to embed new governance arrangements including strengthening policy development, engagement processes and formal ratification processes.

Safer Recruitment

HDFT is fully compliant with the following standards:

- The organisation has recruitment and selection procedures for all personnel, including volunteers, which is in line with the SSCB's Safer Recruitment guidance and ensures that equality and diversity are part of the recruitment process.
- All staff have been assessed to determine if they are in regulated activity and the relevant checks have been made including enhanced or standard DBS checks.
- Employees involved in the recruitment of staff to work with children have received training as part of a 'safer recruitment' training programme.
- A review of recruitment policies and processes to ensure in line with NYSCP /NYSAB/CYSAB procedures has been completed.

Staff Induction, Training and Development

HDFT is fully compliant with the following standards:

- Additional training (both single and multi-agency) is available for staff working with adults, children and young people appropriate to their role. This training meets the standards and objectives of the training requirement and includes learning from serious case reviews and good practice.
- Staff understand the when and how to make a referral to Children's Services or when instead to initiate Early Help Assessment
- Senior staff are kept up to date with changes in statutory requirements and new, evidence-based, ways of working

HDFT is partially compliant with the following standards:

- An induction process is in place for all staff and volunteers who have contact with children including – whilst all staff are expected to achieve compliance with relevant safeguarding training the current Trust Induction does not include safeguarding within its core agenda. Work is taking place to review this to ensure that the Trust Induction does include a safeguarding focus.
- A revised Strategic Safeguarding Training Group has been established which will ensure that all new policies, guidance and legislation regarding safeguarding children is incorporated into training and briefings.
- Outcomes and findings from reviews & inspections are disseminated to appropriate staff and volunteers. This practice works well in some teams but is not embedded across the organisation. A Learning and Improvement Framework is currently in development.

<u>Ongoing work</u>

- Develop robust data to provide assurance re safeguarding training compliance to inform areas where action needed.
- Embedding new Safeguarding Training Steering Group arrangements to strengthen current processes and procedures to provide assurance re arrangements and compliance with national guidance.
- Review of current safeguarding training provision and processes and programme of delivery through new strategic safeguarding training governance arrangements to ensure compliance with Intercollegiate Guidance
- Provision of additional L3 Adult training for all relevant staff groups

- Review of current PREVENT training and compliance as part of new governance arrangements.

Management of Allegations against Staff and Volunteers, Complaints and Whistleblowing

HDFT is fully compliant with the following standards:

- The organisation has effective policies & systems in place to manage concerns and complaints as well compliments from service users or other professionals.
- The organisation has effective policies & systems in place to enable whistle blowing on an organisational and individual level.
- The Organisation has a named senior officer who is trained and responsible to handle allegations and complaints and ensuring the organisation follows these procedures effectively.
- All complaints and allegations of abuse are recorded, monitored and available for internal and external audit.

Ongoing work

- Review of internal escalation policy across the whole organisation to identify areas for further action / development.
- Training programme to be rolled out to line managers in relation to LADO and PiPoT.
- Supervision, mentoring, advocacy, advice and counselling access to be reviewed to ensure a robust support offer is available for staff.
- Supervision policy being drafted currently and will be robustly implemented following ratification in September Safeguarding Governance Forum

Listening to service users / equality and inclusivity

HDFT is partially compliant with the following standards:

- Some business/service plans are informed by the views of service users, including groups who are often excluded e.g. Disabled / Looked After Children
- Some service design and review processes take into account the views of service users and their families with partial consideration given to the way in which a service can be improved to ensure service user safety and welfare.
- Children are made aware of their right to be safe from abuse. This is achieved through information made available, for children, young people and parents about where to go for help in relation to maltreatment and abuse.
- Children are listened to, taken seriously and responded to appropriately, including during individual case decision-making.

Ongoing work

- In 2024 we launched a 12-month “Children and Young People’s Voice” project to develop and implement a framework and processes to improve how we listen to and act on feedback from Children, Young People and their Families. We will be engaging with Children and Young people from all areas of our diverse geography to explore what is important to them, what a great service looks like and to co-create a Children and Young People’s Patient Experience Tool. We will be holding ten focus

groups: one for each of our Children's Public Health services local authority areas and one for our acute services.
- Each group will include 6-10 young people aged 11+, facilitated by youth workers and our children and young people's patient experience leads. Together the groups will present a proposal for the Children and Young People's Patient Experience Tool.

Child Sexual Exploitation

HDFT are fully compliant with the following standards:

- Policies, procedures and guidance are in place for safeguarding and promoting the welfare of children and young people relating to child sexual exploitation (CSE)
- Staff are able to recognise CSE warning signs and risk factors and are able to access the appropriate training, tools and guidance in order to make a referral.

Ongoing Work

- Continued review of training products and support / supervision to frontline staff to raise the profile of CSE.

Supervision

HDFT is partially compliant with the following standards:

- The organisations staff supervision policy supports effective safeguarding. Supervision across maternity and children`s services is embedded with work ongoing to develop supervision model and all age supervision policy for the whole organisation.
- Staff working with children and in maternity services receive regular management supervision on an individual basis and can access further support when required. This model to be extended to adult services.
- There is an annual appraisal process which includes a review of each member of staff's role and their skills, competencies and knowledge around safeguarding. Whilst this is embedded within staff working is specialist safeguarding roles further work is required to embed this across all staff within HDFT
- Clarity of supervision requirements and provision for all staff groups across the organisation reflected in safeguarding supervision policy and compliance figures aligned to policy. Maternity and children`s safeguarding supervision model embedded with local compliance figures collated, to be further implemented across adult services.
- Robust data collation to provide assurance re compliance with safeguarding supervision.

Ongoing work

- Trust wide Supervision policy being drafted currently and will be robustly implemented following ratification in November`s Safeguarding Governance Forum
- Work ongoing with learning and development colleagues to ensure that Learning Lab platform records and reports on safeguarding supervision compliance following ratification of the policy in November 2024

Information Management and Sharing

HDFT is partially compliant in the following standards:

- The organisation has in place robust information systems that enable them to monitor the quality of practice and the management of work with children and families to ensure their welfare is being effectively safeguarded and promoted.
- The organisation has in place a programme of internal audit and review that enables them to continuously improve the protection of children and young people from harm or neglect. Safeguarding audit plan in development for 2024/25
- All appropriate staff understand the need for accurate, clear and on-going case-work recording.

Ongoing work

- Review of CYP leaflets for IHA / RHA / CP medicals for staff or children and families / carers to ensure standardisation across services.
- Take forward the Safeguarding Personal audit which has been completed and ensure actions for improvement are taken forward. New process has been embedded – some outstanding actions from the audit in relation to web-v prompts and face to face training sessions.
- From the project, the groups will become local Children and Young People's committees, and representatives from each group will come together to form a trust wide Children and Young People's Board. Group members will be our "Great Start in Life Young Advisors".

Performance Management and Audit

HDFT is partially compliant with the following standard:

- Strengthened Trust wide safeguarding reporting and assurance to Board through revised organisational governance arrangements.

Ongoing work

- Work with ICB colleagues re development of safeguarding dashboard to enable improved reporting re performance and outcomes.
- Liaison with Designated Professionals to develop external audit programme for Safeguarding Adults
- Ongoing work with continued collaboration with all directorates and engagement from directorates into newly established governance arrangements
- Engage and complete internal audit for All Age safeguarding planned for 2025.

Additional Appendices

Safeguarding Structure	Safeguarding Annual Report Corporate and
Governance Structure	Safeguarding Annual Report Governance In
Governance – 6-month review	Safeguarding Annual Report 6 month gover
Case Studies	Safeguarding Annual Report Case Studies.d

References

Safeguarding Accountability and Assurance Framework (2024)
Version 4. NHS England
https://www.england.nhs.uk

Working Together to Safeguard Children (2023)
A guide to multi-agency working to help, protect and promote the welfare of children.
HM Government

Morrison T (2005)
Staff Supervision in Social Care: Making a Real Difference to Staff and Service Users
(3rd Edition). Pavilion, Brighton.

People and Culture Committee meeting
25th September 2024

Title:	**Workforce Race Equality Standard 2024**
Responsible Director:	**Director of People and Culture: Angela Wilkinson**
Author:	**Equality, Diversity, and Inclusion Manager: Richard Dunston Brady** **Nichola Langdale, Head of Education, Learning and Development**

5

Purpose of the report and summary of key issues:	The Workforce Race Equality Standard 2024 (WRES) focuses on specific metrics regarding minority ethnic employees and their work experiences. Key areas of analysis are measured against data from the electronic staff record (ESR) and the National Staff Survey 2023. The metric framework includes a breakdown of: - BME staff within the agenda for change bandings, in four clusters:1-4, 5-7, 8a-8b, and 8c-9 and VSM. - An assessment of the likelihood of colleagues being appointed from shortlisting, - Colleagues entering the capability or disciplinary process. - The number of minority ethnic employees who are facing bullying or harassment from patients, colleagues, and managers. - Comparisons between the membership of the Board and its contrast with the minority ethnic workforce. Findings from the 2024 report show an improvement in some of the indicators such as: • Increased number of BME disclosing their ethnicity • BME colleagues are more likely to access non-mandatory training. • BME colleagues' perception of the organisation being a place to offer equality in career progression and promotion has also increased from 2023.
Trust Strategy and Strategic Ambitions	**The Patient and Child First** Improving the health and wellbeing of our patients, children, and communities

Best Quality, Safest Care	
Person Centred, Integrated Care, Strong Partnerships	
Great Start in Life	
At Our Best: Making HDFT the best place to work	x
An environment that promotes wellbeing	

	Digital transformation to integrate care and improve patient, child, and staff experience	
	Healthcare innovation to improve quality	
Corporate Risks	N/A	
Report History:	N/A	
Recommendation:	The Board is requested to note the 2024 WRES metrics and the subsequent Action Plan ahead of publication. The data element of this report will be published on the HDFT website on 31 October 2024 following approval by the Board.	

NHS Workforce Race Equality Standard (WRES)

Annual Report 2024

Harrogate and District NHS Foundation NHS Trust

Introduction

Welcome to our Workforce Race Equality Standard (WRES) Annual Report 2024.

The report provides our internal data and metrics for the last twelve months, the progress we have made to date, and an Action Plan to allow us to continue to develop our approaches, initiatives, and activities during 2024 and beyond. This year, the NHSE project teams changed the reporting requirements and therefore there will not be a report for Medical WRES or Bank WRES.

To help contextualise the information in this report, data from the 2021 Census has been sourced from the Office of National Statistics. The demographics of people living in Harrogate and surrounding districts highlight that 1.8% of the population are Asian, 0.6% identify as being Black, Black British, Black Welsh, Caribbean or African and 1.6% are from mixed ethnic groups. Within the town population, Harrogate has 95.4% White communities.

Our Commitment to Promoting Equal Opportunities

The Trust recognises how important it is to support and improve the experiences of our colleagues from minority ethnic groups. Since 2023, the Trust has run a second cohort of the Reciprocal Mentoring programme and relaunched the BME and Allies Staff Network with a more inclusive name, REACH, (Race, Equality and Cultural Heritage). The Trust has also provided our internationally recruited colleagues with equality, diversity, and inclusion training, as well as cultural competency training for all members of staff.

Whether you are a patient, a visitor, or a member of staff, our KITE values are what describe and define our organisational culture:

As a Trust, we want to make Harrogate District Foundation NHS Trust (HDFT) a more inclusive place to work and to help achieve this, an Action Plan is included at the end of this report.

Throughout the report the following colour key applies:

Improvement on previous year

Worse than previous year

Metric 1 – Workforce Ethnicity

In this section, we shall be examining the data regarding employees who are paid using the Agenda for Change pay and Senior Manager pay bands, represented by bands 1-4, 5-7, 8a-8b and 8c-9 and VSM (Very Senior Manager), compared with the percentage of staff in the overall workforce.

The profile of our BME employees versus NHS Averages:

The total percentage number of BME employees in the Trust (excluding Board members) has increased by 3.6% compared to the previous year but is still lower than the overall average for the NHS.

	NHS Average	HDFT: 2024	HDFT: 2023	HDFT: 2022	HDFT: 2021
Staff Who identify as BME	24.2%*	15.4%	11.8%	10.6%	10.5%
Total number of BME staff	-	782	569	484	475

- *NHS England » NHS Workforce Race Equality Standard (WRES)2022 data analysis report for NHS trusts*

Total percentage number of BME employees within each band:

Non-Clinical Staff	HDFT: 2024
Bands 1-4	7.3%
Bands 5-7	12.2%
Bands 8a-8b	2.9%
Bands 8c -9 and VSM	5.6%

Clinical Staff	HDFT: 2024
Bands 1-4	15.8%
Bands 5-7	14.7%
Bands 8a-8b	3.0%
Bands 8c-9 and VSM	9.1%

The bands which have the largest number of BME staff are clinical bands 2, 5 and 6.

Metric 2 – Recruitment shortlisting

Likelihood of staff being appointed from shortlisting across all posts.

31st March 2024					
Indicator		**White**	**BME**	**Not Declared**	**Total**
Number of staff in the Workforce	Headcount	4027	782	260	5069
	%	79.4%	15.4%	5.1%	
Relative likelihood of staff being appointed from shortlisting across all posts	Number of shortlisted applicants	2890	2360	433	5683
	Number appointed from shortlisting	715	239	287	1241
	Likelihood of appointed from shortlisting	24.7%	10.1%	66.3%	

31st March 2023					
Indicator		**White**	**BME**	**Not Declared**	**Total**
Number of staff in the Workforce	Headcount	3,961	569	284	4,814
	%	82.3%	11.8%	5.9%	100%
Relative likelihood of staff being appointed from shortlisting across all posts	Number of shortlisted applicants	3,815	1,504	276	5,595
	Number appointed from shortlisting	733	132	115	980
	Likelihood of appointed from shortlisting	19.2%	8.8%	41.7%	17.5%

Although in 2024 there were less white and BME applicants shortlisted, more BME applicants were appointed in 2024 than 2023. There has been a 1.1% increase in the likelihood of appointment from shortlisting for BME candidates, however when compared to White staff, BME applicants are 2.44 times less likely to be appointed from shortlisting than white staff.

There has been an increase of 213 BME staff members in the workforce since the 2023 report. HDFT sponsor staff if they meet role and salary requirements as defined by United Kingdom Visas and Immigration (UKVI), in regard to Skilled Worker visas and Health and Care visas. Most healthcare professions are covered by the sponsorship system including some non-clinical roles. Other visas can provide staff with the Right to Work in the UK, for example dependant visas and student visas.

Work was undertaken to determine whether factors such as visa status may have influenced the relative likelihood of shortlisting to appointment however, the electronic recruitment system does not provide sufficient data granularity to further analyse this discrepancy.

Metric 3 – Disciplinary action

The relative likelihood of BME staff entering the formal disciplinary process compared White staff.

A relative likelihood below 1.00 indicates that BME staff are less likely than White staff to enter the formal disciplinary process.

2024	White	BME	Unknown
Likelihood of staff entering the formal disciplinary process	0.52%	0.26%	0.38%
Relative likelihood of BME staff entering the formal disciplinary process compared to White staff		0.49	
2023	**White**	**BME**	**Unknown**
Likelihood of staff entering the formal disciplinary process	0.23%	0.00%	0.35%
Relative likelihood of BME staff entering the formal disciplinary process compared to White staff		0.00	

In 2024, BME staff were less likely than white staff to enter the formal disciplinary process than White staff. A comparison with 2023 is not possible since no BME staff entered the disciplinary process during that reporting period.

Metric 4 – Access to training

Relative likelihood of staff accessing non-mandatory training and CPD

A relative likelihood below 1.00 indicates that BME staff are more likely than White staff to access non-mandatory training and CPD.

		White	BME	Unknown		White	BME	Unknown
Number of staff accessing non-mandatory training and CPD	2024	2053	561	163	2023	1,298	294	129
Likelihood of staff accessing non-mandatory training and CPD		50.9%	71.7%	62.7%		32.8%	51.7%	45.4%
Relative likelihood of White staff accessing non-mandatory training and CPD compared to BME staff.		0.71				0.63		

BME colleagues remain more likely to attend non-mandatory CPD than White colleagues. BME staff are actively encouraged to attend the BME Leadership Development Programme and Reciprocal Mentoring. The Trust also offers and promotes other non-targeted, non-mandatory CPD.

Metric 5, 6, 7, and 8 Bullying and Harassment

Bullying and harassment by patients, staff and managers and percentage of staff believing that their Trust provides equal opportunities for career progression or promotion. Figures extracted from the National Staff Survey 2023/24.

Metric		2023		2022	
		White	BME	White	BME
5	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives, or the public in last 12 months	19.9%	26.5%	23.8%	29.9%
6	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	19.5%	24.8%	21.0%	32.9%
8	Percentage of staff experiencing harassment, bullying or abuse from their manager, team leader or other colleague	6.1%	15.6%	5.9%	22.6%
7	Does your organisation act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age (No).	38.1%	46.1%	42.8%	59.8%

Both White and BME staff have experienced a reduction in harassment, bullying or abuse across metrics 5, 6, and 8 as indicated by the following decreases:

- A 3.4% reduction from patients, relatives, and the public
- An 8.1% reduction from staff
- A 7% reduction from managers, team leaders, or other colleagues

The gap between BME and White staff experiences has narrowed for metrics 6, 7 and 8. However, for metric 5, which measures bullying, harassment, or abuse from patients, relatives, or the public, the gap has slightly widened by 0.4%.

13.7% more BME staff believe that the trust provides equal opportunities for career progression or promotion compared to 2023.

Metric 9 – Board Representation

The number of BME directors and non-executive directors compared to the overall workforce.

	2024	White Board Members	BME Board Members	Unknown Ethnicity Board Members		2023	White Board Members	BME Board Members	Unknown Ethnicity Board Members
Total Board Members		81.3%	18.6%	0.00%			77.8%	22.%	0.0%
: Executive Board Members		100%	0.0%	0.0%			87.5%	12.5%	0.0%
: Non-Executive Board Members		66.7%	33.3%	0.0%			70.0%	30.0%	0.0%
	2024	**White Board Members**	**BME Board Members**	**Unknown Ethnicity Board Members**		**2023**	**White Board Members**	**BME Board Members**	**Unknown Ethnicity Board**
Number of staff in overall workforce		4027	782	260			3,961	569	284
Voting Board Member % by Ethnicity		92.7%	7.1`%	0.0%			77.8%	22.2%	0.0%
Non-Voting Board Members % by Ethnicity		0.0%	100%	0.0%			-	-	-

Executive Board Members % by Ethnicity		100%	0.0%	0.0%			87.5%	12.5%	0.0%
Non-Executive Board Members % by Ethnicity		66.7%	33.3%	0.0%			70.0%	30.0%	0.0%
Overall workforce % by Ethnicity		79.4%	15.4%	5.1%			82.3%	11.8%	5.9%
Difference (Total Board - Overall Workforce)		2%	3%	-5%			-4.5%	10.4%	-5.9%

There is a decrease in minority ethnic executive board members during this reporting period.

There is an increase in BME non-executive board members and a decrease in White non-executive board members compared to last year.

There is an increase in ethnicity disclosures from 11.8% (2023) of our workforce to 15.4% (2024). The Trust is proactive in encouraging colleagues to disclose their protected characteristics on the Employee Self-Service portal (ESR).

Has your Trust taken action to facilitate the voices of BME colleagues in your organisation to be heard (provide an example or action plan).

This year, the Trust has implemented several initiatives to further support our BME colleagues, including the launch of Cohort 2 of the Reciprocal Mentoring program. This cohort saw participation from both the Chief Executive and the Director of Finance, building on the success of Cohort 1, where four members of the Trust's Executive Board, along with other senior management, served as Established Leaders. Feedback shows Aspiring Leaders have found this programme to offer them a safe space to speak about their lived experiences and the barriers they have faced in their development.

The Trust also commissioned a BME Leadership and Development Programme in which more than half of the first cohort of The Leadership and Development Programme gained higher banded roles or started vocational training as part of their career development; this programme was positive action taken as a result of the National Staff Survey 2022.

Conclusion and Recommendations

Findings from the 2024 report show an improvement in several of the indicators, such as:

- The proportion of BME staff has increased by 3.6% compared to the previous year, though it remains below the national average.
- BME staff continue to have higher participation in non-mandatory training and CPD compared to their White counterparts.
- There has been a 13.7% improvement in BME staffs perception of equal opportunities for career progression or promotion.
- Whilst there has been an improvement in the percentage of BME staff being appointed from shortlisting, white applicants are 2.44 times more likely to be appointed.
- There has been a reduction in the experience of bullying, harassment or abuse across all 3 metrics. Notably, a 3.4% decrease in incidents involving patients, relatives or the public, an 8.1% decrease in incidents involving staff and a 7% decrease in incidents involving managers, team leaders or other staff.
- There has been a decrease in the representation of minority ethnic individuals among executive board members, though there has been an increase in BME representation among non-executive board members. The overall disclosure of ethnicity among board members has improved.

The report also contains an Action Plan to focus on areas which have not improved, or where there are differences between perceptions or experiences of BME colleagues, this identifies that:

- The relative likelihood of BME applicants being appointed from shortlisting when compared to White applicants has worsened.

- Although there have been improvements in the experience of bullying, harassment and abuse, there remains a discrepancy between the experience of BME staff when compared to White staff.

The Board is requested to and note the 2024 WRES metrics and the Action Plan that will attempt to address areas that need improving for BME colleagues.

The data element of this report will be published on the HDFT website on 31 October 2024 following approval by the Board.

Appendix 1 Action Plan

Action Plan
Workforce Race Equality Standard 2024

Metric	HDFT	National Average	Context	Actions	Timescale
Metric 2 Likelihood of being shortlisted	2.4	Figs not available	The likelihood of a BME candidate being employed is not balanced against White applicants possibly due to changes made in immigration law	• Continue to deliver unconscious bias and cultural competency training to staff. • Targeted adverts to encourage applications from other minority ethnic groups. • Improve access to information related to: ○ Clinical Skills ○ Leadership and Management ○ Job posts ○ Personal Development	Ongoing January 2025 February 2025
Metric 5, 6 and 8				• Continue to deliver the Reciprocal Mentoring and BME Leadership Development. • Continue to embed equality impact assessment template to ensure there is no unintended consequences for people with protected characteristics.	Ongoing Ongoing

Appendix 2: Workforce Race Equality Standard 2024

Points to note:

- **Metric 2** - A figure above 1.00 indicates that BME staff are less likely than White staff to be appointed from shortlisting.
- **Metric 3** - It is 0.00 for 2023 as no BME colleagues entered the formal disciplinary process in 2022/23.
- **Metric 4** - A figure below 1.00 indicates that BME staff are more likely than White staff to access non-mandatory training and CPD.

			March 2023	March 2024		Comment
1	Percentage of BAME staff	Overall	11.8%	15.4%	↑	
2	Relative likelihood of white applicants being appointed from shortlisting across all posts compared to BME applicants		2.19	2.44	↑	
3	Relative likelihood of BME staff entering the formal disciplinary process compared to white staff		0.00	0.49	↑	
4	Relative likelihood of white staff accessing non-mandatory training and continuous professional development (CPD) compared to BME staff		0.63	0.71	↑	
5	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives, or the public in last 12 months	BME	29.4%	26.5%	↓	
		White	28.1%	19.9%	↓	
6	Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months	BME	32.9%	24.8%	↓	
		White	23.4%	19.5%	↓	
7	Percentage of staff believing that their Trust provides equal opportunities for career progression or promotion	BME	40.2%	53.9%	↑	
		White	57.2%	61.9%	↑	
8	Percentage of staff personally experiencing discrimination at work from a manager/team leader or other colleagues	BME	22.6%	15.6%	↓	

		White	5.9%	6.1%	↑	
9	BME board membership	BME	22.2%	18.7%	↓	
		White	77.8%	81.3%	↑	
	Difference (total Board – Overall Workforce)		10.4%	3%	↓	

People and Culture Committee meeting
25th September 2024

Title:	**Workforce Disability Equality Standard 2024**
Responsible Director:	**Director of People and Culture - Angela Wilkinson**
Author:	**Head of Education, Learning and Development** **Nichola Langdale** **Equality, Diversity and Inclusion Manager** **Richard Dunston Brady**

Purpose of the report and summary of key issues:	The purpose of this report is to present the Workforce Disability Equality Standard (WDES) metrics for 2024. Key areas of analysis are measured against data from the electronic staff record from April 1st, 2023, to 31st March 2024 and the national NHS staff survey 2023. The metric framework includes a breakdown of: - Colleagues with a disability within the agenda for change bandings, in four clusters (1-4, 5-7, 8a-8b, 8c-9 and VSM). - Likelihood of disabled colleagues being appointed from shortlisting. - Colleagues entering the capability process. - Number of colleagues with a disability who are facing bullying and or harassment from patients, colleagues and managers. - Membership of the Board and its contrast with our Disabled workforce. Findings from the 2024 report show an improvement in some of the indicators: • An increase in the overall number of colleagues disclosing their disability or long-term condition on ESR. • A reduction in bullying from 2022 data • Increase in people who have reasonable adjustments to support them in their role.	
Trust Strategy and Strategic Ambitions	**The Patient and Child First** Improving the health and wellbeing of our patients, children and communities	
	Best Quality, Safest Care	
	Person Centred, Integrated Care; Strong Partnerships	

	Great Start in Life	
	At Our Best: Making HDFT the best place to work	x
	An environment that promotes wellbeing	
	Digital transformation to integrate care and improve patient, child and staff experience	
	Healthcare innovation to improve quality	
Corporate Risks	N/A	
Report History:	N/A	
Recommendation:	The Board is requested to discuss and note the 2024 WDES metrics and the Action Plan, which will attempt to address areas that need improving for disabled colleagues. Following approval by the Board, the data element of this report will be published on our HDFT website on 31 October 2024.	

NHS Workforce Disability Equality Standard (WDES)

Annual Report 2024

Harrogate and District NHS Foundation NHS Trust

Introduction

Welcome to our Workforce Disability Equality Scheme (WDES) Annual Report 2024. This report aims to communicate our internal data and metrics for the last twelve months, the progress we have made to date and proposes an Action Plan to allow us to continue to develop our approaches, initiatives and activities. See appendix 1.

Our Values and Commitments

Whether you are a patient, a visitor, or a member of staff, our KITE values are what describe and define our organisational culture:

The WDES was introduced in 2019 and is designed to improve workplace and career experiences for disabled people working, or seeking employment, in the NHS.

Commissioned by the NHS Equality and Diversity Council, the WDES is mandated through the NHS Standard Contract. It consists of metrics, based on workforce data from the Electronic Staff Records, and staff feedback from the NHS Staff Survey, which enables NHS organisations to compare the workplace and career experiences of disabled and non-disabled staff. The data highlights areas which require improvement and is used to develop and publish an Action Plan, which can then be tracked year on year to demonstrate progress. The WDES complies with the

Public Sector Equality Duty, as part of the Equality Act 2010, which reinforces the improvements set out in the NHS Long Term Plan. This plan also champions the insight and strengths of people with lived experience and promotes becoming a model employer of people with a learning difference. Its function is integral to the NHS People Promise and the Trust People Plan.

The WDES complements the existing Workforce Race Equality Standard (WRES), and both are vital to ensuring that the values of equality, diversity and inclusion lie at the heart of the NHS. The WDES is important because it enables NHS organisations to better understand the experiences of their disabled staff and to support positive change for all employees by creating a more inclusive environment for disabled people working and seeking employment in the NHS.

Research shows that a motivated, included and valued workforce helps to deliver high-quality patient care, increase patient satisfaction and improved patient safety.

The data collected is drawn from the Electronic Staff Record (ESR) April 2023 to March 2024, and the National Staff Survey (NSS) from November 2023.

Throughout the report the following colour key applies:

Improvement on previous year

Worse than previous year

Metric 1 – Workforce Representation

The profile of our disabled employees versus the NHS declaration rate for April 2023 / March 2024. HDFT declaration in 2024

	NHS Average 2024	HDFT 2024	Variance
Staff Declaring a Disability	-	6.3%	1.4%
	NHS Average 2023	**HDFT 2023**	**Variance**
Staff Declaring a Disability	4.9%	5.3%	+0.4%

The number of employees declaring a disability in 2024

	Disabled	Unknown	Non-disabled
Staff Declaring a Disability 2024	319	496	4254
Staff Declaring a Disability 2023	257	582	3975

9.8% of HDFT colleagues have not disclosed their disability or long-term condition status.

The number of HDFT colleagues who have disclosed a disability or long-term condition is 1.4% higher than the NHS average for 2024. Declarations of a disability or long-term condition have increased by 1% since 2023.

The table below highlights the percentage of staff on Agenda for Change (AfC) pay bands, medical and dental subgroups and very senior managers compared with the percentage of staff in the overall workforce.

WDES 2024 Non-Clinical Staff	2024			2023		
AfC Pay-Bands	Disabled	Non-Disabled	Unknown	Disabled	Non-Disabled	Unknown
1-4	7.5%	84.6%	7.9%	6.5%	83.3%	10.2%
5-7	9.5%	83.3%	7.2%	6.3%	83.2%	10.5%
8a-8b	8.8%	88.2%	2.9%	6.6%	85.2%	8.2%
8c-9 and VSM	0.0%	100%	0.0%	5.3%	94.7%	0.0%
WDES 2024 Clinical Staff	2024				2023	
AfC Pay-Bands	Disabled	Non-Disabled	Unknown	Disabled	Non-Disabled	Unknown
1-4	6.6%	80.9%	12.5%	5.2%	80.9%	14.0%
5-7	6.2%	85.2%	8.6%	5.5%	83.4%	11.1%
8a-8b	8.4%	80.7%	10.8%	7.0%	79.6%	13.4%
8c-9 and VSM	0.0%	90.9%	9.1%	0.0%	87.5%	12.5%

Medical and Dental Staff	Disabled	Non-Disabled	Unknown	Disabled	Non-Disabled	Unknown
Consultants	2.4%	76.8%	20.8%	2.5%	74.7%	22.8%
Non-consultant Career Grades	0.7%	82.4%	16.9%	0.0%	81.3%	18.7%

Trainee Grades	4.7%	89.1%	6.2%	4.0%	88.7%	7.4%

There has been an increase in non-clinical staff disclosing a disability in cluster bands 1-4, 5-7, 8a-8b and an increase in non-consultant career grades and trainee grades compared to 2023.

There has been a reduction in non-clinical Band 8c to 9 and VSM (Very Senior Manager) who have disclosed their disability.

Across all clusters, the percentage of disability status 'Unknown' has decreased.

Metric 2 - Recruitment

Relative likelihood of non-disabled staff compared to disabled staff being appointed from shortlisting across all posts.

A relative likelihood above 1 indicates that non-disabled applicants are more likely to be appointed from shortlisting compared to Disabled applicants.

	National Average 2024	Relative likelihood in 2024	Relative likelihood in 2023
Relative likelihood of non-disabled people being appointed from shortlisting compared to disabled staff	-	1.15	1.09

The relative likelihood of a person with a disability being appointed from shortlisting compared to a person with no disability has increased by 0.06 since last year, meaning colleagues with a disability are .15 times less likely to be appointed than a non-disabled applicant. It is not possible to further analyse protected characteristic information on the recruitment system to help prevent bias and ensure fairness in the recruitment process.

The national figure suggests applications from disabled and non-disabled applicants are equal, but experience varies at trust level. NHS England » Workforce Disability Equality Standard: 2023 data analysis report for NHS trusts

Metric 3 - Capability

Relative likelihood of colleagues with a disability compared to non-disabled staff entering the formal capability process on the grounds of performance, as measured by entering formal capability procedures.

	Relative likelihood in 2024	Relative likelihood in 2023
Relative likelihood of disabled staff entering formal capability process compared to non-disabled staff	3.33	0.00

Metric 3 is taken from a two-year rolling average of the current and previous year (1st April 2022 – 31st March 2024 divided by two). Last year (1st April 2022 – March 31st 2023) no staff members with a disability or LTC were capability managed. This year (1st April 2023 – 31st March 2024) 1 staff member with a disability was capability managed.

Based on this information, the likelihood of a staff member entering capability:

- With a disability is 0.16%
- Without a disability is 0.05%

Disabled colleagues are over 3 times more likely to be capability managed. This figure is above the national average recorded for 2023 which was 2.17.

Metric 4 – Harassment, Bullying or Abuse

Percentage of colleagues with a disability compared to non-disabled staff experiencing harassment, bullying or abuse from patient/service users, their relatives or other members of the public, managers or other colleagues.

Metric 4 (a-d)	National Average Disabled Staff	*2024* Disabled Staff	*2024* Non-Disabled Staff	*2023* Disabled Staff	*2023* Non-Disabled Staff
a) In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from patients/service users, their relatives or the public?	29.8%	26.7%	18.3%	29.7%	22.5%

In the last 12 months, how many times have you personally experienced harassment, bullying or abuse at work from managers?	15.3%	11.0%	6.8%	14.5%	8.2%
In the last 12 months, how many times have you personally experienced harassment, bullying or abuse at work from other colleagues?	25.3%	22.1%	13.9%	21.2%	15.4%
The last time you experienced harassment, bullying or abuse at work, did you or a colleague report it? (Yes)	50.6%	56.1%	52.0%	49.3%	45.1%

In the 2023 National Staff Survey, there were fewer incidences of bullying and harassment compared to 2022 towards people who have disclosed a disability or a long-term condition from patients/service users, their relatives or the public and from managers. There is a small increase in incidences of bullying, harassment or abuse from other colleagues. The data also shows there continues to be a higher incidence of bullying and harassment for disabled staff compared to non-disabled colleagues, but the gap between disabled and non-disabled has reduced in metrics 4b and 4d since last year.

HDFT disabled staff experience less bullying and harassment or abuse across all metrics than the national average. HDFT disabled staff are more likely than their non-disabled counterparts, as well as the national average to report bullying and harassment or abuse.

There is a 6.8% improvement in disabled staff reporting incidences of bullying and harassment between 2023 and 2024.

Metric 5 – Career Progression

Percentage of staff with a disability compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion.

	2024		2023	
	Disabled	**Non – Disabled**	**Disabled**	**Non – Disabled**
Does your organisation act fairly with regard to career progression/promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age? (Yes)	57.9%	62.4%	51.0%	57.1%

More disabled staff feel that the Trust acts fairly with regard to promotion and career progression than they did in 2022. HDFT has more disabled staff feeling like the organisation acts fairly than the national average of 51.5%.

Metric 6 – Presenteeism

Percentage of colleagues with a disability compared to colleagues without a disability responding to whether they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.

	National Average	2024		2023	
		Disabled 2023	Non-Disabled	Disabled	Non-Disabled
Have you felt pressure from your manager to come to work? (yes)	28.6%	18.4%	14.1%	21.7%	15.9%

Disabled staff feel higher levels of pressure to attend work whilst unwell than their non-disabled counterparts. Less disabled staff at HDFT feel Presenteeism than last year and the national average.

Metric 7 – Feeling Valued

Percentage of colleagues with a disability compared to colleagues without, declaring whether they are satisfied with the extent to which their organisation values their work.

	National Average	2024		2023	
		Disabled	Non-disabled	Disabled	Non-disabled
The extent to which my organisation values my work (Satisfied /Very Satisfied)	35.7%	42.9%	52.6%	33.9%	44.7%

Disabled staff report that HDFT values their work more than in 2022. The gap between Disabled and non-Disabled staff has reduced by 1.1%.

Metric 8 – Reasonable Adjustments

Percentage of colleagues with a disability responding to their employer making reasonable adjustments to enable them to carry out their work.

More disabled colleagues are receiving reasonable adjustments to enable them to be present and work than in 2022. There has been an increase in accessing reasonable adjustments of 8.1%. HDFT disabled staff access reasonable adjustments more than the national average.

	National Average	2024 Disabled	2023 Disabled
Has your employer made reasonable adjustment(s) to enable you to carry out your work? (Yes)	73.4%	75.9%	67.8%

Metric 9 – Staff Engagement

NHS staff survey and the engagement of staff with a disability

The staff engagement score has increased for both disabled and non-disabled colleagues compared to last year, however the increase has been greater for non-disabled colleagues, meaning the gap has widened.

	Trust Staff Engagement Score	NHS Staff Average Engagement Score
2023	7.05	6.91
2024	6.44	6.42

	National Average	2024		2023	
	(Disabled)	Disabled	Non-disabled	Disabled	Non-disabled
Staff engagement score (0-10)	6.5%	6.8%	7.9%	6.4%	7.0%

Metric 10 - Board Representation

Percentage difference between the organisation's Board voting membership and its organisation's overall workforce disaggregated. Voting and non-voting membership of the Board, by Executive and Non-exec membership of the Board for 2023

2024	Disabled	Non - Disabled	Unknown
Total Board Members	0.0%	87.5%	12.5%
Of which: Voting Board Members	0.0%	92.9%	7.1%
Non-Voting Board Members	0.0%-	50.0%	50.0%
Of which: Exec Board Members	0.0%	100.0%	0.0%
Non-Exec Board Members	0.0%	77.8%	22.2%
Difference (Total Board - Overall Workforce)	-6.0%	4.0%	3.0%
Difference (Voting Membership- Overall workforce)	-6.0%	9.0%	-3.0%
Difference (Executive Membership - Overall Workforce)	-6.0%	16.0%	-10.0%

2023	Disabled	Non - Disabled	Unknown
Total Board Members	0.0%	83.3%	16.7%
Of which: Voting Board Members	0.0%	83.3%	16.7%
Non-Voting Board Members	-	-	-
Of which: Exec Board Members	0.0%	100.0%	0.0%
Non-Exec Board Members	0.0%	70.0%	30.0%
Difference (Total Board - Overall Workforce)	-5.3%	0.8%	4.6%
Difference (Voting Membership- Overall workforce)	-5.3%	0.8%	4.6%
Difference (Executive Membership - Overall Workforce)	-5.3%	17.4%	-12.1%

Has your Trust taken action to facilitate the voices of colleagues with a disability in your organisation to be heard? (Provide an example or action plan).

The Trust has a strong Disability and Long-Term Conditions staff network, as well as a network for colleagues who are neurodiverse. Both network groups facilitate discussions with their members to talk openly and in a safe space about their conditions and their reasonable adjustments.

Both groups are supported, and meetings are attended, by their Executive sponsor and the EDI Champion / Non-Executive Director. Both network groups have doubled in size in the last six months through robust publicity, word of mouth and campaigns to demonstrate our commitment to colleagues who identify as having a disability or being neurodivergent. These forums enable a regular voice across the organisation for staff with a disability.

Conclusion and Recommendations

Findings from the 2023 National Staff Survey Benchmarking report show an improvement in several indicators:

- There is an increase in the number of staff disclosing a disability or long-term condition.
- There is a decrease in reported incidences of bullying, harassment or abuse, particularly from patients, managers and the public, however issues persist with bullying, harassment or abuse from other colleagues, although the gap between disabled and non-disabled staff has narrowed.
- More disabled staff feel the Trust provides equal opportunities for career progression compared to the previous year and HDFT scores better than the national average for this metric.
- More staff are receiving reasonable adjustments, which supports their ability to perform in their roles effectively.
- Challenges include than disabled people are 3.3 times more likely to enter the formal capability process than their non-disabled peers.
- Disabled staff report higher levels of Presenteeism, although this has been reducing steadily since 2020.
- Disabled staff remain underrepresented at Senior Management and Board levels.

The report also contains an Action Plan to focus on areas which have not improved or where there are differences between the perceptions and experiences of disabled and non-disabled colleagues.

The Board is requested to discuss and note the 2024 WDES metrics and Action Plan that will attempt to address areas for improvement for disabled colleagues.

Following approval by the Board, the data element of this report will be published on our HDFT website on 31 October 2024.

Action Plan
Workforce Disability Equality Standard 2024

Metric	HDFT	National Average	Context	Actions	Timescale
Metric 2: Likelihood of appointment from shortlisting	1.15		Applicants with a disability are less likely to be appointed than those without.	• Continue to deliver unconscious bias training • Improve access to information related to: o Clinical Skills o Leadership and Management o Job posts o Personal Development	Ongoing February 2025
4: Bullying, harassment and abuse	a) 26.5% b) 11.1% c) 22.2%	a) 30% b) 15.4% c) 25.3%	While there has been a reduction in reported instances, disabled staff still experience higher rates of harassment and bullying. Addressing this issue is crucial for creating a safe and supportive work environment for all employees.	Devise and implement a communications plan to better promote access to current resources such as: - Respectful Resolutions - Bullying and harassment training - Speaking up with BUILD	December 2024

Continue to drive bullying and harassment as part of our values

Appendix 1: Workforce Disability Equality Standard 2024

WDES Data 2023/24
(Workforce Disability Equality Standard)

		March 2023	March 2024	
1	Percentage of staff in AfC pay-bands or medical and dental subgroups and very senior managers (including Executive Board members, but excluding Non-Executive Board members) compared with the percentage of staff in the overall workforce.			
	Cluster 1 (up to Band 4)	5.65%	6.9%	↑
	Cluster 2 (Bands 5-7)	5.58%	6.5%	↑
	Cluster 3 (Bands 8a-8b)	6.88%	8.5%	↑
	Cluster 4 (Bands 8c-9 and VSM)	3.70%	0%	↓
	Cluster 5 (Medical/dental consultants)	2.5%	2.4%	↓
	Cluster 6 (Medical/dental, non-consultants)	0.00%	0.7%	↑
	Cluster 7 (Medical/dental, trainees)	4.03%	4.67%	↑
		5.3%	**6.3%**	↑
2	Relative likelihood of non-disabled staff compared to Disabled staff being appointed from shortlisting across all posts.	1.09	1.15	↑
3	Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure.	0.00	3.33	↑
4a	Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from Patients or other members of the public	27.9%	26.7%	↓
4b	Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from Managers	14.5%%	11.0%	↓
4c	Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from Other Colleagues	21.2%	22.1%	↑
4d	Percentage of Disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it	49.3%	56.1%	↑

		March 2023	March 2024	
5	Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion.	51.0%	57.9%	↑
6	Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.	21.7%	18.4%	↓
7	Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.	33.9%	42.9%	↑
8	Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.	67.8%	75.9%	↑
9a	The staff engagement score for Disabled staff, compared to non-disabled staff. (0-10)	6.4	6.8	↑
9b	Has your Trust taken action to facilitate the voices of Disabled staff in your organisation to be heard?	Y	Y	↔
10a	Percentage difference between the organisation's Board voting membership and its organisation's overall workforce (voting membership of the Board)	-5.3%	-6.0%	↑
10b	Percentage difference between the organisation's Board voting membership and its organisation's overall workforce (Executive membership of the Board)	-5.3%	-6.0%	↑

Key:

	The score has worsened
	The score has remained at the same or similar level as the previous year
	The score has improved

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

Date	**4 June 2024**	**Location**	MS Teams
Chair	Brendan Brown	**Minutes prepared by**	Geraldine Morris
Attendees	Foluke Ajayi (FA), Mel Pickup (MP), Brendan Brown (BB), Jonathan Coulter (JC), Clare Smith (CS) (deputising for Phil Wood), Len Richard (LR), Lucy Cole (LC), Ben Roberts (BR), Angie Craig (AC) item 2, Simon Worthington (SW), items 9-12. PwC: Shamil D Ganatra (SG), Nancy Park (NP), Damian Ashford (DA) Deloitte: Liz May (LM), Susie Smith (SS), Gurminder Khaira (GK)		
Apologies	Phil Wood (PW)		

Agenda

ITEM		WHO
1	Welcome and Introductions	Chair
2	NSO Update	Angie Craig
3	Minutes & Actions	All
4	Collaborative Report and HCP Report • Aseptics action plan	LC
5	Specialist commissioning update	LC
6	Cost review and efficiency workstreams update	LC / BR
7	LIMS deployment	Janine Bontoft / David Birkenhead
8	AOB • Chair WYAAT DoFs	All
	Break	
9	Cost review presentation: PwC	PwC
10	Break / changeover between presentations	
11	Cost review presentation: Deloitte	Deloitte
12	Review of presentations and next steps	All
13	Close	Chair

MEETING NOTES		
Agenda Item	**Main Points and Decisions from Discussions**	**Agreed Follow-Up Actions**
1. Welcome and Introductions	Apologies were noted and accepted for PW.	
2. NSO Update	*AC joined the meeting.* AC presented an update on NSO (circulated with the meeting papers), discussing the key points, and the north and the south sectors, as well as the revamp of the workforce group. She noted the first draft of the business case was expected to be completed towards the end of June. *Clare Smith joined the meeting* LR credited Julie Hoole for creating an environment for teams at MYTT and CHFT to work together, which was very positive. He noted that whilst the north sector was slightly different and consisted of a bigger group of trusts, there was much learning from the south sector that could be applied. He commended the great work that had been done. MP commented there was a significant lag for the north sector, and sought assurance that the same level of attention, leadership and focus would be maintained. She highlighted the repatriation for chemotherapy patients as a trade-off for the proposed changes to inpatient beds. AC replied that work was ongoing on options appraisals and once in place, a round of public engagement would be undertaken. JC commended the paper and achievements. He asked if there was anything that members could do to assist AC get to the timeline. AC noted the Leeds data should be available in the coming days; BR agreed this would be the next critical step and would be needed for an initial conversation at DoFs this month. CS drew attention to concern over work volumes that employees were expressing in their current appraisals. She commented on the discretionary effort happening across organisations and noted that it, and the goodwill, could stop. Staff felt they were being taken for granted and objected to the thought of working like this indefinitely. She was concerned the sustainable model was built on the current ask and questioned if we had reasonable workloads for colleagues and whether we were attractive places to work. AC responded that people had forgotten about discretionary effort and additional hours, and this hindered	

	the data gathering. Capacity and demand would be flushed out so we can build it in. LC commented this was a commissioning decision, as it was changing the way patients access services. She stressed the need to ensure a high level of assurance before the case was progressed to the ICB for a decision. BB commended AC's work. He wondered if a review was needed of what was originally agreed to see if we were on track for the original business case, and whether we all had sight of where we were going to get to. LR noted the business case would give us assurance that we've been able to describe what we need, that there was consistency between the two sectors and consistent with the original description of the model and doing this before the business case would be adding in work. BB clarified this wasn't a criticism or escalation, it was whether as CEOs we were asking the right questions for some of the scale of change we were leading in NSO and other schemes and whether we had we truly learned lessons. The question we needed to ask ourselves was whether the business case would be signed off as planned. AC shared that the original objectives had been reviewed for the business case. She would send the list of these to LC for review and comment and suggested meeting again to discuss any gaps in the business case. MP was concerned this was going to be a more expensive model. LC noted the intention to conduct a review by a group of individuals which had not been close to the development of the case to then provide feedback. This was an approach agreed as a lesson learned in aseptics. If we had changed course, then we should question why and seek the evidence. The narrative would need to be strong to demonstrate the pre-requisite engagement should public consultation not be required. MP was right, doing all these things would cost more. It would be important to have this as a clear WYAAT narrative and ensure we're all on the same page before it goes to ICB, Cancer Alliance and others. FA commented we would need a handling strategy following this. We would need to think through and support each other through some of the issues. BB thanked AC for her paper on this huge piece of work. AC was keen for success and happy to do what was needed to get this over the line. She would be in touch with LC. *AC left the meeting.*	**ACTION: AC to send original list of objectives to LC for review and comment.**
3. Minutes & Actions	The minutes and actions from the previous meeting were reviewed and three corrections were noted.	

	MP highlighted the penultimate paragraph in item 3 on page 4, which and would read as follows: • "MP shared that she was aware some organisations had asked for the Centre to progress with the mutually Agreed Resignation Scheme (MARS) approval." FA noted two corrections from DC which would read as follows: • Trust updated typo on page 3: "The Trust was five months until EPR go live;" • LIMS deployment wording page 10: FA stated DC had asked for it to be noted that there would be an impact following decoupling. FA would share some wording on this with LC. No further changes to the previous minutes were noted and the minutes were otherwise approved pending changes. **The action log was reviewed, and the following updates were given:** • ***Action 149:*** *Collaborative Report & WY HCP Report - Pathology governance to be included in future agenda* – deferred to July as current focus is on LIMS • ***Action 158****: Specialised Commissioning - Spec comm to be discussed at future meeting.* – Agenda item 5 • ***Action 187:*** *WYVaS - Update and remaining programme activities - LC to provide WYVaS update at future CiC meeting and invite JL back to update further at the Programme Executive in the autumn.* • ***Action 189:*** *Secondary prevention - MP to link directors of public health with MDs on antimicrobial prescribing* – MP to email LC about this to ensure it's added to MD agenda. • ***Action 190:*** *AOB - LC to invite Julian Hartley and / or Steve Russell to 7 May meeting, or otherwise convene an extraordinary meeting with Julian* - SR unable to join. Seeking alternative date. Confirming date with JH when he returns from leave • ***Action 197:*** *Hosting arrangements - LC to include preferred hosting model within the corporate services workstream once established.* • ***Action 201:*** *Haematology - JW / SU to establish a clinical network upon closure of the haematology programme.* • ***Action 202:*** *AOB - CS to reach out to Peter Reading at YAS from UEC perspective* – CS updated this was still ongoing. **The following actions are complete:**	**ACTION: FA to share wording with LC for DC's correction to regarding LIMS deployment in the previous minutes.**

	• ***Action 161:*** *Haematology - Sal Uka to report back on haematology workplan at future meeting –* Agenda item 2 • ***Action 191:*** *Cost Review - Develop ToRs for cost review and share with Programme Exec for approval* • ***Action 192:*** *Cost Review - LC to set up further meeting for Programme Exec and SW on Monday to review progress* • ***Action 193:*** *Cost Review - SW to contact NHSE to confirm cost review and identify if any resources are available to support* • ***Action 194:*** *Cost Review - BB to contact Rob Webster and Jonathan Webb to confirm how cost review will be progressed* • ***Action 195:*** *Cost Review - LC and BR to develop tender documentation and contact IMAS to identify potential resources* • ***Action 196:*** *Cost Review - LC to request comms to trust teams and reactive statements are developed to use as required* • ***Action 198:*** *LIMS Deployment - JB to share a summary of the risks and issues for LIMS deployment with each CEO for their own trust* • ***Action 199:*** *LIMS Deployment - CS and CE to ensure JB is invited to internal project boards in LTHT and MYTT respectively* • ***Action 200:*** *AOB - LC to schedule further LIMS update for next Programme Exec meeting –* Agenda item 7	
4. Collaborative Report and HCP Report Aseptics action plan	LC presented an update on the WYAAT Collaborative Report and HCP Report (circulated with meeting papers). **Endoscopy** • Regional training centre that was established at MYTT. The Diagnostics Board had received the closure report and was now in BAU, with management team running it, including clinical leadership. This formally closed this element of the programme. **Haematology** • Haematology was transitioning into network, and a Chair was being sought. **Imaging** • Work continues, with slow progress, on final technical issues. HDFT was ready to go pending sign off and we were in the final stages for the live system. There was still information governance to do for chest AI and BTHFT will be the first site to go live. The contract was signed at the end of March. **Pharmacy**	

	• RIBA 2 had been finalised for the redesign process. There had been a review around the procurement approach, with support for a procurement strategy. Power supply was a low risk. **Vascular** • Progress being made in the East with good engagement from LTHT and MYTT colleagues around clinical support. Work continued on the repatriation work and rehab model. A major learning event was organised for around 90, mainly nursing, people, with another event scheduled in June to maximise the number that can attend. It was a useful and very cost-effective way for people to do CPD in the current climate. It was well received, and evaluation had been really strong. **Stroke** • Following the workshop, work had been undertaken to confirm priority areas. Matt Spencer was working on a model around the core areas of prevention, acute pathway, rehab and discharge that would give us a targeted view of how to take stroke forward. JC would chair this programme. **Planned Care** • Planned care TUPE transfer from the ICB was scheduled for 1 July. A good working structure with place-based leads for planned care had already been established, with good plan for the crossover of priorities. **Spec Comm Delegation** • This was a risk and would be covered in more detail later around what we would need to do. Teams from LTHT and BTHFT would be discussing a renal dialysis statement. **Lessons learned** • LC had reviewed Board memberships for WYAAT Programme Boards and identified some minor changes. A full view of this would be provided at next meeting. LC had agreed with JC to use ICB lobby to feedback to NHS E on this. Capital flows across ICSs had been agreed, with final sign off with DoFs was scheduled for 21 June 2024. The risk management approach would form part of TOR review and appended to the report. LC and BR had completed a programme prioritisation review with managers which had been enlightening and had resulted in capacity being created and the focus being where it should be. BB questioned if there were any red flag issues to be aware of. LC responded that was LIMS on the agenda but otherwise there was nothing insurmountable in terms of work happening.	
5. Specialist commissioning update	LC noted a briefing paper was in the pack. She explained that articulating the model for this had been challenging both regionally and nationally. She discussed that when East of England, the Northwest and Midlands regions had done spec comm, it had revealed issues nationally with TUPEing staff. Further detail of the model was expected by the month end. LC reflected that it was a challenging space to work in, with	

	commissioner and provider split focus. Understanding the risks in service lines was the medium-term focus. LC noted a conversation was needed around leadership capacity, as well as whether there was an WYAAT appetite around 'delegation' from ICB to provider collaboratives through a lead provider style arrangement, which was an established way of working. LTHT were keen to do avoid an ICB model due to ICBs lack of experience in this very complex area. CS acknowledged there was a lot of risk here for us all, adding she would have grave concerns if it went to ICB due to this being a very niche area of expertise. She stated LTHT were keen for WYAAT to take this, but if WYAAT did not, then LTHT by extension would look at doing it, although this would not be ideal. Members supported CS's comments. LR agreed it was a question of skills, detail, and risk across the system and supported the view that WYAAT should lead this. JC explored how we would manage the risk better than we were presently, without further resource. LC noted we were c.10% underfunded in the region and she had concern about the budget arriving in the ICB and being seen as a mechanism to fund other core services. She noted that many services were specialised only for a time, until they were offered in all DGHs. She suggested further discussion around changing some of the pathways. She further suggested making quick assessments of further opportunities in the acute sector. JC reflected that we could all do it better but asked if we would be able to. FA agreed with LC and commented that the challenge around deployment of the plan was due to lack of resource and noting that specialist skills would mean not enough people. We would need to develop skills as well as look elsewhere for skills. BB noted agreement that WYAAT could/should step into this space, but there were concerns around what we would be stepping into and taking on, however the alternative would be worse. LC suggested a conversation in the first instance with Rob Webster (RW) to say we believed WYAAT was the right thing to do and ask him if it's palatable. There was a general lack of understanding around what delegation meant. ICB were doing stuff, alongside LC, but we would take the lead with ICB support. BB explored if we could obtain the mental health process to use as part of our conversation. LC agreed to speak to Keir Shillaker, as there would be some really good learning from it. MP questioned if we should start small and often to test it out. Without clarity, it would drift, and there would be a degradation of the service.	**ACTION: LC to ask Keir Shillaker for details of mental health process.**

	CS agreed there were many risks involved in this but the risk of not was even greater where, if you were already operating at a reduced level, it would worsen. Whether a test case was done or not, we would not want to scare ourselves out of it, as the alternative was worse. LC updated that conversation with other provider collaboratives and tertiary centres in our region as well as further afield, was important for leverage and a consistent approach. She noted PW had already spoken to Jim Mackey in Newcastle. CS shared that PW would be happy to host if we were to get into those details. BB summarised a conversation with RW was needed, that everyone agreed as the alternative of sitting back was not palatable and that it would be helpful for conversations with Jim Mackey to continue. LC agreed arrange a meeting with RW and Ian Holmes.	**ACTION: LC to arrange a meeting to discuss spec comm with Rob Webster and Ian Holmes.**
6. **Cost review and efficiency workstreams update**	LC discussed that PwC and Deloitte would be joining the meeting after the break. The review had been cost capped in hopes of smaller providers coming forward, which did not transpire. The two companies were asked to give a brief presentation on their proposals. They had accepted what we had asked in that they had agreed to deliver our TOR over a four-week period. There would be opportunity to ask questions, which didn't need to be identical for each. LC proposed that BB would do the welcome and announce the start of members' questions. SW was to join us, as it would be helpful to have a DoF perspective. LR was concerned we had ended up where had not wanted to, with two of the Big Four coming in. He LC confirmed that a decision would be made on PwC and Deloitte today, after they had presented. Also, if we proceeded with a cost review, the six efficiency workstreams would start after that, with a more medium term focus. JC reflected that we must challenge ourselves to get external organisations to review what we do; there were a number of reasons it would be helpful. The challenge would be if we were then given unrealistic targets. LR responded that none of us had experience of delivering over 5% cost improvement. There was a chasm between what was generated in these reviews and what was realistic and therefore this should be used as a tool.	
7. **LIMS deployment**	*David Birkenhead and Janine Bontoft joined the meeting* JB reflected that she had discussed the ongoing deployments last time. She noted HDFT was going well and deployment of the blood transfusion module would be complete that day. LTHT was due to go live August but were significantly behind where they needed to be; she had been reporting on this three times a week. ANHSFT and BTHFT were still on track for LIMS but were still exploring decoupling from EPR. MYTT and	

	CHFT were still reviewing plans; CHFT were happy to bring their plan forward and MYTT were exploring options and may push into 2026 in order to manage local interdependencies. OpenNet testing for ICE was nearly complete; JB would escalate ANHSFT if theirs was not complete by the end of week, as it was causing delay. She hoped to roll this out in the next two weeks. DB noted it was really positive that we had HDFT who at short noticed had been really responsive; he congratulated the team. Key issues remained though. We had been trying to get LTHT over line on 5 August, as it would impact on other organisations. There was some risk in EPR in the go live process. LTHT colleagues were working hard with a lot to do but were hampered by the challenges of work pressures and summer holidays looming. CS confirmed that following the last meeting, JB now attended the meetings. She noted execs now received weekly updates. She noted the whole team were working to the August date, but it had not been escalated to executives that the date would not be met. CS had asked for an update on where the recovery timeframe would occur if we fell behind. BB thanked JB and DB for their update. He commended JC and the HDFT in getting this over line. He noted that FA would discuss with JB this week. He thanked CS for her clarity and noted if we were in escalation, there would be a conversation on what recovery would look like. FA was aware of increased confidence in LTHT for 5 August and believed it would be achieved. She commented we were close to saying we would decouple but cautioned it would cost more and be riskier if we did decouple at the last minute, noting that August would be last minute. It was a balancing act for us. BB agreed it felt more optimistic than last time, but acknowledged we were not out of the woods yet. DB stated there was still some significant risk associated with LTHT on 5 August. Whilst he was confident that LTHT had a focus on it with executive oversight, he remained unsure we would get it over the line. JB confirmed it was still red and at risk. She believed LTHT could do it, but not all of it. LC commented that we might get a big chunk but not all of it done in August, but it may impact ANHSFT and BTHFT with EPR. BB noted the next meeting was on 2 July and suggested JB and DB attend with a further update, which they agreed to. LR suggested the next diagnostic board may be another opportunity to review this at system level. LC confirmed it was in July. FA requested that JB email her with the ICE requirement before the end of the week. *JB and DB left the meeting*	**ACTION: JB and DB to update on LIMS at 2 July Programme Executive meeting and at the Diagnostic Board meeting on 16 July.** **ACTION: JB to email FA with the ICE requirements.**

8. **AOB** **Chair WYAAT DoFs**	LC noted that the current Chair of DoFs SW would retire in July. After asking who would be interested in chairing, Amy Whitaker, incoming LTHT DoF Jenny Ehrhardt, Gary Boothby and Jordan McKie had all come forward. LC asked members if there was a preference as to who chairs. Historically, this had been rolling for three years as no one had wanted to chair. LC suggested reviewing this annually as per CEOs. She noted that MDs was chaired by Ray Smith BTHFT, CNs by Emma Nunez HDFT, DoS was James Goodyear LTHT, COOs was CS LTHT, CIOs was also LTHT. HRDs also need chair which LC would review. This was an opportunity to review equity of who chaired what. BB acknowledged that LC was trying to balance out for fairness amongst the groups. MP was happy for Amy to be appointed Chair of DoFs and members agreed.	**ACTION: LC to notify DoFs that CEOs had agreed that Amy Whitaker would be the new DoFs Chair.**
	BREAK	
9. **Cost review presentation: PwC**	*SW joined the meeting.* *Shamil D Ganatra (SG), Nancy Park (NP), Damian Ashford (DA) of PwC joined the meeting (NP shared that they were all in the same meeting room but using separate laptops)* BB briefly introduced that colleagues representing all the acute WYAAT trusts were present and invited PwC to make their introductions and presentation. **PwC PRESENTATION:** NP introduced herself and PwC colleagues Sham Ganatra and Damian Ashford and stated she and her colleagues were all leaders in the PwC healthcare restructuring team. She gave a brief presentation on their experience and results on recent projects e.g., at Northern Care Alliance, Greater Manchester (GM), and East Kent Acute Trust. NP also introduced PwC colleague Stephen Hay (SH) (not present today). Detailed CVs were in the pack. NP noted WYAAT's challenging specification and timescales and was confident that she and her senior team colleagues who would all be directly involved in the work, would be able to deliver the required financial improvement. DA detailed the support that PwC had provided across GM, at the request of Richard Barker and Julian Kelly, in improving its £400m run rate deficit to £180m. Safety was a core part of this review. SG discussed the approach and methodology, and the excitement at the prospect of working with WYAAT. PwC preferred on site face-to-face working but were flexible to also work virtually. They would spend as much of the four weeks on site as possible and would want to meet everyone in the first week. Data would be reviewed in the first week. In weeks two and three PwC would discuss further with WYAAT teams to get under the skin of the position. At the end of week three, PwC would discuss the findings with WYAAT and	

	recommendations to shape the document in week four. They would get a dashboard of the six trusts. This would be worthy of further investigation and would be rag-rated. PwC would meet at the end, separately or together, to discuss. NP noted three takeaways: PwC's senior leadership team with the personal involvement of NP, SG, DA and SH; experience and track record; tangible results would be seen after the four-week piece of work and WYAAT would have clarity of focus areas. **Q&A:** BB thanked the PwC team, noting it was good to see the energy in their presentation. LR referenced NP's opening comment that safety runs through the work PwC do and asked her to describe how this was done. He noted the interaction and scale of the task would be a challenge and asked how this would be built in. DA responded that they would look at QIAs to review Trusts' key ways of working, as well as the wider clinical involvement, financial leadership, clinical directors and reviewing from the ground up. He shared that NP, SG and himself had been doing this work for over ten years and their work was shaped by the experience of when things were not done appropriately in the NHS. NP added this was a focus for them, noting the pace of their work was very important. MP stated four weeks was a small amount of time and was interested in their methodology for identifying WYAAT opportunities. She explored if this was by looking for commonalities between Trusts. NP confirmed that PwC would focus on trusts as set out in the scope and would recommend any opportunities they saw of benefit across WYAAT that WYAAT were not tackling. MP discussed clinical directors, general managers and nurses that may have been promoted during COVID-19, with no experience in cost improvements. She asked if they had seen this in their work at GM and how it was addressed. DA shared that PwC believed the financial control freedoms during COVID-19, and management coming into post with no experience of SIP pre-COVID-19, had led to the quick growth of GM'S financial situation. In GM, they specifically started the financial improvement with the Chair and CEO, not CFOs (DoFs), as they controlled the spends who used their Boards to make the savings happen.	

	FA references NP's point on engagement and working with WYAAT teams. The added benefit was really important, and she was in how PwC would delineate this from what teams had already worked up. NP responded it would be a tailored approach. WYAAT had six organisations, with variation across. PwC could test if your foundations were robust. Some Trusts may need a deeper dive and require more support. PwC could flex its approach according to what WYAAT had. FA noted she was not suggesting ANHSFT was perfect, clarifying she was asking how PwC would demonstrate the added benefit. SG stated it would be obvious to PwC what was in place when they came in. They would review if things were sufficiently robust and provide WYAAT a view of plans we already had and what needed to be better, highlighting what we could look at. Each organisation would have different levels of progress. WYAAT would not want a situation where PwC were not telling us anything new at the end of four weeks. PwC would want to make suggestions. DA encouraged WYAAT to discuss with CEOs in GM the benefits of PwC's work, adding that if WYAAT were unhappy with PwC's work, then don't pay. JC referenced quality and safety. In terms of engaging our people, quality improvements would bring big productivity and financial benefits quite quickly would be helpful. SG discussed comms around benefits to staff and patients. PwC had many examples of how to keep staff engaged. BB thanked PwC for their presentation and for taking questions and advised that BR and LC would be in touch in due course. *SG, NP, DA left the meeting.*	
10. **Break**	*BREAK / changeover between presentations*	
11. **Cost review presentation: Deloitte**	*Liz May (LM), Susie Smith (SS), Gurminder Khaira (GK) of Deloitte joined the meeting* BB asked for introductions. Deloitte made their introductions and began their presentation. **PwC PRESENTATION:** LM introduced herself as a partner at Deloitte leading their health account in the north. For Deloitte, it was important to have senior finance experts to work with WYAAT. Four members of the Deloitte team were	

	senior NHS experts in financial improvements and review. GK introduced himself as qualified accountant and was a director in the finance team with waste reduction expertise. *SS* introduced herself as a chartered account, worked recently on five trusts at South Yorkshire and discussed other members of the team. Deloitte had worked with five acute Trusts in South Yorkshire ICB, Northeast and North Cumbria providers, Liverpool University Hospital. LM had wanted to give a flavour of their depth of experience, with a track record for delivering in taking costs out of the NHS and delivering reviews as WYAAT had specified. The team included five accountants in the team and had worked with some of the most financially challenged systems. GK described how Deloitte would work to understand WYAAT through interviews and observations. Deloitte would review the effectiveness of governance and reporting arrangements; how robust the financial arrangements were and observe meetings and the effectiveness of chairing and attendance. Deloitte would also review how robust WYAAT's plans were and whether they were on track and spend time with the WYAAT PMO. SS commented that Deloitte would review stakeholder management, leadership and robustness of delivery, and set up waste reduction meetings, regular meetings with department and divisional leads to ensure they were on board. GK concluded that Deloitte would look at recent investments, cash versus cost control post COVID-19, and review opportunities to push further. He highlighted the project report, stating Deloitte would hold a workshop with leaders, a feedback session to discuss key findings, and provide a follow up review at no cost after three months to see how WYAAT were doing. LM closed the presentation saying she hope WYAAT would see that Deloitte had many tools. She stated this would not be a desktop exercise and that Deloitte would get under WYAAT's skin. Deloitte's review would be heavily focused on having time with WYAAT as Trusts. Despite this being a rapid review Deloitte saw it as essential to have the interviews and observations to understand the waste reduction. Deloitte would use their experience of what works elsewhere to independently challenge. BB thanked Deloitte colleagues for their presentation. **Q&A:** MP was interested in Deloitte's COVID-19 observation. We all appreciated how COVID-19 had turned financial management in organisations on its head, but in the current environment some things would be paused, stopped, or delayed. COVID-19 presented an opportunity to invest in clinical advancement. MP explored Deloitte's strategy around helping WYAAT do some of this. LM responded that understanding	

	where some of that growth had come from, whether from safe staffing and quality improvement for example, and what the rationale was. Deloitte had seen a number of Trusts that didn't have the depth of understanding around investments. GK added it was around understanding the evidence based around the investments made. Deloitte has observed that Trusts had made investments in isolation and Deloitte would review for any duplication and unpick this across organisations. JC discussed financial improvement review and that this felt more systemic. He questioned how Deloitte would help WYAAT beyond the basic housekeeping to enable the step change. LM responded that Deloitte found many Trusts do many things very well. Deloitte would be able to share interesting bits of excellent practice that WYAAT could learn from. Deloitte would bring independent challenge to WYAAT where they believed WYAAT could go faster in areas. Deloitte had expertise with global experience and would use the breadth of their experience. Deloitte would need to thing about this differently; the scale of challenge was not what Deloitte had seen before. Bringing innovative thinking and doing things differently as a collaborative was really important. GK noted the WYAAT plan and delivery pillars was a starting point, but these would need a delivery plan. Deloitte would help frame this across a three-to-five-year journey. Deloitte would help articulate and deliver that as a narrative. LM commented it was added value for Deloitte to challenge what WYAAT could achieve through additional rigour and control. Deloitte could bring added value around what WYAAT could do differently. BB thanked Deloitte for their presentation and for taking questions and advised that BR and LC would be in touch in due course. *LM, GK, SS left the meeting.*	
12. Review of presentations and next steps	LC invited members to express their views on the two presentations by PwC and Deloitte. FA favoured PwC, noting Deloitte's presentation felt as if they hadn't taken time to understand WYAAT, which was disappointing. They had some very good points, but as time went on, she felt they had not understood us. PwC were able to demonstrate evidence of what they had done more than Deloitte could. LR commented that what had drawn him to the Deloitte presentation was their understanding that some solutions would take time and structural things they would help to identify and their delivery over a one-to-three-year period. Our role would be to maintain quality, access and manage risks.	

	MP observed that PwC were highly polished, and Deloitte less so, however Deloitte had referenced WYAAT a lot more compared to PwC. Nonetheless, PwC made her think that they understood quite a bit about WYAAT and had understood the relationship we have as WYAAT. Although she was a bit torn, she favoured PwC. CS favoured PwC as she felt the Deloitte presentation felt generic. She didn't feel that Deloitte would delve into this in the same way as it felt PwC might do. She through PwC were better, more polished and benefited from knowing us as system, whereas Deloitte did not and were general. JC was more impressed by PwC and what they would do over the course of the next four weeks. SW commented that both organisations were credible and capable of doing the job. He highlighted that PwC were sent into Manchester and Deloitte were sent into South Yorkshire which in itself sent a message. SW did not disagree with the consensus for PwC. LC spoke for BR as his laptop was faulty, noting that his preference was for PwC. LC added that she held the same view for PwC as Deloitte were a bit generic. The PwC team came across as more experienced. *SW left the meeting.* BB summarised that the overwhelming view was for PwC. He asked members if they were in support of PwC being awarded the contract. All members confirmed their agreement with this. BB proposed that LC and BR notify PwC in order for the work to start and asked LC report back with the start date for the work. LC confirmed she send a note round to all members. BB proposed we regroup on 2 July, but before if needed.	**ACTION: LC to notify PwC that their bid was successful. LC and BR to proceed with next steps and notify CEOs with the cost review start date.**
13. Close		

OTHER ISSUES TO NOTE
INSERT SLIDE PACK IF AVAILABLE:

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

NEXT MEETING			
Date Time		**Location**	*MS Teams*

WEST YORKSHIRE ASSOCIATION OF ACUTE TRUSTS

Date:	30 July 2024	**Agenda Item:**	9
Meeting:	WYAAT Committee in Common		
Title:	Review of the WYAAT MoU		
Strategy Pillar:	Ways of Working		
Programme	N/A		
Author:	Company Secretaries, WYAAT Trusts Lucy Cole, WYAAT Director		
Presented By:	Lucy Cole, WYAAT Director Jo Bray, Company Secretary LTHT		
Lead Exec:	N/A		
SRO:	N/A		

Purpose of the Report

The purpose of the paper is to outline the proposed updates to the WYAAT Memorandum of Understanding (MoU) based on review by WYAAT Company Secretaries and the WYAAT Director.

Key Points to Note

The WYAAT MoU was co-produced and signed by all WYAAT trusts in 2017. This defined the objectives, scope, and ways of working (through a Committee in Common model) for WYAAT. Further reviews and updates were approved by CIC on 30 July 2019 and 27/07/2021.

Following the development of the WYAAT Strategy (supported by CIC on 30 January 2024) and the Lessons Learned exercise reported to WYAAT CIC on 30 April 2024, a review of the MoU was agreed by WYAAT Programme Executive as required.

The revised document proposes a number of changes to reflect current legislation and operation of WYAAT in light of the approval and publication of the Five Year Strategy and to reflect the learning from the aseptics programme.

The changes were supported by WYAAT Programme Executive at its meeting on 2 July 2024.

Recommendation

WYAAT Committee in Common is recommended to:

- Approve the recommendation for HR Directors and Estates and Facilities Directors to be included in the formal assurance framework as part of Schedule 2 of the MoU.
- Note that approval from CIC will require each trust to update its governing documents.

1

WYAAT incorporates Airedale NHS Foundation Trust, Bradford Teaching Hospitals NHS Foundation Trust, Calderdale and Huddersfield NHS Foundation Trust, Harrogate and District NHS Foundation Trust, Leeds Teaching Hospitals NHS Trust, and Mid Yorkshire Teaching NHS Trust.

Review of the WYAAT Memorandum of Understanding (MoU)
July 2024

1. Purpose

The purpose of the paper is to outline the proposed updates to the WYAAT Memorandum of Understanding (MoU) based on review by WYAAT Company Secretaries and the WYAAT Director.

2. Background

The WYAAT MoU was co-produced and signed by all WYAAT trusts in 2017. This defined the objectives, scope, and ways of working (through a Committee in Common model) for WYAAT. This was reviewed and approved by CIC on 30 July 2019 and further update approved on 27/07/2021 to Schedule 2 which included Chief Information Officers in the assurance framework.

Following the development of the WYAAT Strategy (supported by CIC on 30 January 2024) and the Lessons Learned exercise reported to WYAAT CIC on 30 April 2024, a review of the MoU was agreed by WYAAT Programme Executive as required.

3. Process

The MoU was reviewed by a number of the WYAAT Company Secretaries in conjunction with the WYAAT Director. Updates were made based on the discussion and the revised draft was then reviewed by all WYAAT Company Secretaries. The proposed draft (Appendix 1) is presented for review by WYAAT Programme Executive. Subject to approval of the group, this will be included for review at the WYAAT CIC on 30 July 2024. Subject to support of CIC, each trust will need to update within its governing documents. This will be actioned by the Company Secretary.

4. Proposal

The document proposes the following revisions:

- Made contemporaneous in language reflecting the July 2022 legislation e.g. removal of references to Sustainability and Transformation Partnerships (STPs) in favour of Integrated Care Boards (ICBs) and Integrated Care Partnerships (ICPs).
- Reference to the ‘WYAAT Strategy’ encompassing the development of the strategy, and delivery of the associated priorities and programmes in the annual plan rather than the ‘Collaborative Programme’ terminology in the originally drafted document.
- Updates to Code of Governance referenced in Section 4.1.4 to ensure the most contemporaneous guidance is referenced.
- Clarified reporting through public boards via the Annual Report (Section 6.1.5)
- Removed reference to competition and procurement compliance (section 12). Review of the updated provider licence would deem this section no longer relevant or required.
- Schedule 2 – it is recommended that the assurance framework is updated to include HR Directors and Estates and Facilities Directors’ Groups in the formal governance framework.

- Schedule 2 (Section 6.8) provision to instigate a programme review when it progresses through a stage e.g. from business case approval to implementation, based on aseptics lessons learned review.
- Schedule 5 – CIC Terms of Reference (ToRs) refined in respect of our risk management approach.
- Schedule 5 – inclusion of a provision to which prevents the chairing of two collaboratives simultaneously (Section 5.4)
- Schedule 5 – broaden measures to assess effectiveness in line with committee reviews in trusts / good practice (Section 5.10)
- Schedule 5 – New section (Section 6) on extraordinary meetings based on the learning from the aseptics lessons learned exercise.
- Schedule 6 – updated with ability to communicate notices via email (Section 9).

5. Recommendations

WYAAT Committee in Common is recommended to:

- Approve the recommendation for HR Directors and Estates and Facilities Directors to be included in the formal assurance framework as part of Schedule 2 of the MoU.
- Note that approval from CIC will require each trust to update its governing documents.

WYAAT incorporates Airedale NHS Foundation Trust, Bradford Teaching Hospitals NHS Foundation Trust, Calderdale and Huddersfield NHS Foundation Trust, Harrogate and District NHS Foundation Trust, Leeds Teaching Hospitals NHS Trust, and Mid Yorkshire Teaching NHS Trust.

YORKSHIRE ASSOCIATION OF ACUTE TRUSTS

DATE 30TH JULY 2024

1. AIREDALE NHS FOUNDATION TRUST
2. BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST
3. CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST
4. HARROGATE AND DISTRICT NHS FOUNDATION TRUST
5. LEEDS TEACHING HOSPITALS NHS TRUST
6. MID YORKSHIRE TEACHING NHS TRUST

MEMORANDUM OF UNDERSTANDING FOR WEST YORKSHIRE ASSOCIATION OF ACUTE TRUSTS

8

l Committee in Common 30th July 2019

:ks Solicitors LLP 2016

WEST YORKSHIRE ASSOCIATION OF ACUTE TRUSTS

No	Date	Version Number	Author
1	11/10/16	1-1.4	CB/RM
2	10/11/2016	V2	Co Secs
3	14/11/2016	V3.4	CB/RM/ CG
4	17/11/2016	V3.5	Co Secs
5	5/12/2016	V4	Co Secs
6	5/12/2016	V5	Co Secs
7	6/1/2017	V6	Co Secs
8	02/2017	FINAL	Boards
9	30/07/2019	CiC review	Co Sec
10	30/07/2019	CiC Approved	CiC Members
11	27/07/2021 – schedule 2 only	CiC Approved v2	CiC Members
12	30/07/24	CiC Approved (July 24)	CiC Members

Insert approval date

WEST YORKSHIRE ASSOCIATION OF ACUTE TRUSTS

CONTENTS

Insert approval date

WEST YORKSHIRE ASSOCIATION OF ACUTE TRUSTS

Date: July 2024

This Memorandum of Understanding (**MoU**) is made between:

(1) **AIREDALE NHS FOUNDATION TRUST** of Skipton Road, Keighley, West Yorkshire, BD20 6TD;

(2) **BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST** of Duckworth Lane, Bradford, BD9 6RJ;

(3) **CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST** of Acre Street, Huddersfield, HD3 3EA;

(4) **HARROGATE AND DISTRICT NHS FOUNDATION TRUST** of Lancaster Park Rd, Harrogate, North Yorkshire HG2 7SX;

(5) **LEEDS TEACHING HOSPITALS NHS TRUST** of Great George Street, Leeds, West Yorkshire, LS1 3EX;

(6) **MID YORKSHIRE TEACHING NHS TRUST** of Aberford Road, Wakefield, WF1 4DG; and

(each a "**Party**" and together the "**Parties**").

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RECITALS

I. In entering into and performing their obligations under this MoU, the parties are working towards a collaborative programme incorporating corporate services, clinical support services, and clinical services including ownership and commitment to collaboration as set out in the WYAAT Five Year Strategy (2024 – 2029). In particular, this MoU is intended to support the Parties' on-going work towards the delivery of more efficient acute services for patients in the WYAAT service area.

II. The Parties together form the West Yorkshire Association of Acute Trusts ("**WYAAT**") and have agreed to collaborate to bring together NHS trusts delivering acute hospital services across the WYAAT service area in delivering region-wide efficient and sustainable healthcare for patients. WYAAT will develop and deliver a collaborative approach across acute care providers. The Parties have formed a WYAAT Committee in Common ("**WYAAT CIC**") which has the specific remit of leading the strategic development of WYAAT, setting overall ambition and direction to deliver the WYAAT Strategy and programmes and initiatives for an acute provider transformation to a more collaborative model of care for the WYAAT service area, the intention being to deliver a system model, operating as a network, that is coherent, integrated, consistent (reducing unwanted variation) and focused on quality and value for the population and patients (the "**WYAAT Strategy**").

Insert approval date

III. This MoU is focused on the Parties' agreement to develop the detail in relation to the function and scope of the WYAAT CIC; developing the principles that will underpin collaborative working and the timetable for implementation in order to tackle a number of significant operational, clinical and financial challenges for acute services in the WYAAT service area.

OPERATIVE PROVISIONS

1. **DEFINITIONS AND INTERPRETATION**

1.1 In this MoU, capitalised words and expressions shall have the meanings given to them in this MoU.

1.2 In this MoU, unless the context requires otherwise, the following rules of construction shall apply:

1.2.1 a reference to a "**Party**" is a reference to the organisations party to this MoU and includes its personal representatives, successors or permitted assigns and a reference to "**Parties**" is a reference to all parties to this MoU;

1.2.2 a reference to writing or written includes faxes and e-mails.

2. PURPOSE AND EFFECT OF MOU

2.1 The Parties have agreed to work together on behalf of patients and the population to deliver the best possible experience and outcomes within the available resources for corporate and acute services across the WYAAT service area. The aim is for the Parties to organise themselves around the needs of the West Yorkshire and Harrogate population rather than planning at an individual organisational level so as to deliver more integrated, high quality cost effective care for patients as detailed in Schedule 1. The Parties wish to record the basis on which they will collaborate with each other through the WYAAT in this MoU.

2.2 This MoU sets out:

2.2.1 the key objectives for the development of WYAAT;

2.2.2 the principles of collaboration;

2.2.3 the governance structures the Parties will put in place; and

2.2.4 the respective roles and responsibilities the Parties will have during the development and delivery of the collaboration model.

2.3 The Parties agree that, notwithstanding the good faith consideration that each Party has afforded the terms set out in this MoU, save as provided in paragraph 2.4 below, this MoU shall not be legally binding.

2.4 Paragraphs 17, 19 and 20 shall come into force from the date hereof and shall give rise to legally binding commitments between the Parties.

2.5 Included as Schedules 6-8 to the MoU are agreements on the management of relationships for confidentiality (legally binding), conflicts of interest and sharing of information in line with competition law between the Parties.

3. KEY PRINCIPLES

3.1 The Parties shall undertake the development and delivery of the WYAAT Strategy in line with the Key Principles as set out in Schedule 1 (the "**Key Principles**").

3.2 The Parties acknowledge the current position with regard to the WYAAT and the contributions, financial and otherwise, already made by the Parties.

4. PRINCIPLES OF COLLABORATION

4.1 The Parties agree to adopt the following principles when carrying out the development and delivery of the WYAAT Strategy (the "**Principles of Collaboration**"):

4.1.1 address the vision. In developing WYAAT the Parties seek to establish a model of collaborative care and corporate services across a network of acute hospital trusts that are focused on the delivery of high quality, sustainable acute care for the population, enabled by integrated solutions and delivering best value for the taxpayer and operating a financially sustainable system;

4.1.2 collaborate and co-operate. Establish and adhere to the governance structure set out in this MoU to ensure that activities are delivered and actions taken as required to deliver change collectively and in partnership with each other and the wider NHS ;

4.1.3 be accountable. Take on, manage and account to each other, the wider NHS and the WYAAT service area population for performance of the respective roles and responsibilities set out in this MoU;

4.1.4 be open and transparent and act with integrity. Communicate openly with each other about major concerns, issues or opportunities relating to WYAAT and comply with the seven Principles of Public Life established by the Nolan Committee (the Nolan Principles) and the Code of Governance of NHS England (April 2024) including implementing a transparent and explicit approach to the declaration and handling of relevant and material conflicts of interests arising.

4.1.5 adhere to statutory requirements and best practice. Comply with applicable laws and standards including procurement rules, competition law, data protection and freedom of information legislation;

4.1.6 act in a timely manner. Recognise the time-critical nature of the WYAAT Collaborative Programme development and delivery and respond accordingly to requests for support;

4.1.7 manage stakeholders effectively. Ensure communication and engagement both internally and externally is clear, coherent, consistent and credible and in line with

the Parties' statutory duties, values and objectives.

4.1.8 deploy appropriate resources. Ensure sufficient and appropriately qualified resources are available and authorised to fulfil the responsibilities set out in this MoU; and

4.1.9 act in good faith to support achievement of the Key Principles and in compliance with these Principles of Collaboration.

5. GOVERNANCE

5.1 The governance structure summarised below of this MoU provides a structure for the development and delivery of the WYAAT Strategy.

5.2 The governance arrangements will be:

5.2.1 based on the principle that decisions will be taken by the relevant organisations at the most appropriate level in accordance with each organisation's internal governance arrangements (as defined by each trust's Constitution, Standing Orders, Standing Financial Instructions and Scheme of Delegation), particularly in respect of delegated authority;

5.2.2 shaped by the Parties in accordance with existing accountability arrangements, whilst recognising that different ways of working will be required to deliver the transformational ambitions of the WYAAT Collaborative Programme. The Parties intend that there should be as far as permissible a single governance structure to help oversee and deliver the WYAAT Collaborative Programme in accordance with the Key Principles; and

5.2.3 underpinned by the following principles:

i. the Parties will remain subject to the NHS Constitution, compliance with regulatory bodies and their provider licence (Code of Governance) and retain their statutory functions and their existing accountabilities for current services resources and funding flows; and

ii. clear agreements will be in place between the providers to underpin the governance arrangements.

6. ACCOUNTABILITY AND REPORTING LINES

Accountability and reporting should be undertaken at the following levels within WYAAT:

6.1 WYAAT Committee in Common ("WYAAT CIC")

The WYAAT CIC will receive reports at each meeting from the Programme Executive highlighting but not limited to:

6.1.1 progress throughout the period;

6.1.2 decisions required by the WYAAT CIC and their recommendation to respective Trust Boards for approval;

6.1.3 issues being managed;

6.1.4 issues requiring escalation to the WYAAT CIC; and

6.1.5 progress planned for the next period.

Under a standing agenda item, WYAAT CIC will agree the key communications arising from its meetings that should be relayed to the Parties' respective organisations. The minutes, and a summary report from the WYAAT Director will be circulated promptly to all WYAAT CIC Members as soon as reasonably practical for inclusion on the private agenda of each Parties' Board meeting. The WYAAT Director will provide an Annual Report summarising achievements of WYAAT for the preceding financial year which, following approval from WYAAT CIC, will be published in the public domain.

6.2 WYAAT Programme Executive

The WYAAT CIC will hold each of the Parties' Chief Executive to account for the delivery of their sponsored workstreams within the WYAAT Strategy via the WYAAT Programme Executive.

7. ROLES AND RESPONSIBILITIES

The Parties shall undertake the roles and responsibilities set out in this MoU to help develop the WYAAT Strategy in line with the Key Principles

7.1 WYAAT Committee in Common

7.1.1 The WYAAT CIC comprises senior members of the Parties and defines the strategy and holds accountability for its delivery, alongside providing overall oversight and direction to the development of WYAAT . It is chaired by existing Chairs of the Parties, on a rotational basis, as underpinned by principles of continuity and equity collectively agreed by members, for a minimum duration of six months or three meetings, whichever is the lesser.

7.1.2 The WYAAT CIC shall be managed in accordance with the governance arrangements in section 5 and the Terms of Reference in Schedule 5.

7.2 WYAAT Programme Executive

7.2.1 The WYAAT Programme Executive will provide assurance to the WYAAT CIC that the key deliverables are being met and that the development of the WYAAT Strategy is within the boundaries set by the WYAAT CIC. It will provide management at programme and workstream level.

8. DECISION MAKING

8.1 The Parties intend that WYAAT CIC Members will each operate under a common model scheme of delegation whereby each WYAAT CIC Member shall have delegated authority to make decisions on behalf of their organisation relating to:

8.1.1 matters falling under the scope of the WYAAT CIC and agreed collaborative

programme underpinned by 'case for change';

8.1.2 the devolving of the Key Principles set out in Schedule 1; and,

8.1.3 in accordance with the WYAAT Gateway Decision Making Framework set out in Schedule 4 on behalf of their respective organisations.

8.2 Each party will reflect in its Standing Orders, Standing Financial Instructions and scheme of Delegation the authority delegated to its representatives on the WYAAT CIC.

8.3 The Parties intend that WYAAT CIC Members shall report to and consult with their own respective organisations at Board level, (noting that decisions on recommendations made by the CIC will always be made by the Boards of Member Trusts) providing the governance assurance that ensures compliance with their regulatory and audit requirements, for organisational decisions relating to, and in support of, the WYAAT Key Principles and facilitating these functions in a timely manner.

9. ESCALATION

9.1 If any Party has any issues, concerns, or complaints regarding the WYAAT Strategy, or any matter in this MoU, such Party shall notify the other Parties and the Parties acknowledge and confirm that they shall then seek to resolve the issue by a process of discussion.

9.2 Subject as otherwise specifically provided for in this MoU, any dispute arising between the Parties out of or in connection with this MoU will be resolved in accordance with Schedule 3 (Dispute Resolution Procedure).

9.3 If any Party receives any formal or media enquiry, complaint, claim or threat of action from a third party (including, but not limited to, claims made by a supplier or requests for information made under the Freedom of Information Act 2000) in relation to the development of the WYAAT, the matter shall be promptly referred to the WYAAT Director in the interests of consistency, however recognising the request remains the responsibility of the receiving organisation.

10. CONFLICTS OF INTEREST

10.1 The Parties agree that they will:

10.1.1 disclose to each other the full particulars of any relevant or material conflict of interest which arises or may arise in connection with this MoU, the development of the collaboration model or the performance of activities under the WYAAT Strategy, immediately upon becoming aware of the conflict of interest whether that conflict concerns the Parties or any person employed or retained by the Parties for or in connection with the development and delivery of the WYAAT Strategy; and

10.1.2 not allow themselves to be placed in a position of conflict of interest or duty in regard to any of their rights or obligations under this MoU (without the prior consent of the other Parties) before participating in any action in respect of that matter.

10.1.3 comply with the terms of any agreed conflict of interest protocol as set out in paragraph 2.5 above.

11. FUTURE INVOLVEMENT AND ADDITION OF PARTIES

The Parties are the initial participating organisations in the development of the WYAAT Strategy but it is intended that other providers to the WYAAT service area population may also come to be partners (including for example independent sector and third sector providers). Partner organisations may where appropriate be invited to meetings of the WYAAT CIC as observers or through an additional stakeholders forum. If appropriate to achieve the key deliverables, the Parties may also agree to include additional party or parties to this MoU. If they agree on such a course the Parties will cooperate to enter into the necessary documentation.

12. REVIEW

12.1 The WYAAT CIC shall discuss and agree as a minimum:
- 12.1.1 the principles of collaboration;
- 12.1.2 the governance arrangements as set out in Section 5;
- 12.1.3 the scope of the WYAAT Strategy and individual workstreams;
- 12.1.4 the progress against the key deliverables; and
- 12.1.5 key decisions required in support of Schedule 4.

13. TERM AND TERMINATION

13.1 This MoU shall commence on 2 February 2017 (having been executed by all the Parties) and shall expire on termination as outlined in section 14.2 of this MoU.

13.2 This MoU may be terminated in whole by:
- 13.2.1 mutual agreement in writing by all of the parties
- 13.2.2 in accordance with Clause 15.2; or
- 13.2.3 in accordance with paragraph 1.5) of schedule 3.

13.3 Any Party may withdraw from this MoU giving at least six calendar months' notice in writing to the other Parties. The MoU will remain in force between the remaining parties (unless otherwise agreed in writing between all the remaining parties) and the remaining Parties will agree such amendments required to the MoU in accordance with Clause 16.

13.4 In the event a Party is put into administration, special measures and/or is otherwise not able to perform its role under the WYAAT Strategy and this MoU, the remaining Parties shall be entitled to consider and enforce, on a case by case basis, a resolution of the WYAAT CIC for the removal of the relevant Party from the MoU on a majority basis provided that:
- 13.4.1 reasonable notice shall have been given of the proposed resolution; and
- 13.4.2 the affected Party is first given the opportunity to address the WYAAT CIC meeting at which the resolution is proposed if it wishes to do so.

13.5 This MoU shall be terminated in accordance with the provision at 14.2.

Insert approval date

14. CHANGE OF LAW

14.1 The Parties shall take all steps necessary to ensure that their obligations under this MoU are delivered in accordance with applicable law. If, as a result of change in applicable law, the Parties are prevented from performing their obligations under this MoU but would be able to proceed if a variation were made to the MoU, then the Parties shall consider this in accordance with the variation provision at paragraph 16.

14.2 In the event that that the Parties are prevented from performing their obligations under this MoU as a result of a change in applicable law and this cannot be remedied by a variation or a variation is not agreed by all Parties, then the Parties shall agree to terminate this MoU on immediate effect of the change in applicable law.

15. VARIATION

This MoU may only be varied by written agreement of the Parties signed by, or on behalf of, each of the Parties.

16. CHARGES AND LIABILITIES

16.1 Except as otherwise provided, the Parties shall each bear their own costs and expenses incurred in complying with their obligations under this MoU, including in respect of any losses or liabilities incurred due to their own or their employee's actions.

16.2 No Party intends that any other Party shall be liable for any loss it suffers as a result of this MoU.

17. NO PARTNERSHIP

Nothing in this MoU is intended to, or shall be deemed to, establish any partnership or joint venture between the Parties, constitute any Party as the agent of another Party, nor authorise any of the Parties to make or enter into any commitments for or on behalf of the other Parties.

18. COUNTERPARTS

18.1 This MoU may be executed in any number of counterparts, each of which when executed and delivered shall constitute an original of this MoU, but all the counterparts shall together constitute the same agreement.

Insert approval date

18.2 The expression “counterpart” shall include any executed copy of this MoU transmitted by fax or scanned into printable PDF, JPEG, or other agreed digital format and transmitted as an e-mail attachment.

18.3 No counterpart shall be effective until each Party has executed at least one counterpart.

19. GOVERNING LAW AND JURISDICTION

This MoU shall be governed by and construed in accordance with English law and, without affecting the escalation procedure set out in paragraph 9 above, each Party agrees to submit to the exclusive jurisdiction of the courts of England.

Insert approval date

WEST YORKSHIRE ASSOCIATION OF ACUTE TRUSTS

We have signed this Memorandum of Understanding on the date written at the head of this memorandum.

SIGNED by) .....

Duly authorised to sign for and on) Authorised Signatory

behalf of) Title:

AIREDALE NHS FOUNDATION TRUST) DATE:

SIGNED by) .....

Duly authorised to sign for and on) Authorised Signatory

behalf of) Title:

BRADFORD TEACHING HOSPITALS)

NHS FOUNDATION TRUST) DATE:

SIGNED by) .....

Duly authorised to sign for and on) Authorised Signatory

behalf of) Title:

CALDERDALE AND HUDDERSFIELD)

NHS FOUNDATION TRUST) DATE:

Insert approval date

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WEST YORKSHIRE ASSOCIATION OF ACUTE TRUSTS

SIGNED by	)	.....
Duly authorised to sign for and on	)	Authorised Signatory
behalf of	)	Title:
HARROGATE AND DISTRICT NHS FOUNDATION TRUST	)	DATE:

SIGNED by	)	.....
Duly authorised to sign for and on	)	Authorised Signatory
behalf of	)	Title:
LEEDS TEACHING HOSPITALS NHS TRUST	)	DATE:

SIGNED by	)	.....
Duly authorised to sign for and on	)	Authorised Signatory
behalf of	)	Title:
MID YORKSHIRE TEACHING NHS TRUST	)	DATE:

Approved by those present at the meeting on 30 July 2024. Linda Pollard, Chair LTHT
Phil Wood, CEO LTHT
Sarah Armstrong, Chair, HDFT
Jonathan Coulter, CEO, HDFT
Andrew Gold, Chair, ANHSFT
'Foluke Ajayi, CEO, ANHSFT
Brendan Brown, CEO, CHFT
Helen Hirst, Chair, CHFT
Sarah Jones, Chair, BTHFT
Mel Pickup, CEO, BTHFT
Keith Ramsay, Chair, MYTT

Insert approval date

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WEST YORKSHIRE ASSOCIATION OF ACUTE TRUSTS

Len Richards, CEO, MYTT

Insert approval date

SCHEDULE 1 THE KEY PRINCIPLES

1. Significant financial pressures within the WYAAT service area health system, linked to increasing service demand, longer life and medical advances, require a different approach to the delivery of good health and well-being for the population of West Yorkshire and Harrogate (WYH).
2. There are significant variations in the current corporate and acute care system ranging from, for example average unit cost for trauma and orthopaedic day case activity and use of differing national providers for pathology services to differing workforce staffing solutions.
3. Through the WYAAT Strategy, the Parties' Key Principles are to achieve a sustainable, safe, high quality and cost effective acute care system across WYH, based on clear integrated and standardised models, networks and alternative service delivery models where risk and benefits will be collectively managed. This will be achieved through addressing the following:
   - 3.1 Achieving clinical and financial stability across the WYAAT service area health system
   - 3.2 Enhancing partnership working between providers, leading to interdependency, care delivered by stream or pathway rather than by individual organisations and by collective provider responsibility
   - 3.3 A five step approach to collaboration which will deliver the following objectives:
     - 3.3.1 Developing a 'centres of excellence' approach to higher acuity specialties e.g. hyper-acute stroke, neurology, cancer, vascular, Ear Nose and Throat (ENT), maxillofacial surgery, eliminating avoidable cost of duplication and driving standardisation
     - 3.3.2 Developing WYH standardised operating procedures and pathways across services, building on current best practice and using Getting it Right First Time (GIRFT) and Model Health System data to drive out variations in quality as well as operational efficiency and facilitating safer free movement of bank staff across providers.
     - 3.3.3 Collaborating to develop clinical networks and creating alliances as a vehicle (e.g. hyper acute stroke, cancer etc.) which will protect local access for patients whilst consolidating skills (and therefore resilience) and reducing operational cost of duplicated facilities. Using GIRFT, Model Hospital, outcome variation data and WYAAT work on sustainable services to identify the case for change for specific services, the model being based on the 'chain' concept.
     - 3.3.4 Developing workforce planning at scale to secure the pipeline of fit for

purpose staff and improved productivity, managing workforce risk at system level and supporting free movement of bank and agency staff with the aim of reducing spend on agency and reduce the administration costs of the flexible workforce.

3.3.5 Delivering economies of scale in support functions such as procurement, pathology services, estates and facilities management and other infrastructure e.g. IT.

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SCHEDULE 2 GOVERNANCE FRAMEWORK

1. INTRODUCTION

The purpose of the West Yorkshire Association of Acute Trusts (WYAAT), as set out in the Memorandum of Understanding (MoU), is for the trusts to work together on behalf of patients and the population to deliver the best possible experience and outcomes within the available resources for corporate and acute services across the WYAAT service area. The aim is to organise around the needs of the West Yorkshire and Harrogate (WYH) population rather than planning at individual organisational level so as to deliver more integrated, high quality, cost effective care for patients.

2. PURPOSE

The purpose of this Schedule to the MoU is to provide a Governance Framework for the WYAAT Strategy. It provides a systematic approach to the initiation and management of the Strategy.

3. OBJECTIVES OF THE WYAAT COLLABORATIVE PROGRAMME

WYAAT's objectives are set out in Schedule 1 to the MOU.

The purpose of the WYAAT Strategy is to deliver these objectives in order to deliver more integrated, high quality, cost effective care for patients across the WYAAT service area. WYAAT programmes will design services across multiple organisations, consider innovative, collaborative models of care to improve collective outcomes and performance and make collective efficiencies.

4. WYAAT STRATEGY DRIVERS

The WYAAT Strategy will be a portfolio of individual programmes covering clinical services, clinical support services and corporate services. Its priorities will be generated from a range of external and internal drivers including:

- National NHS strategies, priorities and programmes e.g. NHS Long Term Plan, The Long Term Workforce Plan, NHS Delivery plan for tackling the Covid-19 backlog of care, The NHS Patient Safety Strategy
- WY Integrated Care Board and Partnership strategies, priorities and workstreams
- NHS E Operational Planning guidance and process
- WYAAT clinical, operational, and financial sustainability priorities
- WYAAT baseline analysis of variation

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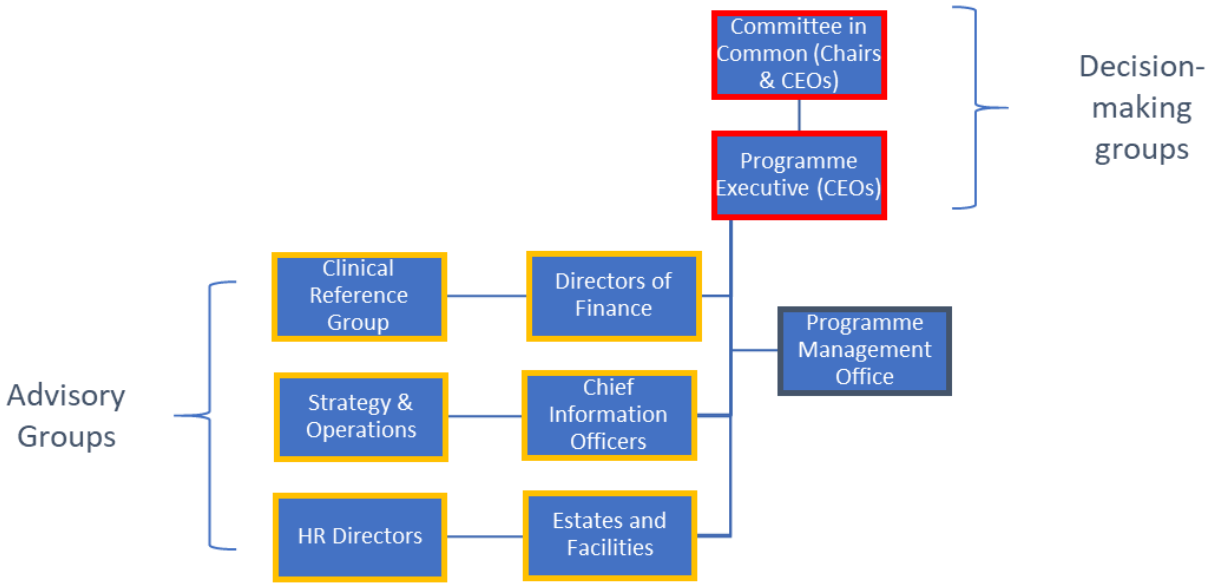
5. GOVERNANCE STRUCTURE

The WYAAT MoU establishes the Committee in Common (CIC) and the Programme Executive. This Schedule establishes the governance structure below to support the CIC and Programme Executive.



5.1. Committee in Common.

5.1.1 The role and terms of reference of the CIC are set out in the main WYAAT MOU and Schedule 5 (CIC Terms of Reference) as providing strategic oversight and direction to the WYAAT Strategy. The CIC oversees delivery of the programmes, reviewing key deliverables, ensuring adherence to timescales and receiving assurance that risks are being managed.

5.1.2 The CIC consists of the Chairs and Chief Executives of the WYAAT trusts. It meets quarterly, or more frequently if required, and is chaired by one of the trust chairs for the lesser of six months or three meetings. The WYAAT Programme Director and the Company Secretary of the trust holding the Chair also attend the meetings.

5.1.3 As set out in the MoU and CIC Terms of Reference, members of the CIC shall only exercise the functions and powers of a party to the extent that they are actually permitted to ordinarily exercise such functions and powers under that party's internal governance. Members are expected to report to and consult

with their own organisation at Board level, providing governance assurance that is compliant with their regulatory and audit requirements.

5.1.4 The CIC has no delegated powers from the trusts beyond those already held by its members under their organisation's Constitution, Standing Orders, Standing Financial Instructions and Scheme of Delegation. In practice this means that decisions on gateway approvals for WYAAT programmes (see section 7 below) will usually be made by trust boards (or another appropriate board sub-committee in line with each trust's governance) based on a recommendation from the CIC.

5.2. Programme Executive.

5.2.1 The role of the Programme Executive is to oversee the delivery of the WYAAT Collaborative Portfolio, holding to account the Senior Responsible Owners and Executive leads for delivery of their WYAAT programme and receiving assurance that risks associated with delivery of programmes are being identified, mitigated and managed. The members of the group are the Chief Executives of the constituent trusts and the WYAAT Programme Director (non-voting). Meetings are held on a monthly basis.

5.2.2 In a similar way to the CIC, members of the group can only exercise functions and powers to the extent that they ordinarily exercise these under the governance arrangements of their employing trust.

5.3. Advisory Groups (Clinical Reference Group, Directors of Finance Group, Strategy & Operations Group, Chief Information Officers Group).

5.3.1 The Advisory Groups provide advice and assurance to the Programme Executive and CIC at gateway approval stages. They are responsible for reviewing strategic outline cases and business cases from the following perspectives and making a recommendation whether the case should be recommended to the CIC for approval by the trusts:

Group	Assurance Perspective & Considerations
Clinical Reference Group	**Quality** Clinical effectiveness and outcomes Patient safety Patient experience Clinical governance Ensuring a robust Quality Impact Assessment has been completed Ensuring a robust Equality Impact Assessment has been completed Workforce implications

Group	Assurance Perspective & Considerations
Directors of Finance Group	**Financial Sustainability** Financial benefits and costs Capital requirements Commercial, contractual, legal, tax risks and implications Financial governance
Strategy & Operations Group	**Operations & Performance** Alignment with national, ICS, place and organisational strategies Public, commissioner, system engagement and communications Operational benefits and risks Implications for performance against NHS Constitutional Standards and other performance measures Workforce implications
Chief Information Officers Group	**Information Management and Technology** Alignment with national, ICS, place and organisational IM&T strategies Cyber security Capacity and compatibility of trust IM&T infrastructure with new systems IM&T implementation, capacity and costs
Human Resources Directors Group	**Workforce** Alignment with national, ICS, place and organisational workforce strategies Workforce implications Workforce implementation, capacity and costs
Estates and Facilities Directors Group	**Estates and facilities** Alignment with national, ICS, place and organisational infrastructure strategies Infrastructure and capital requirements Estates and facilities implementation, capacity and costs

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5.4. Programme Governance.

5.4.1 Each programme is led by one of the Chief Executives as Senior Responsible Owner (SRO). As a minimum each programme will also have a lead Executive Director (often a Strategy Director or Chief Operating Officer), a lead Medical Director and lead Finance Director.

5.4.2 Each programme will establish a steering group/board which meets on a regular basis. It will be chaired by the lead Executive Director and will include other lead directors and senior leaders from all participating trusts. Following approval of the Strategic Outline Case, most programmes will establish a formal programme

board, often at executive level, with representatives from all trusts and from a range of disciplines (e.g. Chief Nurse, HRD, CIO, Estates Director). Members are responsible for contributing to the successful delivery of the programme and for communicating key messages and issues to their respective organisation and feeding back any responses in return.

5.4.3 Programmes will be supported by programme and project management capacity. Initially this may be from existing resources within the WYAAT PMO, prioritised by the Programme Director, but as the programme develops dedicated resources will be provided as agreed by either the Programme Executive or CIC. The programme manager is responsible for the creation and maintenance of the: milestone plan, benefits log, risk register, quality and equality impact assessments. Each month they will produce a Highlight Report covering key activities in the month and those planned for the next; current and planned milestones; risks and issues including those requiring escalation; and benefits tracking. They are also responsible for managing the change control process.

5.4.4 Programme steering groups or programme boards are responsible for delivery of the programme across all trusts. They must ensure good trust engagement and commitment to delivery of agreed activities and integration into 'business as usual' arrangements on completion and have authority to manage the programme within the bounds of time, cost and quality agreed by the Programme Executive or CIC. Changes to the programme which exceed the agreed bounds must be escalated to the Programme Executive and, if necessary, the CIC.

6. ASSURANCE

Assurance on the progress of the Strategy overall and its constituent programmes is provided by the following:

6.1. **SRO/Programme Board/Programme Leads**. The CIC, Programme Executive and the advisory groups are able to hold the leadership of each programme to account for its delivery. They can also hold the Programme Director to account for oversight of the Strategy overall.

6.2. **Strategy Milestone Plan**. Setting out overall timescales and gateway approvals. Maintained by the WYAAT PMO on behalf of the Programme Director. Provided to the Programme Executive monthly and to the CIC quarterly.

6.3. **Strategy Risk Register**. Capturing the most significant risks on individual programmes and also common risks to multiple programmes which create a significant risk to the Strategy overall. Maintained by the WYAAT PMO on behalf of the Programme Director. Provided to the Programme Executive monthly and to the CIC quarterly.

6.4. **Benefits Map**. Shows how the outputs of the projects and programmes will lead to benefits for patients and the population of WYH. At the initial stages of programmes, the

outputs and benefits will be broadly described, but they will be more tightly defined and quantified as the programme develops through to full business case and into implementation. Maintained by the WYAAT PMO on behalf of the Programme Director. Provided to the Programme Executive monthly and to the CIC quarterly.

6.5. **Individual Programme Highlight Reports**. A monthly report describing progress, actions completed and planned milestones, risks and benefits for each programme. Maintained by each programme manager on behalf of the programme board and SRO. Provided to the Programme Executive monthly and to the CIC quarterly.

6.6. **Programme Brief and Programme Initiation Document**. These documents, approved by the Programme Director and Programme Executive respectively, ensure that new programmes are only initiated where they are in line with WYAAT's objectives and strategy, and there is a clear description of the scope of any further work to define the programme and the resources required.

6.7. **Gateway Approvals of Strategic Outline Cases & Business Cases**. Formal approval is required at each gateway to enable the project or programme to continue and to be provided with the necessary resources for the next stage. The case should be signed off by the programme board and SRO for review by the advisory groups. The advisory groups provide advice to the Programme Executive on any issues with the case and make a recommendation whether it should be recommended to the CIC. Where appropriate, for instance programmes which require DHSC or HM Treasury approval, external assurance and review of cases will also be undertaken. The Programme Executive makes a recommendation to the CIC and the CIC decides whether to recommend to trust boards that the case should be approved. If the case is not approved the programme would be closed down.

6.8. **Programme Reviews**. The CIC, Programme Executive or advisory groups may require programme SROs and programme boards to complete and provide a formal programme review at any time. A programme review will be instigated when a programme enters a new stage e.g. from business case to implementation to ensure the governance, leadership and resources are aligned to the required objectives of the subsequent phase.

6.9. **Annual Report**. While the primary purpose of the WYAAT Annual Report is to provide trust boards and other stakeholders with an annual update on the Strategy delivery, it also provides assurance to the CIC and Programme Executive about the overall progress of WYAAT and the delivery of the strategy. It is formally approved by the CIC each year and published in the public domain.

6.10. **WYAAT PMO**. The PMO is responsible for ensuring the adoption of a systematic programme approach aimed at maximising delivery. This includes identifying any interdependencies and integrating activities across different programmes and projects to avoid duplication. It maintains a milestone plan, risk register and benefits map for the overall Strategy and manages a programme assurance process to ensure all programmes are robustly established and managed. It is led by the WYAAT Programme Director who, along with the Finance Lead and Clinical Lead, is responsible for the

governance, coordination and alignment of programmes with the overall WYAAT objectives. The WYAAT Director is accountable to the Chair of the Programme Executive.

7. PROGRAMME LIFECYCLE

Each programme will follow a four stage programme lifecycle set out below. At each stage of the lifecycle there should be appropriate:

- Clinical and staff engagement and involvement (e.g. facilitated workshops)
- Patient, public, political (e.g. MPs, Overview and Scrutiny Committees, Health and Wellbeing Boards) and commissioner engagement and involvement
- Governor engagement
- External scrutiny (e.g. Clinical Senate, NHS England)
- Use of systematic, evidence based, quality improvement and change models
- Quality and equality impact assessment
- Use of a transparent options appraisal process

Stage	Description	Decision making
Initiation	**Programme Brief.** Short description of the opportunity, the rationale for it being a collaborative project, the approach that could be taken and a programme preparation plan.	WYAAT Director
	Programme Initiation Document. Description of the project: rationale, purpose and objectives, scope, desired outcomes and benefits, approach, estimated timescales and required resources. Includes initial quality and equality impact assessments.	Programme Executive
Planning	**Strategic Outline Case** Description of services, the challenges facing them, sets out the opportunity and potential benefits from changing the existing operating model. Includes quality and equality impact assessments, costs and resource estimates for developing the new operating model and the business case, likely return on investment, contribution from each trust and outline risk/gain share arrangements. Sets out the proposed governance arrangements and evaluation framework. A single Strategic Outline Case will always be completed for the whole programme.	Committee in Common **Gateway 1** CIC makes recommendation to trusts to approve the SOC and confirm their commitment to developing the OBC.

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	Outline Business Case(s) Sets out the future operating model and the ways in which it could be delivered. Refines the quality and equality impact assessments, benefits, costs and timescales. Evaluates a range of options and recommends selection of the preferred option. Depending on the programme, there may be a single OBC for the whole programme, or there may be a number of project OBCs. Recommendations to trusts on approval of smaller, less complex project OBCs may be delegated by the CIC to the Programme Executive.	Committee in Common: **Gateway 2** CIC makes recommendation to trusts to approve the OBC and to confirm their support for the preferred option and their continuing participation to develop the FBC.

Stage	Description	Decision making
	Full Business case(s). A detailed description of the proposed model and associated benefits, costs and risks. Full quality and equality impact assessments. Financial and non- financial appraisal for each trust and for WYAAT in total. Sets out the investment profile, implementation plan and benefits realisation plan, including its constituent projects, activities, timescales and accountability for implementing the new model. As for the OBC there may be a single FBC for the whole programme, or a number of project FBCs.	Committee in Common: **Gateway 3** CIC makes recommendation to trusts to approve the FBC and to confirm their support for implementation and any formal agreements/ contracts required.
Implementation	**Implementation Plan** All projects and activities required to implement the programme and realise the benefits are initiated. Regular monitoring and management of progress by the Programme Board; reporting of costs and benefits; maintenance of risk register; and review and updating of quality and equality impact assessment. Includes the management of the formal change control process. Regular reports on progress to the Programme Executive and CIC.	Programme Board within delegated limits. Programme Executive or CIC where changes to the programme exceed the delegated limits.
Post implementation Evaluation	**Programme Closure Report** Once the programme has completed implementation of its constituent projects a recommendation will be made to close the programme. The report will evaluate whether the programme has delivered the outputs expected and whether these have led to the outcomes and benefits required (NB some benefits may remain to be realised by operational teams after programme closure). The report will also include a review of how effectively the programme was managed and what lessons can be learned for future programmes.	Committee in Common **Gateway 4** CIC make recommendation to trusts to approve closure of the programme.

8. RISK AND GAIN SHARING PRINCIPLES

8.1. Some WYAAT programmes (or their constituent projects) will have the potential to disproportionately benefit some participating WYAAT organisations at the expense of others. The Strategic Outline Case will set out the potential impact of the implementation of a programme or project and will describe the 'risk and gain share' model between the WYAAT members affected by the programme or project, in preparation for selection of the preferred option in the OBC. The model will be tailored

to each programme or project and will be designed on the following principles reflecting that organisations are working for the delivery of better care and a more sustainable system for patients in the WYAAT service area:

8.1.1 Any losses made by a WYAAT member as a direct result of the implementation of a programme or project will be reimbursed by the other affected members.

8.1.2 The costs of implementing the programme or project will be met by the participating WYAAT members in the proportions set out in the FBC and agreed at Gateway 3.

8.1.3 The net financial benefits of the programme or project will be allocated to member trusts on a “fair shares” basis with the precise method being tailored to the programme or project. The method will be set out in the FBC and agreed at Gateway

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SCHEDULE 4 - DISPUTE RESOLUTION PROCEDURE

4. **AVOIDING AND SOLVING DISPUTES**

1.1 The Parties commit to working co-operatively to identify and resolve issues to their mutual satisfaction so as to avoid all forms of dispute or conflict in performing their obligations under this MoU.

1.2 The Parties believe that:

1.2.1 by focusing on the agreed Key Principles underpinned by the five step approach as set out in the MoU and in Schedule 1;

1.2.2 being collectively responsible for all risks; and

1.2.3 fairly sharing risk and rewards.

they reinforce their commitment to avoiding disputes and conflicts arising out of or in connection with this MoU.

1.3 A Party shall promptly notify the other Parties of any dispute or claim or any potential dispute or claim in relation to this MoU or its operation (each a '**Dispute**') when it arises.

1.4 In the first instance the WYAAT Programme Executive shall seek to resolve any Dispute to the mutual satisfaction of each of the Parties. If the Dispute cannot be resolved by the WYAAT Programme Executive within ten Business Days (a **Business Day** being a day other than a Saturday, Sunday or public holiday in England when banks in London are open for business) of the Dispute being referred to it, the Dispute shall be referred to the WYAAT CIC for resolution.

1.5 The WYAAT CIC shall deal proactively with any Dispute on a "Best for Meeting the Key Principles" basis in accordance with this MoU so as to seek to reach a majority decision. If the WYAAT CIC reaches a decision that resolves, or otherwise concludes a Dispute, it will advise the Parties of its decision by written notice. The Parties recognise that any dispute or operation of this procedure will be without prejudice to and will not affect the statutory duties of each Party. This MoU is not intended to be legally binding save as provided in clause 2.4 and, given the status of this MoU (as set out in Section 2), if a Party disagrees with a decision of the WYAAT CIC or the independent facilitator, they may withdraw from the MoU at any point in accordance with paragraph 14.

1.6 If a Party does not agree with the decision of the WYAAT CIC reached in accordance with Section 4 above, it shall inform the WYAAT CIC within ten Business Days and request that the WYAAT CIC refer the Dispute to an independent facilitator in accordance with paragraph 2 below.

1.7 The Parties agree that the WYAAT CIC, on a 'Best for Meeting the Key Principles' basis, may determine whatever action it believes is necessary including the following:

1.7.1 If the WYAAT CIC cannot resolve a Dispute, it may request that an independent facilitator) assist with resolving the Dispute; and

1.7.2 If an independent facilitator is selected then they shall:

i. be provided with any information he or she requests about the Dispute;

ii. assist the WYAAT CIC to work towards a consensus decision in respect

of the Dispute;

iii. regulate his or her own procedure and, subject to the terms of this MoU, the procedure of the WYAAT CIC at such discussions;

iv. determine the number of facilitated discussions which must take place within 20 Business Days of the independent facilitator being appointed; and

v. have its costs and disbursements met by the Parties.

1.7.3 If the independent facilitator cannot facilitate the resolution of the Dispute, the Dispute must be considered afresh in accordance with this Schedule and in the event that after such further consideration again fails to resolve the Dispute, the WYAAT CIC may decide to:

i. terminate the MoU; or

ii. agree that the Dispute need not be resolved.

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SCHEDULE 4 WYAAT DECISION MAKING

1. The Memorandum of Understanding (**MoU**) and Terms of Reference (**TOR**) for the WYAAT Committee in Common (**WYAAT CIC**) take into consideration existing accountability arrangements of participating trusts and decisions being made under a scheme of delegation.

2. Whilst it is recognised that some decisions taken at the WYAAT CIC may not be of obvious benefit to all individual participating trusts, it is anticipated that the WYAAT CIC will look to act in the basis of the best interests of the wider population by investing in a sustainable system of healthcare across the WYAAT service area in accordance with the Key Principles when making decisions at WYAAT CIC meetings.

3. There are expected to be two categories of decision making:
   - 3.1 **Mandatory Participation Decisions**. All affected WYAAT members need to participate in the initiative for reasons of interdependency, safety or financial viability. These decisions will be made on the basis of all WYAAT members reaching an agreed decision in common.
   - 3.2 **Voluntary Participation Decisions**. Participation in the initiative is consensual and voluntary, so WYAAT members will need to confirm their own commitment and involvement at key stages (Gateways) in order to ensure the Business Case assumptions (e.g. benefits, costs and risks) are robust. Only trusts participating in the initiative (the eligible constituency) will be able to vote at the decision Gateways.

4. GATEWAY DECISION MAKING

4.1 The WYAAT 'Gateway' decision making mechanism should be used (where appropriate) to achieve agreements that will be binding across relevant members. The mechanism will follow a staged approach and unless new material comes to light, once progression has been made through the respective stages, progress will remain at the relevant stage that has been reached and will not 'fall back'. On agreement of progression through stages, members will commit to the next steps in developing the proposal. Once a trust has committed to participate at a specific Gateway it cannot withdraw until the next Gateway.

4.2 All programmes proposed as part of the WYAAT Strategy will require a Strategic Outline Case which will include a detailed case for change (Gateway 1). At this stage the WYAAT CIC will determine if the proposal warrants further development and consideration and is appropriate to pass to the next stage of development. This stage will also consider whether this a mandatory or voluntary participation programme and which WYAAT members would be directly or indirectly affected and eligible/required to vote (to be known as the eligible constituency).

4.3 The Gateways and decision-making requirements are shown in the table below:

Gateway	Mandatory Participation Decisions	Voluntary Participation Decisions
Gateway 1 **Strategic Outline Case** (Case for Change, initial options appraisal)	Unanimous support of all WYAAT members	Support of all participating WYAAT members
Gateway 2 **Outline Business Case** (Recommendation of preferred option)	Unanimous support of all WYAAT members	Support of all participating WYAAT members
Gateway 3 **Full Business Case** (Detailed description of preferred model and implementation plan)	Unanimous support of all WYAAT members	Support of all participating WYAAT members
Gateway 4 **Programme Closure** (Confirmation that the programme has delivered the expected outputs, outcomes and benefits)	Unanimous support of all WYAAT members	Support of all participating WYAAT members

4.4 Where a unanimous decision cannot be reached initially, the dispute resolution process set out in Schedule 3 to the MoU will be used.

4.5 If a Trust does not support or vote for a proposal then it will not be bound to act in accordance with that proposal as the trusts remain independent statutory bodies under the WYAAT Strategy.

5. BILATERAL AND TRIPARTITE AGREEMENTS BETWEEN INDIVIDUAL TRUSTS

5.1. The WYAAT MoU and its schedules, including this Gateway Decision-Making Framework, do not preclude any Party from developing bilateral or tripartite agreements with other trusts in WYAAT outside the WYAAT Strategy. It is expected that there will be transparency in developing such agreements. The associated benefits and risks of such agreements should be appropriately considered in terms of their impact on other providers and the WYAAT Strategy. The option for other WYAAT trusts to join an initiative should also be considered.

5.2. The WYAAT MoU and its schedules, and being part of the WYAAT CIC, does not preclude existing Parties alliances or existing relationships with other organisations.

5.3. Parties may wish to invite other organisations to be party to initiatives agreed by the WYAAT CIC.

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SCHEDULE 5
TERMS OF REFERENCE FOR
THE WYAAT COMMITTEE IN COMMON

THESE TERMS OF REFERENCE FORM PART OF THE WYAAT MEMORANDUM OF UNDERSTANDING. DEFINITIONS AND TERMINOLOGY ALIGN TO THE MEMORANDUM OF UNDERSTANDING

1 SCOPE

1.1 The WYAAT Committee in Common (WYAAT CIC) will be responsible for leading the strategic development of WYAAT in accordance with the Key Principles*, setting overall ambition and direction in order to deliver the WYAAT Strategy.

2 STANDING

2.1 Members shall only exercise functions and powers of a Party to the extent that they are actually permitted to ordinarily exercise such functions and powers under that Party's internal governance.

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3 GENERAL RESPONSIBILITIES OF THE WYAAT CIC

3.1 The general responsibilities of the WYAAT CIC are:

i. Defining the strategy and providing strategic oversight and direction to the development of WYAAT as a provider collaborative;
ii. ensuring alignment of all Parties to the vision and strategy;
iii. formally recommending the final form of the Strategy; including determining roles and responsibilities within the workstreams;
iv. reviewing the key deliverables and ensuring adherence with the required timescales and budget;
v. Defining risk appetite and tolerances;
vi. receiving assurance that workstreams have been subject to robust quality impact assessments
vii. reviewing of the risks associated with the performance of any of the Parties in terms of the impact to the WYAAT Strategy – recommending remedial and mitigating actions across the system;
viii. receiving assurance that risks associated with the delivery of the WYAAT Strategy, and wider system risks impacting the Parties are being identified, managed and mitigated;
ix. promoting and encouraging commitment to the Key Principles;

Insert approval date

x. formulating, agreeing and implementing approaches for delivery of the WYAAT Strategy;

xi. seeking to determine or resolve any matter referred to it by the WYAAT Programme Executive or any individual Party and any dispute in accordance with the MoU;

xii. reviewing and approving the Terms of Reference of the WYAAT Programme Executive;

xiii. agreeing the Programme Budget and financial contribution and use of resources in accordance with the Risk and Gain Sharing Principles;

4 MEMBERS OF THE WYAAT CIC

4.1 Each Party will appoint their Chair and Chief Executive as WYAAT CIC Members and the Parties will at all times maintain a WYAAT CIC Member on the WYAAT CIC.

4.2 Each WYAAT CIC member will nominate a deputy to attend on their behalf. The Nominated Deputy will be a voting board member of the respective Party. The Nominated Deputy will be entitled to attend and be counted in the quorum at which the WYAAT CIC Member is not personally present and do all the things which the appointing WYAAT CIC Member is entitled to do.

4.3 Each Party will have one vote.

4.4 The Parties will all ensure that, except for urgent or unavoidable reasons, their respective WYAAT CIC Member (or their Nominated Deputy) attend and fully participate in the meetings of the WYAAT CIC.

5 PROCEEDINGS OF WYAAT CIC

5.1 The WYAAT CIC will meet quarterly, or more frequently as required by the Committee.

5.2 The WYAAT CIC shall meet in private where appropriate in order to facilitate discussion and decision making on matters deemed commercially sensitive and by virtue of the confidential nature of the business to be transacted across the WYAAT members. It is agreed by the Parties that the necessary checks and balances on openness, transparency and candour continue to exist and apply by virtue of the Parties each acting within existing accountability arrangements of the Parties' respective organisations and the reporting arrangements of the WYAAT CIC into the Parties' Trust Boards.

5.3 The Parties will select one of the Parties' Chairs to act as the Chair of the WYAAT CIC meetings on a rotational basis for a period of six months or three meetings, whichever is the lesser.

5.4 The Chair of WYAAT will not simultaneously act as Chair of another Collaborative in West Yorkshire and Harrogate.

5.5 The WYAAT CIC may regulate its proceedings as they see fit save as set out in these Terms of Reference.

5.6 No decision will be taken at any meeting unless a quorum is present. A quorum will not be present unless every Party has at least one WYAAT CIC Member present.

5.7 Members of all Parties will be required to declare any interests which will be recorded and set out in a register and reviewed at the beginning of each meeting.

5.8 A meeting of the WYAAT CIC may consist of a conference between the WYAAT CIC Members who are not all in one place, but each of whom is able directly or by telephonic or video communication to speak to each of the others, and to be heard by each of the others simultaneously.

5.9 Each WYAAT CIC Member will have an equal say in discussions and will look to agree recommendations in line with the Principles of the WYAAT Strategy.

5.10 The WYAAT CIC will review the meeting effectiveness at the end of each meeting. Additionally, a survey of CIC members to assess effective will be undertaken on an annual basis. The findings of this will be reviewed by CIC in order to ensure continuous improvement.

6 EXTRAORDINARY MEETINGS

6.1 In exceptional circumstances, where a decision is required, an extraordinary meeting of the CIC can be called between the scheduled meetings.

6.2 A request for an extraordinary meeting can be instigated by any Party and must be supported by at least two further Parties.

6.3 All attempts will be made to provide five working days' notice for an extraordinary meeting, with a minimum notice period of 48 hours where there is an urgent requirement for CIC to meet.

6.4 All extraordinary meetings will comply with the provisions within these terms of reference, in line with ordinary meetings of the CIC.

7 DECISION MAKING WITHIN THE WYAAT CIC

7.1 Each WYAAT CIC Member will comply with the existing accountability arrangements of their respective appointing organisation and will make decisions which are permitted under their organisation's Standing Orders, Standing Finance Instructions and Scheme of Delegation. The Parties intend that WYAAT CIC Members shall report to and consult with their own respective organisations at Board level, (noting that decisions on recommendations made by the CIC will always be made by the Boards of Member Trusts) providing the governance assurance that ensures compliance with their regulatory and audit requirements, for organisational decisions relating to, and in

support of, the WYAAT Key Principles and facilitating these functions in a timely manner.

7.2 Recognising that some decisions may not be of obvious benefit to or impact directly upon all Parties, WYAAT CIC Members shall seek to pay due regard to the best interests of the wider population in investing in a sustainable system of healthcare across the WYAAT service area in accordance with the Key Principles when making decisions at WYAAT CIC meetings.

7.3 In respect of matters which require decisions where all Parties are affected the Parties will seek to make such decisions on the basis of all WYAAT CIC Members reaching an agreed consensus decision in common in accordance with the Key Principles.

7.4 In respect of the matters which require decisions where only some of the Parties are affected, then the Parties shall reference the WYAAT Gateway Decision Mechanism at Schedule 4 of the Memorandum of Understanding.

8 ATTENDANCE OF THIRD PARTIES AT WYAAT CIC MEETINGS

8.1 The WYAAT CIC shall be entitled to invite any person to attend but not take part in making decisions at meetings of the WYAAT CIC.

9 ADMINISTRATION FOR THE WYAAT CIC

9.1 Meeting administration for the WYAAT CIC will be provided by the WYAAT Programme Office including responsibility for governance advice, maintaining the register of interests and the minutes of the meetings of the WYAAT CIC.

9.2 The Agenda for the meeting will be agreed by the WYAAT CIC Chair. Papers for each meeting will be sent from the Programme Office to WYAAT CIC Members no later than five working days prior to each meeting. By exception, and only with the agreement of the Chair, amendments to papers may be tabled before the meeting.

9.3 The draft minutes, and a summary report from the WYAAT Director will be circulated promptly to all WYAAT CIC Members as soon as reasonably practical for inclusion on the private agenda of each Parties' Board meeting. The Chair of the meeting will be responsible for approval of the first draft set of minutes for circulation to members. The WYAAT Director will provide a summary for sharing in the public domain.

9.4 The WYAAT CIC will produce an annual report to the Boards of all Parties.

10 REVIEW

10.1 The WYAAT CIC will review these Terms of Reference at least annually for approval by the Parties.

Insert approval date

WEST YORKSHIRE ASSOCIATION OF ACUTE TRUSTS

SCHEDULE 6 CONFIDENTIALITY AGREEMENT

RECITALS

1. The Parties together have formed the West Yorkshire Association of Acute Trusts ("WYAAT") and have agreed to collaborate to bring together NHS trusts delivering acute hospital services across the WYAAT Service Area in delivering region-wide efficient and sustainable healthcare for patients. WYAAT, as partner in the West Yorkshire Integrated Care System ("WYICS"), will develop and deliver a WYAAT Strategy to facilitate integrated methods of working across acute care providers.
2. The Parties have formed a WYAAT Committee in Common (WYAAT CIC) which has the specific remit of overseeing a comprehensive system wide integration programme to deliver the objective of an acute provider transformation to a more collaborative model of care for the WYAAT Service Area, the intention being to deliver a system model, operating as a network, that is coherent, integrated, consistent (reducing unwanted variation) and focused on quality and value for the population and patients. This "WYAAT Strategy" is to be initially developed and delivered by the WYAAT CIC.
3. The Parties are engaged in a phased approach towards developing the governance of the WYAAT collaborative working, the initial step being the formation of the WYAAT CIC for the delivery of more efficient acute services for patients in West Yorkshire and Harrogate District.
4. The Parties have entered into a protocol for managing the sharing of information to agree the ways of protecting the use of data (including confidential information) within each Party's organisation throughout the WYAAT Strategy development and delivery. The Parties have entered into a Conflict of Interest Protocol (Conflict of Interest Protocol) to govern the treatment of conflicts of interest that may arise in the WYAAT Strategy.
5. The purpose of this Agreement is to ensure that Confidential Information (as defined below) revealed to each other in the course of the WYAAT Strategy development process remains confidential and is not used by the Parties for any purpose other than the further development of the WYAAT Strategy.
6. The Parties intend this Confidentiality Agreement to be legally binding.

8

Insert approval date

WEST YORKSHIRE ASSOCIATION OF ACUTE TRUSTS

OPERATIVE PROVISIONS

1. Definitions

The definitions in this clause shall apply to this Agreement:

1.1 **Operational Day**: a day other than a Saturday, Sunday or a bank holiday in England.

1.2 **Confidential Information**: means

1.2.1 information (however recorded, preserved or disclosed) that is directly or indirectly disclosed, whether before or after the date of this Agreement, as part of or ancillary to:

i. the Parties responses to the WYAAT Strategy;

ii. any due diligence process for the WYAAT Strategy;

iii. any business case(s) for the WYAAT Strategy;

iv. any submission to the Competition and Markets Authority;

v. the preparation of other documents to progress and conclude the development of the WYAAT Strategy; and

vi. any post WYAAT Strategy implementation plans; or

1.2.2 the nature, content or substance of any discussions and/or negotiations taking place concerning the WYAAT Strategy and the status of those discussions and/or negotiations; or

1.2.3 information contained in any version of the Memorandum of Understanding which set out the terms upon which the development and delivery of the WYAAT Strategy will take place; or

1.2.4 information contained in any version of a WYAAT Strategy business case of any Party; or

1.2.5 any other information that the Parties agree in writing is confidential; or

1.2.6 any information that would be regarded as confidential by a reasonable business person relating to:

i. the business, affairs, patients, customers, clients, suppliers, plans, intentions, or market opportunities of the Disclosing Party; or

ii. the operations, processes, product information, know-how, designs, trade secrets or software of the Disclosing Party; or

1.2.7 any information developed by the Parties in the course of carrying out this Agreement; but does not include any information if:

1.2.8 the information is, or subsequently becomes, public knowledge other than as a direct or indirect result of the information being disclosed in breach of this Agreement or of any other undertaking of confidentiality addressed to the Party to whom the information relates (except that any compilation of otherwise public information in a form not publicly known shall nevertheless be treated as Confidential Information); or

1.2.9 a Party can establish, to the reasonable satisfaction of the other Parties, that it found out the information or the information was, is or becomes available to a Party from a source not connected with the other Parties and that such source is not under any obligation of confidence in respect of that information; or

1.2.10 a Party can establish, to the reasonable satisfaction of the other Parties, that the information was known to the Party or lawfully in the possession of the Party before the date of this Agreement and that it was not under any obligation of confidence in respect of that information (but, for the avoidance of doubt, information that was provided prior to the date of this Agreement but which is caught by Clause 1.1.2 (b) above shall be treated as information that was provided under an obligation of confidence); or

1.2.11 the Parties agree in writing that it is not confidential or may be disclosed; or

1.2.12 a Party can establish, to the reasonable satisfaction of the other Parties, that it developed the information independently of the Confidential Information; or

1.2.13 a Party can establish, to the reasonable satisfaction of the other Parties, that the information legitimately and lawfully came in to its possession otherwise than for the Purpose (as defined below).

i. **Disclosing Party:** a Party which discloses or makes available directly or indirectly Confidential Information.

ii. **Purpose:** considering, evaluating and negotiating the development and delivery of the WYAAT Strategy.

iii. **Recipient:** a Party which receives or obtains directly or indirectly Confidential Information.

iv. **Representative:** employees, agents and professional advisers (including

but not limited to accountants, lawyers and management consultants) of the Recipient appointed to assist on the evaluation, development and delivery of the WYAAT Strategy.

1.3 Clause, schedule and paragraph headings shall not affect the interpretation of this Agreement.

1.4 A person includes a natural person, corporate or unincorporated body (whether or not having separate legal personality) and that person's legal and personal representatives, successors and permitted assigns.

1.5 Words in the singular shall include the plural and vice versa: words denoting the masculine gender include the feminine gender; words denoting persons include bodies corporate and unincorporated associations and partnerships.

1.6 A reference to a statute or statutory provision is a reference to it as it is in force for the time being, taking account of any amendment, extension, or re-enactment, and includes any subordinate legislation for the time being in force made under it.

1.7 Any obligation in this Agreement on a person not to do something includes an obligation not to agree or allow that thing to be done.

2. CONSIDERATION

2.1 In consideration of the benefits to all Parties in sharing Confidential Information for the purpose of pursuing the WYAAT Strategy development and delivery and in further consideration of each Party agreeing to pay the other Parties on demand GBP £1, the Parties agree to be bound by the terms of this Agreement.

3. OBLIGATIONS OF THE PARTIES AND REPRESENTATIVES

3.1 Each Recipient will (and will direct and procure each of its Representatives that he or she will):

i. keep the Confidential Information secret;
ii. use or exploit the Confidential Information only for the Purpose;
iii. not directly or indirectly disclose (or knowingly allow it to be disclosed) or make available, in whole or in part, any Confidential Information to any person who is not a Representative who needs to know this Confidential Information for the Purpose;
iv. take all reasonable steps to ensure that no Confidential Information is visible to, or capable of being overlooked by any person who is not a Representative who needs to know this Confidential Information for the Purpose;
v. ensure that reasonable endeavours are taken to ensure that the Confidential Information is protected against theft or unauthorised access;
vi. not alter, modify or vary any of the Confidential Information in any way;

vii. apply the same security measures and degree of care to the Confidential Information as the Recipient applies to its own confidential information, which the Recipient warrants as providing adequate protection from unauthorised disclosure, copying or use;

viii. inform the other Parties immediately on becoming aware, or suspecting, any person who is not a Representative has become aware of Confidential Information;

ix. comply with Clause 5 of the Information Sharing Agreement; and not use any previously shared information in an anti-competitive manner; and in respect of any such previously shared information, the Parties agree that this Agreement applies and the Parties agree that the Conflict of Interest Protocol and the Information Sharing Agreement shall also apply.

3.2 The Recipient may only disclose the Disclosing Party's Confidential Information to those of its Representatives who need to know this Confidential Information for the Purpose, provided that:

i. it informs these Representatives of the confidential nature of the Confidential Information before disclosure or upon signing this Agreement (whichever is the later) and obtains from its Representatives enforceable undertakings to keep the Confidential Information confidential in terms at least as extensive and binding upon the Representatives as the terms of this Agreement are upon the Parties; and

ii. at all times, it is responsible for these Representatives' compliance with the obligations set out in this Agreement.

3.3 Each Party is responsible for its Representatives' compliance with the obligations set out in this Agreement.

3.4 Representatives may only make such copies of, reduce to writing or otherwise record the Confidential Information as are strictly necessary for the Purpose and shall:

i. clearly mark all such documents as 'Confidential';

ii. ensure that all such documents supplied to him or her made by him or her can be separately identified from his own information; and

iii. use all reasonable endeavours to ensure that all copies within their control are protected against theft or unauthorised access.

3.5 If discussions in relation to the development and delivery of the WYAAT Strategy cease, or the Disclosing Party so requests in writing at any time, the Parties shall immediately:

i. return to the Disclosing Party all Confidential Information received; and

ii. destroy or permanently erase all documents and materials and any copies supplied to it or made by it or by its Representatives containing, reflecting incorporating or based on Confidential Information; and

iii. erase all of the Confidential Information from its computer systems or

which is stored in electronic form (to the extent possible).

3.6 Nothing in Clause 3.5 shall require a Party to return or destroy Confidential Information or copies that the Party is required to retain by applicable law or to be able to evidence due compliance with good governance and the proper discharge of its functions or to satisfy the rules or regulations of any applicable governmental or regulatory body to which such person is subject and to the extent reasonable to permit the Recipient to keep evidence that it has performed its obligation under this Agreement.

3.7 Each Party will establish and maintain adequate security measures (including any reasonable security measures proposed by the other Parties from time to time) to safeguard Confidential Information from unauthorised access or use.

3.8 Each Party is aware of its obligations under Clause 4.2 of the Information Sharing Agreement.

3.9 No Party shall make, or permit any person to make, any public announcement concerning this Agreement, the Purpose or its prospective interest in the Purpose without the prior written consent of the other Parties (such consent not being unreasonably withheld or delayed) except as is required by law or any governmental or regulatory body or by any court or other authority or competent jurisdiction. No Party shall make use of the other Parties' names or any information acquired through its dealing with the other Parties for publicity or marketing purposes without the prior written consent of the other Parties.

3.10 If a Party develops or uses a product or a process (other than for the Purpose) which, in the reasonable opinion of the other Parties, might have involved the use of any of the Disclosing Party's Confidential Information, the Party shall, at the request of the Disclosing Party, supply to the other Parties information reasonably necessary to establish that the Confidential Information has not been used in the development of the product or process.

3.11 The provisions of Clauses 3.5, 3.6 and 3.10 of this Agreement shall continue to apply to any such documents and materials retained by a Party, subject to Clause 8.3.

4. FORCED DISCLOSURE

4.1 Subject to Clause 4.2, a Party may disclose Confidential Information to the extent:

i. required by law (including in response to a request pursuant to the Freedom of Information Act 2000) or any order of any court or other authority of competent jurisdiction or any competent judicial, governmental or regulatory body (including the Health Select Committee and the Information Commissioner); or

ii. necessary to enable a Party to comply with any statutory function or duty of that Party or to satisfy the requirement for public accountability and good governance in the discharge of its functions, which requires disclosure of Confidential Information.

4.2 Before a Party discloses any information under this Clause 4, it shall (to the extent permitted by law) use all reasonable endeavours to:

i. give the other Parties as much notice as possible;

ii. inform the other Parties of the full circumstances of the disclosure and the information that will be disclosed;

iii. consult with the other Parties as to possible steps to avoid or limit disclosure and take those steps where they would not result in significant adverse consequences to other Parties, including considering whether any exemptions under the Freedom of Information Act 2000 apply; and

iv. where the disclosure is by way of public announcement, agree the wording with the other Parties in advance.

4.3 Each Party shall co-operate with the other Parties if it decides to bring in any legal or other proceedings to challenge the validity of the requirement to disclose Confidential Information.

4.4 If a Party is unable to inform the other Parties before Confidential Information is disclosed, it shall (to the extent permitted by law) inform the other Parties immediately after the disclosure of the full circumstances of the disclosure and the information that has been disclosed.

5. RESERVATION OF RIGHTS AND ACKNOWLEDGEMENT

5.1 All Confidential Information shall remain the property of the Disclosing Party. Each Party reserves all rights in its Confidential Information. No rights, including, but not limited to, intellectual property rights, in respect of a Party's Confidential Information are granted to the other Parties and no obligations are imposed on the Parties other than those expressly stated in this Agreement.

5.2 Except as expressly stated in this Agreement, no Party makes any express or implied warranty or representation concerning its Confidential Information, or the accuracy or completeness of the Confidential Information.

5.3 The disclosure of Confidential Information by a Party shall not form any offer by, or

representation or warranty on the part of, the Disclosing Party to enter into any further agreement in relation to the Purpose, or the development or supply of any product or service to which the Confidential Information relates.

5.4 Each Party shall be liable to the other Parties for the actions or omissions of its Representatives under this Agreement, as if they were the actions or omissions of the Recipient.

6. INDEMNITY

6.1 Each Party warrants that it has the right to disclose its Confidential Information to the other Parties and to authorise the other Parties to use such Confidential Information for the Purpose.

6.2 Each Party shall indemnify and keep fully indemnified the other Parties at all times against all liabilities, costs (including legal costs on an indemnity basis), expenses, damages and losses (including any direct, indirect or consequential losses, loss of profit, loss of reputation and all interest, penalties and other reasonable costs and expenses suffered or incurred by the other Parties) arising from any breach of this Agreement as a result of its breach.

7. TERM AND TERMINATION

7.1 The obligations contained in this Agreement shall take effect on the date of the Agreement and shall continue for the Term.

7.2 Subject to clause 7.2 this Agreement will be terminated:

i. If any of the Parties decide not to become, or continue to be involved in the Purpose; or

ii. on discontinuance of the development and delivery of the WYAAT Strategy**.**

7.3 If any Party decides not to become or continue to be involved in the Purpose it shall notify the other Parties in writing immediately. The obligations of each Party shall, notwithstanding any earlier termination of negotiations or discussions between the Parties in relation to the Purpose, continue for a period of six years from the termination of this Agreement.

7.4 Termination of this Agreement shall not affect any accrued rights or remedies to which any Party is entitled.

8. GENERAL LEGAL PROVISIONS

8.1 This Agreement, the Memorandum of Understanding, the Information Sharing Protocol and the Conflict of Interests Protocol constitute the whole agreement between the Parties and supersedes all previous agreements between the relevant Parties relating to their subject matter. Each Party acknowledges that, in entering into

this Agreement, it has not relied on, and shall have no right or remedy in respect of, any statement, representation, assurance or warranty (whether made negligently or innocently) other than as expressly set out in this Agreement, the Memorandum of Understanding, the Information Sharing Agreement and the Conflict of Interests Protocol. Nothing in this Clause 8.1 shall limit or exclude any liability for fraud or for fraudulent misrepresentation.

8.2 This Agreement shall be governed by the laws of England.

8.3 No variation or waiver of this Agreement or any part of it will be effective unless made in writing, signed by or on behalf of all the Parties (or their authorised representatives) and expressed to be such a variation or waiver.

8.4 Failure to exercise, or any delay in exercising, any right or remedy provided under this Agreement or by law shall not constitute a waiver of that or any other right or remedy, nor shall it preclude or restrict any further exercise of that or any other right or remedy.

8.5 No single or partial exercise of any right or remedy provided under this Agreement or by law shall preclude or restrict the further exercise of that or any other right or remedy.

8.6 A Party that waives a right or remedy provided under this Agreement or by law in relation to another Party, or takes or fails to take any action against that Party, does not affect its rights in relation to any other Party.

8.7 The Parties shall attempt to resolve any dispute between them in respect of this Agreement by negotiation in good faith.

8.8 Except as otherwise provided in this Agreement, no Party may assign, sub-contract or deal in any way with, any of its rights or obligations under this Agreement or any document referred to in it.

9. NOTICES

9.1 Any notice required to be given under this Agreement, shall be in writing and shall be delivered personally, or sent by pre-paid first class post or recorded delivery or by commercial courier or by secure NHS email with an assigned read receipt, to each Party required to receive the notice at its address as specified by the relevant Party by notice in writing to each other Party.

9.2 Any notice or other communication shall be deemed to have been duly received:

i. if delivered personally, when left at the address and for the contact referred

to in this clause on the date and at the time that the delivery receipt is signed; or

ii. if sent by pre-paid first class post or recorded delivery, at 9.00 am on the second Operational Day after posting; or

iii. if delivered by commercial courier, on the date and at the time that the courier's delivery receipt is signed

iv. if sent by secure email, on the date and time that a read receipt is received by the sender.

10. NO PARTNERSHIP

Nothing in this Agreement is intended to, or shall be deemed to, establish any partnership or joint venture between any of the Parties, constitute any Party the agent of another Party, nor authorise any Party to make or enter into any commitments for or on behalf of any other Party.

11. THIRD PARTY RIGHTS

No person other than a Party to this Agreement shall have any rights to enforce any term of this Agreement whether under the Contracts (Rights of Third Parties) Act 1999 or otherwise.

YORKSHIRE ASSOCIATION OF ACUTE TRUSTS

SCHEDULE 7

PROTOCOL FOR MANAGING CONFLICTS OF INTEREST

IN RELATION TO THE STRATEGY FOR THE WEST YORKSHIRE

ASSOCIATION OF ACUTE TRUSTS

1. INTRODUCTION

1.1 This document forms part of the governance arrangements for the West Yorkshire Association of Acute Trusts (WYAAT) Committee in Common (CIC) and should be considered in conjunction with the overall Memorandum of Understanding and Terms of Reference of that Committee.

1.2 The members of WYAAT will adhere to the NHS England Guidance on Managing Conflicts of interest.

1.3 The objectives of this Protocol are to:

1.3.1 manage any Conflict so that the Parties are able to discuss the development of the WYAAT Strategyand make decisions on its delivery in accordance with principles of probity, fairness, non-discrimination, equality and transparency;

1.3.2 minimise the risk of a successful challenge being brought by a third party as a result of the unmanaged and undisclosed exploitation of a Conflict; and

1.3.3 ensure that the management of the Conflict during the negotiations does not prejudice the ability of any Party or Individual to continue to fulfil their role, does not undermine their ability to make decisions, and does not damage public trust and confidence in the Parties.

2. DEFINITIONS

2.1 For the purposes of this document a ‘conflict of interest’ is defined as:

‘A set of circumstances by which a reasonable person would consider that an individual’s ability to apply judgement or act, in the context of delivering, commissioning or assuring taxpayer funded health and care services is, or could be, impaired or influenced by another interest they hold’.

2.2 A conflict of interest may be:

i. Actual – There is a material conflict between one or more interests.

ii. Potential – There is the possibility of a material conflict between one or more interests in the future.

2.3 A material interest is one which a reasonable person would take into account when making a decision regarding the use of tax-payers money because the interest has relevance to that decision.

2.4 Interests fall into the following categories:

i. Financial interests – where an individual may get direct benefit* from the consequences of a decision they are involved in making

ii. Non-financial professional interest – where an individual may obtain a non-financial professional benefit* from the consequences of a decision they are involved in making such as increasing their professional reputation or promoting their professional career

iii. Non-financial personal interests – where an individual may benefit* personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit because of decisions they are involved in making

iv. Indirect interests – where an individual has a close association ** with another individual who has a financial interest, a non-financial professional interest or a non-financial personal interest who would stand to benefit from a decision they are involved in making.

v. Loyalty interests - Conflicts of interest can arise when decision making is influenced subjectively through association with colleagues or organisations out of loyalty to the relationship they have, rather than through an objective process. The scope of loyalty interests is potentially huge, so judgement is required for making declarations.

A benefit may arise from the making of a gain or avoiding a loss

** These associations may be close family members and relatives, close friends and associates and business partners.

3. CONFLICTS OF INTEREST

3.1 The Parties agree that other than being a party to WYAAT:

3.1.1 a conflict of interest (Conflict) arises when in developing and delivering the WYAAT Strategy an individual or organisation:

i. owes duties to two or more organisations and those duties are in conflict with one another; or

ii. has any financial interest, direct or indirect, in any contract, proposed contract or other matter around the WYAAT Strategydevelopment and delivery and is present at a meeting at which the contract or other matter is the subject of consideration; and/or

iii. the individuals' or organisations' ability to exercise judgement, or act in a role is, could be, or is seen to be impaired or otherwise influenced by their involvement in another role or relationship.

iv. if in doubt, any Individual or Party concerned should assume that a potential Conflict exists.

3.1.2 applying the meaning of a Conflict to an Individual, a Conflict does potentially exist if an Individual simultaneously has a role at more than one Party or has previously had or will have a role at a Party while being employed at another as the case may be;

3.1.3 the existence of a Conflict does not in itself indicate that a person or organisation in question has done anything wrong. Where Conflicts are unavoidable they need to be managed appropriately;

3.1.4 if any Party materially breaches this Protocol then the Parties may agree to discontinue the respective Party involvement in the further discussions around the WYAAT Strategy development and delivery; and

3.1.5 this document accordingly sets out a Protocol that the Parties have agreed to adopt for the purpose of managing a Conflict.

4. PROCESS FOR MANAGING CONFLICTS OF INTEREST

4.1.1 Individuals and the Parties will adhere to the NHS England Guidance on Managing Conflicts of Interest.

4.1.2 The Parties acknowledge that they are independent statutory providers and that the intent of the WYAAT Strategy is to deliver region wide efficient and sustainable healthcare for patients, so whilst it is contemplated that there will be Conflicts, the Parties expect these to be managed in a reasonable manner to ensure the objective is met and that the appropriate Parties are part of WYAAT discussions and, where reasonable, any decisions.

4.1.3 Each individual must ensure that their declarations are up to date on the register of their own organisation in the first instance. An up to date register of interests of all Committee members will be provided to the Chair (noting adherence to Schedule 5 section 5.4) of the WYAAT Committee in Common prior to each meeting.

4.1.4 Where a Party is aware of a Conflict which:

i. has not been declared, either in the register or orally, they will declare this at the start of the meeting;

ii. has previously been declared, in relation to the scheduled or likely business of the meeting, the Party concerned will bring this to the attention of the Chair of the meeting, together with details of arrangements which have been confirmed for the management of the Conflict.

4.1.5 The Chair of the meeting will then determine how this should be managed and inform the Party of their decision. Where no arrangements have been confirmed, the Chair of the meeting may require the individual to withdraw from the meeting or part of it if appropriate. The Party or Individual as applicable will then comply with these arrangements, which must be recorded in the minutes of the meeting.

4.1.6 Where the Chair of any meeting has a Conflict, previously declared or otherwise, in relation to the scheduled or likely business of the meeting, they must make a declaration and a deputy chair will be appointed to act as chair for the relevant part of the meeting. Where arrangements have been confirmed for the management of the Conflict in relation to the chair, the meeting must ensure these are followed. Where no arrangements have been confirmed, the deputy chair may require the chair to withdraw from the meeting or part of it. Where there is no deputy chair, the Parties present at the meeting will select one.

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4.1.7 Any declarations of Conflicts and arrangements agreed in any meeting will be recorded in the minutes and the register of Conflicts for the Parties in respect of the WYAAT Strategy development and delivery. The Chair will make a decision as to whether the relevant section of the minutes should be redacted for those individuals who declared a conflict and this decision will be recorded in the minutes.

4.1.8 Where more than 50% of the Parties representatives at a meeting are required to withdraw from a meeting or part of it, owing to the arrangements agreed for the management of Conflicts, the Chair (or deputy) will determine whether or not the discussion can proceed.

4.1.9 In making this decision the Chair will consider whether the meeting is quorate, in accordance with the number and balance set out in the WYAAT CIC Terms of Reference. Where the meeting is not quorate, owing to the absence of certain Parties, the discussion will be deferred until such time as a quorum can be convened. Where a quorum cannot be convened from the Parties owing to the arrangements for managing Conflicts, the chair shall consult with the Conflict Leads on the action to be taken. This may include inviting on a temporary basis alternate individuals from the affected Parties to make up the quorum (where these are permitted members who are not subject to a Conflict) so that they can progress the item of business.

YORKSHIRE ASSOCIATION OF ACUTE TRUSTS

SCHEDULE 8

INFORMATION SHARING PRINCIPLES

IN RELATION TO THE DEVELOPMENT OF A STRATEGY FOR WEST YORKSHIRE ASSOCIATION OF ACUTE TRUSTS

1. INTRODUCTION

This document forms part of the governance arrangements for the West Yorkshire Association of Acute Trusts (WYAAT) Committee in Common (CIC) and should be considered in conjunction with the overall Memorandum of Understanding and Terms of Reference of that Committee.

2. DEFINITIONS

2.1 In this Agreement the following words and expressions shall have the following meanings:

2.1.1 Business as Usual: all activities undertaken by any Party in the ordinary course of business save for any activity in connection with the WYAAT Strategy development and delivery;

2.1.2 Confidential Information: shall have the meaning given to it in the Confidentiality Agreement;

2.1.3 Competitively Sensitive Information: any Confidential Information which would or might enable the recipient to alter its commercial strategy and may include, by way of illustration, trade secrets, confidential financial information and confidential commercial information, including without limitation, information relating to the terms of actual or proposed contract or sub-contract arrangements (including bids received under competitive tendering), future pricing, business strategy and costs data, as may be utilised, produced or recorded by any Party, the publication of which an organisation in the same business would reasonably be able to expect to protect by virtue of business confidentiality provisions; and

2.1.4 Data: information, data and material recorded in any form and shared between any or all of the Parties including Confidential Information and Commercially Sensitive Information.

3. PRINCIPLES

The following key principles guide the sharing of data between the Parties

3.1 The Parties endorse, support and promote the accurate, timely, secure and

confidential sharing of both person identifiable and anonymised data where such data sharing is essential for the provision of effective and efficient services to the local population.

3.2 The Parties are fully committed to ensuring that if they share data it is in accordance with their legal, statutory and common law duties, and, that it meets the requirements of any additional guidance.

3.3 Where it is agreed that the sharing of data is necessary, only that which is needed, relevant and appropriate will be shared and that would only be on a "need to know" basis.

3.4 The data being shared will only be used for the purpose for which it was originally intended.

3.5 All Parties must have in place policies and procedures to meet the national requirements for Data Protection, Data Security and Confidentiality [https://ico.org.uk/for-organisations/guide-to-data-protection]. The existence of, and adherence to, such policies provide all Parties with confidence that data shared will be transferred, received, used, held and disposed of appropriately.

3.6 In line with these policies, the Parties have developed and approved a single Information Sharing Agreement to allow the sharing of non-person identifiable information to support WYAAT programmes and projects. If the Parties need to share person or patient identifiable information to support a WYAAT programme or project, an individual information sharing agreement will be put in place for each programme or project, where required, in order to ensure secure and appropriate sharing of information.

3.7 The Parties acknowledge their 'Duty of Confidentiality' to the people they serve. In requesting release and disclosure of data from other Parties' employees and contracted volunteers will respect this responsibility and not seek to override the procedures which each organisation has in place to ensure that data is not disclosed illegally or inappropriately. This responsibility also extends to third party disclosures; any proposed subsequent re-use of data which is sourced from another organisation should be approved by the source organisation.

3.8 When disclosing data about individuals, Parties will clearly state whether the data being supplied is fact, opinion, or a combination of the two.

3.9 The Parties will have in place effective procedures to address complaints relating to the disclosure of data, and information about these procedures should be made available to service users.

4. CONFIDENTIAL INFORMATION

4.1 The Parties can share information with each other and NHS England for the purpose of the WYAAT Strategy development and delivery subject to the provisions of the Confidentiality Agreement.

4.2 The WYAAT Programme Office and each Party shall maintain clear records of all the Confidential Information exchanges they are part of.

5. COMPETITIVELY SENSITIVE INFORMATION

5.1 The Parties shall not disclose to each other any Competitively Sensitive Information. The Parties acknowledge that:

5.1.1 information is not Competitively Sensitive Information if it relates to activities or markets in which the relevant Parties do not currently compete and where there is no realistic prospect that they will in future compete;

5.1.2 subject to section 6, information is not Competitively Sensitive Information if it relates to any arrangements involving information exchange and collaboration (including for the purpose of joint projects contemplated or being implemented by the Parties under WYAAT) for the purpose of Business as Usual activities; and

5.1.3 information is not Competitively Sensitive Information if it relates to activities or markets in which the respective Parties are actual or potential competitors and disclosure of the relevant information would not affect the recipient Party's commercial strategy or decisions; this may apply if, for example:

i. the information is historical, aggregated (as defined below) and/or anonymised; or

ii. the information is freely available in the public domain.

5.2 In this clause 5 "aggregated" means that the price, cost and volume of individual services or contracts for the provision of services, the subject matter of which forms or could form the basis of competition between the Parties, cannot be determined from the Data.

6. DOCUMENT CREATION

6.1 The Parties acknowledge that documents created by any Party for the WYAAT Strategy development may be required to be disclosed to the UK merger authorities.

6.2 The Parties agree to take due care and attention when creating documents (including but not limited to emails and handwritten notes) to avoid the use of language that could be misinterpreted.

6.3 If any Party is asked by external legal advisors to provide Data, any documents must be clearly marked "Privileged and confidential: prepared at the request of external legal advisers".

WEST YORKSHIRE ASSOCIATION OF ACUTE TRUSTS
COMMITTEE IN COMMON
DRAFT MINUTES

30 July 2024 09:30-12:30
Research & Innovation Centre, Leeds Teaching Hospitals NHS Trust

Participants:
Nadira Mirza, Deputy Chair, ANHSFT
Sarah Jones, Chair, BTHFT
Helen Hirst, Chair, CHFT
Sarah Armstrong, Chair, HDFT
Dame Linda Pollard, Chair, LTHT
Keith Ramsay, Chair, MYTT (CiC Chair)
Foluke Ajayi, CEO, ANHSFT
Mel Pickup, CEO, BTHFT
Anna Basford, Deputy CEO & Director of Transformation & Partnerships, CHFT
Jonathan Coulter, CEO, HDFT
Prof. Phil Wood, CEO, LTHT
Len Richards, CEO, MYTT
Lucy Cole, Director, WYAAT

Apologies:
Andrew Gold, Chair, ANHST
Brendan Brown, CEO, CHFT

In Attendance:
Geraldine Morris, WYAAT Office Manager
Rachel Coleman, WYAAT Communications Manager (Item 11 – Communications – Key Messages)
Jo Bray, Company Secretary, LTHT
Sal Uka, WYAAT Medical Lead

Guests:
Amy Whitaker, Chief Finance Officer, MYTT,
Ben Roberts, WYAAT Associate Director of Finance,
Nancy Park, Lead Partner, PwC,
Shamil Ganatra, Director, PwC, (Item 4 – WYAAT Cost Review, Outputs, Next Steps, Communications)

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Item	Description
1.	**Attendance and Apologies** Chair for CiC: Keith Ramsay (KR). Attendance and apologies as above, with Nadira Mirza (NM) representing Andrew Gold (AG) and Anna Basford (AB) representing Brendan Brown (BB). Following introductions, Sarah Armstrong (SA) informed members that she would be the next Chair of the CiC from October 2024. KR noted that NM and Sarah Jones (SJ) were running late and would join the meeting shortly. He reflected on the desire for a discussion on the ICB WYAAT dynamic, given the change in Government, and the impact of this moving forward. KR noted the retirement of long-serving member of CiC and Chair of ANHSFT, AG, at the end of September. AG had made a significant contribution to WYAAT and various ICS working groups and would be sent a formal note expressing thanks for his contribution. **ACTION: LC to draft a formal letter of thanks to AG.**
2.	**Declarations of Interest (DOI)** There were no additional DOIs noted, and KR encouraged members to liaise with Geraldine Morris (GM) or Lucy Cole (LC) regarding any amendments moving forward.
3.	**Minutes & Actions** The minutes from the previous meeting were approved as a true and accurate record. FA sought assurance that the feedback AG had provided on the previous Minutes had been seen and taken on board, given AG was not in attendance at this meeting. ***Post-meeting note**:* 1. *GM confirmed that AG's feedback had been actioned and included in the 30 April minutes which were circulated with the papers for the 30 July meeting.* 2. *GM updated the "In Attendance" list in the previous minutes dated 30 April to include Sal Uka's name, which had been omitted.* ***The Action Log was reviewed, and the following updates were given:*** • ***Action 227:** Minutes & Actions. LC to discuss expressions of interest for the WYAAT Strategy pillars with Sarah Jones at BTHFT and confirm at the next CiC meeting.* LC confirmed this action was complete and the nominee information would be circulated with the minutes. **ACTION: LC to circulate WYAAT Strategy pillars nominee information with the minutes.** • ***Action 229:** Collaborative Report, West Yorkshire Health & Care Partnership Report. LC to invite Cancer Alliance to future CiC meeting to explain how they operate.* • ***Action 230:** Pharmacy Aseptics: Lessons Learned. A forward plan for all WYAAT capital schemes was proposed. LC to include in the infrastructure focus session of the CiC.* • ***Action 239:** Communications – Key Messages. LC to develop a*

	Communications Plan and ensure attendance of a communications representative at every CiC meeting. Communications plan in development. Scheduled for review at October CIC meeting. KR noted the communications plan would be reviewed at the CiC meeting on 29 October 2024. Assurance was provided by LC that all other actions listed on the action tracker were complete.
4.	**WYAAT Cost Review** • **Outputs** • **Next Steps** • **Communications** *SJ, Amy Whitaker (AW) and Ben Roberts (BR) joined the meeting.* KR welcomed AW to the meeting, noting she had taken over as Chair of the WYAAT Directors of Finance following Simon Worthington's (SW) retirement, and BR WYAAT Associate Director for Finance. *Nancy Park (NP) Partner at PwC and Shamil Ganatra (SG) Partner at PwC joined the meeting.* KR briefly reviewed the CiC agenda, explaining that the WYAAT Strategy Pillar discussion on Research and Innovation had been replaced by the PwC Cost Review report. KR welcomed the guests. SG summarised the results of the work and outlined the scope. He explained that PwC had spent the last four to five weeks working on this rapid piece of work, liaising with BR, LC, plus colleagues within the six trusts. The overarching work was focussed on the financial position and delivery. He thanked all involved for the senior engagement and commitment of Teams and information supplied which had yielded 2,500 document and responses to the survey were in the hundreds, all in support of the work. PwC had felt welcomed in their work to support WYAAT as opposed to 'doing to' WYAAT. A survey of Band 7s and above was conducted to gain feedback on the involvement of financial understanding across organisations. A report on each trust and overarching summary would be provided in the report. There were some key findings and real positives from an operational perspective. Leadership was clear on the financial challenge across WYAAT and what needed to be done about this, with support by communications and Finance Committees and Boards. The survey indicated that more could be done for a wider understanding by staff of the role they could play in this. SG drew attention to the significant financial deficit which had been £200m at the start of the year and £70m at year end. This presented a challenging year for WYAAT evidenced by some trusts being off plan at month two, but with improvement in controls, pay and non-pay, in month three. Significant changes and controls were positive to see over the last year, as well as opportunities for real learning from each other. The underlying position at the start of the year was a significant deficit and this was compounded by non-delivery at the end of the last financial year to be carried forward. The Waste Reduction Programme (WRP) was summarised, noting the risk of WRP plans that were not fully worked up at this stage

	in the year, which needed to flip from non-recurrent to current savings where possible, to continue the 'drumbeat' for focus and internal drive for deliverability and assurance of the waste reduction across organisations. There was variability to the approach around WRP across organisations, which was okay as one size doesn't fit all. The level of capacity also varied, as well as the themes to the messages of communication. Tracking of delivery was important and the focus to the back end of the year and the level of run rate improvement that was assumed in plans. This also linked to cash which was tight in a number of organisations and would get ever tighter. PwC would want trusts to think about the timing of a re-frame of the forecast and as this would be required if making applications for cash support. PwC had not spoken with Trust Chairs yet. They had set themselves findings by Trust and had tried to be specific, looking at timings for improvements and where, acknowledging WYAAT would not always agree on numbers, but that it could be helpful for opportunities to explore this further. SG explained the report contained a WYAAT chapter. This included a review by PwC of risks and was RAG-rated by Trust, to provide easy navigation. *NM joined the meeting.* NP stated that each of the Trust recommendations versus WYAAT opportunities was set out in the report where, across WYAAT trusts, PwC had grouped opportunities into two brackets which described where trusts could do something collectively or deliver or plan once as an action but deliver locally within individual trusts, noting similar themes within each Trust report for opportunities, but with the common theme for improvement. On collaborative opportunities, a strong theme had emerged described as a temporary staffing framework. PwC had taken the holistic approach of grip and control, looking at synergies and rate harmonisation and use of digital platforms, noting the variation. NP suggested other areas of work across WYAAT; housekeeping using grip and control strategy, as well as other areas like finance and accountancy policies, as there was some variation in how policies were applied. Processes were in place but there were further 'things to go at' if these were standardised. There were other areas that were more transformational with operational approaches to service delivery where there was also 'more to go at'. There were good areas that WYAAT was already undertaking. PwC had reviewed how WYAAT could work collectively to look at the elective waiting list and varying rates in services across trusts. If we started planning now this could result in savings in-year and moving forward for future years. For example, procurement collaboration and medicine management. There were common opportunities coming out of each trust such as approach to WRP and Cost Improvement Programmes (CIPs), types of documentation and PMO monitoring structures, job planning and rotas. It was important WYAAT had the common structures for; job planning and rota planning, as well as business case governance review, including improvements on return on investment and assurance of delivery. Communications and a wider understanding across the organisations and opportunities further down the structures could be better. It was stressed the importance of checking the achievement and delivering of business cases, thus understanding importance of generates benefits realisation. NP shared insight to the national NHS E mandated Investigation and Intervention

	(I&I) programme of work, which was a four-week rapid review, involving grip and control and a review of the financial plan, currently across nine ICSs to date. It was similar to the WYAAT scope, which was good news, as WYAAT had already proactively done this. There had been a recent announcement of a further eleven ICSs that were to undertake this review. The quicker WYAAT identified the actions the better, as it would put us in a strong position. **Q&A** LP referenced the overall position nationally and explored the local l position of WY ICS, noting WYAAT did not cover mental health or community services and PwC was not party to this. Len Richards (LR) shared the slow engagement and recent positive engagement of the similar approach for mental health and community trusts for financial review/s for wider understanding of the overall WY ICS position. He commented that the I&I was an ICS approach, and not a provider collaborative approach. Helen Hirst (HH) explored if learning from the national work aligned with WY. NP explained they had commenced their work of reviewing the nine ICBs, which varied in week one and week two. There were similar themes, but they lacked the strong collaborative work that was coming through from the WYAAT review and the overall financial problems presented more risk. In response to NP, KR noted PwC had talked a lot about what could be done by WYAAT's six acute trusts. He asked if PwC had identified the opportunities explained in the reports and if this might result in a reduction in deficit. NP explained the indication was set out in the single trust reports but given the nature of the rapid review, PwC had not done the detailed pounds and pence opportunities but instead had given a range of what that could look like. AW welcomed the discussion of the I&I process and explored if this would give WYAAT more time to implement. She asked PwC how convinced they were that WYAAT could implement the recommendations. SG discussed there were aspects of scope in the I&I programme where the specification was a far deeper process than the 'ask' of the WYAAT review, but there were similar themes coming through, such as opportunity and education. KR referenced the report, exploring the second stage which would be discussed in taking the report to implementation. BR confirmed WYAAT would be driving this and AW gave assurance that guidance through this would be provided. There were no further questions for PwC and KR thanked them for their presentations. *NP and SG left the meeting.* KR noted the key aspect was to take this forward and discussed the "what's next". Phil Wood (PW) referenced the discussion from the CEO report the previous week, reflecting the PwC reports needed to be taken through individual Boards, but this could take another couple of months, which would not shield us from national scrutiny. He was concerned about waiting until October, stating we needed to act now and sign off and share it. LR agreed that we needed to share this, noting the summary for MYTT was a fair report but there could be learning and action together

	to commence work. He stressed the learning and sharing from our positions would put WYAAT trusts on the 'front foot' to address issues, shielding us from I&I. LP echoed LR's comments and stressed the need to commence work immediately. MP reflected that the I&I was a system-wide review, but others across WY needed to catch up and go deeper to mirror the approach, as these were not captured in the PwC review which should be across WY ICB. Jonathan Coulter (JC) commented we needed to consider at what point we would share outside WYAAT, noting the ICB was waiting. He suggested not waiting until Boards in September. The question was when we would share this with the outside world, outside of WYAAT. SA replied that, in reference to the Board, that there was nothing revolutionary within the report but agreed this needed to be commenced sooner rather than later. AW reflected on individual governance and supported this to be shared. LR stated we should agree to share this with WYAAT CEOs and Chairs and share with our own Boards. He was minded of comments by Simon Worthington (SW) in that we would be stronger from the sharing and would also go further to share wider. He would advocate the wider sharing of this good report beyond WYAAT and communicate that this was how we were handling the working of this. **ACTION: LC to circulate PwC report with WYAAT CEOs and Chairs for sharing with their Boards and more widely.** LP stressed this was our report commissioned by us, otherwise this would have been 'done to us'. Hence, this was the WY ICB report, but this needed the wider picture of the ICB and ICS partners to avoid being pushed into the national I&I process. Big issues such as service delivery, estate/capital and transport would take the big money out of the system. She stressed there was no money in the system to support Trusts and no bailouts were coming. She noted CHFT had received 25% of cash support it had recently requested. She reflected on the cash position of trusts and that LTHT had never previously been as low in cash. Pressure would only increase in the system therefore we needed big thinking outside the I&I position. AW commended the incredible work that had been achieved by teams inside two months to support PwC. BR presented an update, summarising findings, and areas of best practice. Recommendations were grouped individually, allowing organisations to review and initiate themselves. BR discussed best practice for peer collaboration and sharing. Improvement opportunities were highlighted which focussed on procurement optimisation and there were suggested actions KR clarified the report had not been shared with WY ICB, with LC explaining that this would be shared with CEOs and DoFs. LP stressed this needed to be shared promptly. LC updated it would be shared with Rob Webster (RW) and Jonathan Webb (JW) at the Programme Executive meeting on 6 August 2024, with further discussion at the ICS System Oversight and Assurance Group (SOAG) meeting in September. BR summarised the six workstreams and actions in place, with three-month timescales. SA explored if there were any 'golden nuggets' within anyone's report.

	Responding, LR reflected that there were no major surprises, and the report did not identify any big impacts, this was about tightening up and sharing best practice for learning. He added we were not in the worst of ICSs nationally, but we were facing problems. He was reminded of previous conversations relating to this and questioned if this could be solved in one year, given this was a longer-term programme. SA reflected on the longer-term transformational issue. LP disagreed it would buy us more time. LR noted this was a three-to-five-year programme and we would have to start it somewhere. PW commented we did not request an assessment of transformational opportunities within the PwC ToR. The report stated we all had processes in place that may not be working very well. The challenge was about the six transformational issues which would take time and would need trusts to be bolder. FA reflected that the test would be to be bold to close the deficit and without any progress this year we would be the top of the list next year for national and external intervention. The focus was for WYAAT collectively and for each trust. KR referenced the ICB Board briefing. He was concerned about capacity and balancing all of the demands. LP stressed it was about addressing it all. She went on to reflect on the reputation of WY ICB which was dependant on WYAAT performance, hence their concern and anxiety. The discussion reflected on the skills and historic delivery by WYAAT on which the ICB was dependant. If the yearend was not delivered, then there would be no capital funding next year. We needed review what we could do about our estate. MP reflected the steer for the sense of urgency to address the current challenges. The ICB needed to shift pace, as this was more urgent, and there was a need for a refocus by the ICB for action versus preventative work with longer term aspirations and benefits. This should be for a point in the future. If we needed capacity of the ICB, then it needed to recognise and support the actions required. AW noted that from the PwC report we had heard that one of the risks had not gone as far as I&I; it was a deep dive into opportunities, which was a current focus. She reflected on whether there would be a different list of priorities had we done this, but also this needed to be across the wider WY trusts, beyond acute trusts. She wondered if this was an approach we may need to consider. FA commented we needed to understand what we had missed in the wider sense with community providers, and this should be raised with ICB to garner the view outside acutes. We needed to agree what we were prioritising, or we would never get to the longer-term transformation. LC noted there were existing workstreams and programmes in place, but these were not delivering e.g., the medicines optimisation programme across the ICS. We could maximise these for greater benefit but would need to review how we strengthen that. PW commented we needed to articulate from WYAAT where we were for the ICB. Place needed to be factored in regarding the ICB. These were not big tickets in the PwC report. We could tinker around the edges, or we could be bold and say we would want to save 25% of cost and what this was an opportunity. This would avoid re-checking if the list was right. We need to set an ambition for these workstreams which needed delivery and output for the population. AB commented on the historic intervention by Monitor, which was about gaining grip. This was needed right now to help drive the here and now. AB stated we needed dialogue with the ICB immediately to discuss the urgency of the situation around provision of additional

	capacity. KR agreed the whole landscape of this needed to be understood by the ICB. Sal Uka (SU) agreed with comments but there was a degree of priority. He explored how much of this we would lead on for the ICB, but we needed their support to harness delivery. All would have overlaps with Place. JC commented we needed to be brutal and focus priorities with key people into two or three, not six. LR examined that our priorities were short, medium, and long term, and reminded of clinical service reviews which historically had always led to more cost to resolve. The ToR needed to be set out differently for defining the outcome. We needed to be tough on what we were doing, why and experience of what worked. SU commented that fragile services review was about sustainability, but this was about whole pathways, with LR adding this was not solely a WYAAT issue but impacted community services and pathways. LP referenced the work of a District General Hospital (DGH) and not specialised commissioning (spec comm), sharing radical thoughts. All capital would be driven by service delivery. She referred to RAAC and questioned the build at ANHSFT and the service delivery of a replacement hospital. She referred Wharfedale Hospital with LTHT sharing the use with HDFT and cited the opportunity regarding the ICS alignment. She encouraged bold solutions that would gain us respect nationally. SA advocated six CEOs focussing on one priority on the list. AW cautioned on the focus on smaller numbers but needed to guard against I&I review further down the line. There was a need for discussion with ICS on Tuesday with CEOs. She stated we had workstreams and the PwC report and we should maximise the output as an ICB to close the gap on any intervention. KR clarified the combined PwC report would be circulated to Chairs for onward sharing with their respective Boards within days. He suggested that Chairs should hold a meeting in the next two weeks, chaired by RW and/or Cathy Elliott, to discuss what they would be doing individually. He proposed that CEOs report back with a plan of action. **ACTION: LC to share report with Chairs. Chairs to meet with Cathy Elliot at ICB to discuss individual plans. CEOs to report back to CiC with plan of action.** AB was unclear of the ICB concern about I&I. FA perceived that the ICB did have insight to the I&I process. BR updated on the concern and the inevitability of the WY ICB going through the I&I process. LP reflected on the spend on management consultants and the pressure for more capacity of managers that had a day job and whether managers had the skills and time. KR explored if this was an option as an online Teams extraordinary WYAAT CiC meeting with the ICB before the end of August, after the Bank Holiday. LP noted that LC had been asked to prepare a report for the ICB. LC responded, noting she had been requested to prepare papers on spec comm and acute collaboration for Paul Corrigan's visit to WY on 9 August 2024, noting there was an undertone of a policy move towards group models. **ACTION: GM to find convenient date for the CiC to meet online via Teams at the end of August or beginning of September.** *BR left the meeting* ***Post-meeting note:***

	It was agreed by all members that an extraordinary CiC meeting was not required with CEOs to reconvene to develop a proposal for discussion at CIC in October.
	BREAK
5.	**Chairs' Update** KR reminded that this agenda item was an opportunity for any Chair to share anything of note from their local, regional, or national network. LP noted previous information she had shared from national engagement, summarising that RAAC was not a priority but was about what could be delivered in the financial envelope that would set the whole priorities. She noted those in the 40 proposed the New Hospital Programme which would not now be funded, as there was not enough money within HM Treasury. She explained more details to the priority review that was taking place and shared wider insight from her recent discussions. SA shared insight from Humber and North Yorkshire ICB. LR reflected on the joined up and consistent view of feedback from PwC, noting there was a consistency of messaging within the organisation. NM noted the opening of ANHSFT's new urgent treatment centre and that the Trust was open for advert for their position of Chair. SJ updated on the learning and insight from South Yorkshire's current position and leadership by the ICB. KR would request a meeting and plan for engagement with ICB support. **ACTION: LC to circulate the PwC report to WY ICB.**
6.	**Programme Executive Report** **6a – WYAAT Programme Executive FINAL Minutes 020424.pdf** **6b – WYAAT Programme Executive Meeting Minutes FINAL 070524 V0.3.pdf** **6c – WYAAT Programme Executive Meeting Minutes FINAL 040624 v.03.pdf** **6d – WYAAT Programme Executive Action Log (updated 250624) v1.0.pdf** FA provided an update on behalf of Brendan Brown (BB). FA noted the actions on the PwC review will be picked up at Programme Executive next week and come back to planned meeting in August or September. The ICB had been prioritising the efficiency and productivity agenda. There was a continued focus to reduce out of area mental health placements, review medicines optimisation and enable secondary prevention interventions. WYAAT would continue the work around evidence-based interventions clinical policies, exploring what we were not going to do and what we should be doing. Opportunities were reviewed to support the prevention agenda, along with transformation of outpatients. FA noted a lot of time had been spent on LIMS deployment and shared that LC would provide further update on LIMS deployment and the collective work later in the meeting. FA noted ANHSFT and BTHFT were linked to EPR deployment in September. There was a potential risk of industrial action in primary care by GPs, but the outcome of the ballot was currently unknown, with COOs sharing work and planning. FA raised spec comm and the risks in a transferring the commissioner role to the

	ICB. PW reminded of NHS E's decision for spec comm to be taken over by ICBs and the likely shift by April 2025. WYAAT CEOs wanted to take spec comm as a delegated function to WYAAT and had agreed the programme of work and direction of travel on this with the ICB but needed to understand what the delegation would look like. PW highlighted that the gap in funding meant NEY was significantly underfunded for spec comm services and citing initial development work required on radiotherapy and renal dialysis. This would need national pressure by the ICB for improved funding allocation and he was to Chair this Programme Board. He noted LC would state that provider collaboratives were the best way to delivery spec comm at the upcoming meeting with Paul Corrigan on 9 August. LP referred to the budget for spec comm and the management of this from South Yorkshire, expressing her concern in their leadership of this given the financial position in South Yorkshire. She updated that she had sought confirmation of who had made this decision. LP stressed the wider risks and impact to LTHT from delays with LIMS. *The CiC received the Programme Executive Report, the Programme Executive Minutes for 2 April, 7 May and 4 June 2024 and Action Log (updated 25.06.2024), noting the ICB's prioritisation of efficiency and productivity, the ballot outcome on possible industrial action in primary care and the visit by Paul Corrigan due to take place on 9 August.*
7.	**Collab Report, West Yorkshire Health and Care Partnership Report** **7a – WYAAT Collab Report 30 July 24 (1 June-30 June).pdf** **7b – WY HCP Report.pdf** **7c – WYAAT System Risks v.1.1.pdf** **7d – 2024.07.02 Proposal to establish the approach to continuation of the imaging platform (PACS) in WYAAT beyond the current contract v1.0.pdf** **7e – Monthly update June 2024.pdf** **7a – WYAAT Collab Report 30 July 24 (1 June-30 June).pdf** *LC draw attention to the new format of the Collab Report with red, amber and no green and discussed the positives from the last quarter*. She *provided the following updates on items within the Collab Report:* • **Endoscopy Academy.** This was up and running and closed as a project. • **Senior Leadership Programme (SLP).** This was working well. The second cohort of 20 participants had attended recent workshop and were now on their placements, with community, mental health and YAS included. The midpoint evaluation would take place soon. • **Haematology.** Work service fragility had been targeted, LTHT HDFT in particular, to make it more sustainable. LC reported it felt like it was in a better place than previously, and a model of support was being created. • **Collaborative Procurement**. This had begun as a WYAAT programme and had grown since the COVID-19 pandemic with other providers. CEOs proposed moving to a different service model of BAU, hosted by LTHT, which would yield savings in-year of c.£4m. The move would take place on 1 August, with a formal programme closure report to follow. • **Specialised Commissioning.** PW noted that spec comm programme would start in August 2024. **7e – Monthly update June 2024.pdf**

	LC provided the following updates on items within the Monthly update: • **Pathology.** The main issue remained around LIMS deployment. Resource was driving the issue. LIMS had been under monthly review with CEOs since April 2024. LC noted it was still a collaborative effort and highlighted the mitigations. The next go live with CliniSys would be with ANHSFT and BTHFT in September 2024 and CliniSys were working to agree a new date for LTHT. Governance learning was being applied. The rebuild in haematology risk was now resolved. If a new date could be agreed for LTHT, we could maintain the overall implementation plan. ANHSFT and BTHFT were on plan, so the risk, once completed, would ease for everyone else moving forward and learning could be applied to future deployments. • **Imaging/shared reporting solution.** HDFT were now in live testing, with ANHSFT and BTHFT expected next. It was anticipated that all trusts would be in the system soon and we continued to push on this. There were likely to be three deployments of Chest AI before Christmas 2024, with more to follow going into 2025. **7d – 2024.07.02 Proposal to establish the approach to continuation of the imaging platform (PACS) in WYAAT beyond the current contract v1.0.pdf** *LC provided the following updates on items within the Proposal to establish the approach to continuation of the imaging platform (PACS) in WYAAT beyond the current contract:* • **PACS.** LC highlighted there were six instances of the same system and contracts were coming up for review. A plan was needed for procurement to progress and develop an outline business case to take to the CiC in January 2025. Papers outlining the business case had been taken to Programme Executive at the beginning of July. • **Industrial Action.** LC discussed the risks around this in general practice felt greater than those experienced in other industrial action in secondary care, but it was noted risks were reduced around elective care, respiratory viruses, and emergency care. There was a brief discussion around the industrial action in general practice, with PW noting that GPs were offered 6% but there was also a second issue around contracts. *The CiC received the Collab Report, WY HCP Report, System Risks, Proposal to establish the approach to continuation of the imaging platform (PACS) in WYAAT beyond the current contract and Monthly update, noting spec comm would start in August; the endoscopy academy project was closed and a programme closure report for collaborative procurement was expected; LIMS was still an issue; all trusts would soon be on the system of imaging and shared reporting solution; the PACS business case would be taken to the CiC in January 2025; general practice risks around the anticipated industrial action felt greater than with secondary care.*
8.	**WYAAT Annual Report 2023/24** LC noted the usual format would be published subject to approval and explained the wider communications to support this, noting that in future years, this would be aligned to the WYAAT Strategy. *MP briefly left the meeting to take an urgent call and returned.*

	LC shared that Rachel Coleman (RC) had developed communications to help promote this. It was a composite of achievements over the last 12 months. SA referenced collaboration, stating we were only achieving this by working together, which was a really important message that should be reinforced. KR explored the wider circulation. RC explained it would be published on the website and shared with ICB and stakeholders and it was explored that this should be proactively owned by WYAAT. LR stated that provider collaboratives were the future. AB suggested improving the return on investment which would need to be stronger within the report to draw this out. SJ proposed a two-page summary that was user-friendly for the public, which would push the message of what we were doing for them as the public. **ACTION: LC to update the Annual Report with ROI prior to publication.** **ACTION: RC to develop public summary version of the Annual Report.**
9.	**WYAAT MoU Review** KR referred to the 2016 inception of the Memorandum of Understanding (MoU). LC thanked Jo Bray (JB) and the Company Secretaries involved in reviewing the MoU. She noted the updated MoU was included with meeting papers, with a track changes version also included. LC shared that the MoU had been reviewed in 2019 and 2021 and the latest review made it more contemporaneous in language. She summarised the changes noting the inclusion of legislative changes, the five-year strategy, extraordinary meetings, and assurance framework. Estates Directors and HR Directors had always been consulted for approvals of business cases; this was now formalised in the assurance framework. LC asked the CiC for support to approve the update. JB confirmed the MoU would need to go through public Boards for approval, noting this should be an appendix to the trusts' Standing Orders as agreed by the Company Secretaries in 2016. KR noted that following approval by public Board, it would be brought back to this meeting. **ACTION: CEOs and Chairs to update MoU in Trust Standing Orders via a Public Board.**
10.	**AOB** PW discussed the service level agreement with ICBs that defined what we deliver as a provider collaborative. Noting this had been formalised by other provider collaboratives, he asked that we consider our relationship with the ICB and how formal we wanted to make that relationship. LC explained the mechanism, noting what we had already was a responsibility agreement. It would be useful to understand the general description of the relationship. FA agreed that understanding the benefits and disadvantages would be good to look at. HH cautioned if the timing was right and whether we should delay doing this. KR agreed to look at other models and bring something back to CiC in October. MP reflected on potential changes to spec comm, noting this would convey a different governance definition, so it would be timely. **ACTION: CEOs to examine service level agreement models with ICBs and review at the October CiC.**
11.	**Communications - Key Messages**

	RC summarised the key messages: • Cost review: next steps and discuss with communications leads to support things out of the report. • Communication the financial challenges to staff at all levels. • Annual Report: an overview of what RC had planned would be shared on social media, in bulletins and web sites. She would take action on how we share the report to celebrate our successes (noting the comment below by LP relating to how this should be used wider system influence) • RC would work on the communications strategy for the next five years.
12.	**Review of the Effectiveness of the Meeting** KR stated the meeting had been really helpful, with the CiC being quite courageous of the discussions, but required being followed through as action, we needed to be bold. He noted we should not underestimate the work to be done. LP commented on communications, noting she would give thought to where the annual report needed to be shared, both at the Centre and nationally. She noted we had a lot to be proud of and next year should look fantastic. LC reflected on the need of the communication strategy, which was targeting and influencing, given the new Government. HH commented on the WYAAT Leading Innovation Through Collaboration Conference scheduled for 11 October 2024, suggesting we think differently about who we would invite to this, noting this was an opportunity and a big platform for us, with keynotes. LP had requested the conference programme, what its purpose was and if the right people were coming, exploring if this was about succession planning and who we were trying to impress. LC responded that we had started in a space of doing this for ourselves, creating a force around innovation and research, and collaboration, and using it as a broader strategy for national policy. LP questioned what we were selling and if the ambition had changed. LC noted the October event would be internally focussed. PW commented there were many collaboratives that were bought into WYAAT, and the event was originally aimed at clinical engagement, which was important. FA supported this, commenting that having an opportunity to showcase was important and the exchange of information would be really powerful. She spoke of clinically led service strategies, noting it was the same for ANHSFT as it was for LTHT, with performance and activity to be understood, and the impact to funding and impact to capital. MP noted the positive influence of having the NHS E CMO endorse collaborative working, if this could be arranged. The discussion concluded that the conference should be retargeted as internally facing, focused on clinical engagement in research, innovation, and improvement across WYAAT. **ACTION: LC and PW to redraft the conference programme and confirm requirements to CIC.** KR gave apologies ahead for 29 October 2024, as he would be away.
Meeting Close	
Date and time of the next meeting:	

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West Yorkshire Association of Acute Trusts

NHS

29 October 2024 09:30-12:30
Research & Innovation Centre, Leeds Teaching Hospital NHS Trust