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	September 2024

Summary:

Aligned with the **CQC SAFE Domain**, the organization is addressing key safety risks to protect staff, patients, and visitors while promoting a culture of continuous improvement.

- **HDH Goods Yard Security (CHS2)**: Temporary security measures are in place to prevent unauthorized access, with permanent improvements targeted by March 2025.
- **Fire Safety (CHS3)**: Fire risk assessments are complete, and infrastructure upgrades are underway to reduce the risk rating by September 2024.
- **Violence and Aggression (CHS5)**: Policy updates, enhanced training, and security reviews are being implemented to safeguard staff and improve safety, including addressing limited security presence and outdated procedures.
- **Health & Safety – Building Security (CRR102)**: Outdated security policies, limited security presence, and inadequate CCTV/access control systems are being addressed through updated risk assessments, infrastructure improvements, and enhanced staff training. Plans include replacing door access systems, expanding CCTV coverage, and preparing for compliance with Martyn's Law by April 2025.
- **Containment Level 3 Microbiology Work (CRR98)**: The unavailability of the onsite CL3 lab has led to outsourcing, posing risks to patient safety and financial sustainability. Plans to recommission the CL3 facility by March 2025 are underway, alongside efforts to improve sample logistics and mitigate delays.

These actions reflect the organization's proactive approach to ensuring safe systems, environments, and staffing, in line with **SAFE Domain** standards.

Corporate Risk ID	Strategic Ambition	Type	Principle Risk:	Appetite	Initial Rating	October Rating	November Rating	Target Rating	Target Date
CRR75: CHS2 Health and Safety	An Environment that promotes wellbeing	Operational; Health & Safety	**CHS2**: HDH Goods yard 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	Current Position	Controls and Plans
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	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: • **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.	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.

Corporate Risk ID	Strategic Ambition	Type	Principle Risk: CHS3: Managing the risk of injury from fire	Appetite	Initial Rating	October Rating	November 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	Nov 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.

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.

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.

Corporate Risk ID	Strategic Ambition	Type	Principle Risk: CHS5: Violence and aggression against staff	Appetite	Initial Rating	October Rating	November 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	Dec 24

Key Targets

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.

Current Position

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

Controls and Plans

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: New policy and procedure are under delopment for staff safety. 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: CHS10: Physical security provisions, training and support resources	Appetite	Initial Rating	October Rating	November Rating	Target Rating	Target Date
CRR102: CHS10 Health and Safety	An Environment that promotes wellbeing	Operational ; Health & Safety	Organisational risk to compliance with legislative requirements, and the risk of major injuries, fatality or permanent disability to employees, patients, visitors or others due lack of suitable policies and procedures, and the subsequent lack of suitable and sufficient control measures, including physical security provision, training, resources to support implementation.	Minimal	16	16	16	8	April 25

Key Targets

Building Security Assessments completed for all premises used by Trust staff (this will not include patient homes which will be referenced in any relevant patient plan)

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. Reported via Security Forum

Use of available data sources, such Datix, sickness absence as part of the monitoring and review process.

Security incidents investigated and remedial action taken where identified.

Effective communications to all staff.

Provision of appropriate training and information to all Trust staff clinical and non-clinical.

Current Position

Outdated Security Policies: Policies related to Security, Lockdown, Bomb Alert, Theft, Damage of Trust assets, personal property, and CCTV are outdated and do not reflect the Trust's geographical footprint or current operations.

Generic Risk Assessments: Existing security risk assessments are generic and do not sufficiently identify hazards or provide clear control measures, particularly for building security, individual response, and lone working.

Limited Security Presence:

- **Acute Setting**: Security is present only from 6 PM to 6 AM daily, with additional coverage on Monday, Friday (7 AM – 5:30 PM), and weekends (6 AM – 6 PM).
- **Community Hospitals**: No dedicated security presence, such as at Ripon Community Hospital.
- **Community Footprint**: A single Local Security Management Specialist (LSMS) covers the entire community setting, limiting response capabilities.

Inconsistent Training: Staff training is limited and not risk-based. Compliance with escalation procedures during violent incidents is inconsistent, and staff are underprepared to manage security threats, including Violence & Aggression.

CCTV and Access Control Limitations:

- **CCTV**: Current coverage at the HDH site is inadequate, with management delegated to the HIF.
- **Access Control**: The swipe card access system is outdated, unsupported, and lacks proper control over keys and lock codes. This has led to poor key management, particularly with contractors and Trust staff.

High Incident Rates: Recent high-risk incidents, including absconded patients and Violence & Aggression (V&A) incidents in hospital corridors and visitor toilets, underline insufficient resources and response capabilities.

Safeguarding Gaps: There is no formal communication between the Safeguarding Team, Trust Security management, and Emergency Department management, despite warnings from local law enforcement regarding County Lines gang activity.

Governance Gaps:

- **Security Leadership**: Lack of clarity around executive leadership and accountability for Security within the Trust.
- **Security Forum**: The Trust Security Forum has been established and now reports to the Health & Safety (H&S) Committee. A review of membership and terms of reference is underway.

Controls and Plans

Policy Updates: The Health & Safety (H&S) team, in coordination with HIF, is currently updating all relevant security policies, including Lockdown, Bomb Alert, Theft/Damage, and CCTV. These updates aim to align policies with the Trust's current structure, services, and geographical footprint.

Risk Assessments: Comprehensive security risk assessments are being developed, with a focus on individual sites, lone working, and staff responses. Departmental risk assessments are ongoing at the local HDH level and across the community footprint.

Security Infrastructure Improvements:

- **Door Access Control**: A new door access system has been costed and will be replaced incrementally as part of the Trust's Backlog Maintenance work.
- **CCTV Coverage**: A review of CCTV systems is in progress, with updates planned where necessary.
- **Security Guards**: HIF is obtaining legal advice regarding the provision and licencing of Security Guards at the HDH site. This will be included in a business case for securing funding for additional security personnel.

Training Improvements: Training on Violence & Aggression and Security risks is under review and will be updated to ensure staff receive appropriate, risk-based training. A new Conflict Resolution program tailored to various risk levels is in development.

Governance and Responsibility Clarification: Discussions are ongoing with HIF to clarify security roles and responsibilities. Additionally, the Trust Security Forum's review will strengthen the governance structure by refining its terms of reference and membership.

Compliance with Martyn's Law: With the impending implementation of the Terrorism (Protection of Premises) Bill (Martyn's Law), the Trust will undergo significant work to ensure compliance, particularly in areas related to terrorism risk management.

Improved Safeguarding Communication: Efforts are being made to establish formal communication channels between the Safeguarding Team, Trust Security management, and Emergency Department management to address security threats, such as County Lines gang activities.

Corporate Risk ID	Strategic Ambition	Type	Principle Risk: Outsourcing of Hazard Group 3 Microbiology Work Due to CL3 Facility Unavailability	Appetite	Initial Rating	October Rating	November 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.
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These actions are critical to mitigating current risks and ensuring patient safety, sample integrity, and operational continuity.

Harrogate and District NHS Foundation Trust Corporate Risk Register

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)	**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 has been addressing risks related to patient safety and colleague health due to low staffing levels in the North Yorkshire 0-19 Service (CRR93). CRR93 scoring was reduced in September 2024 and therefore it has been reduced form the CRR. The Trust continues its 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.
Executive Committee	Quality Management Group (QGMG) (Clinical) Workforce Committee (Workforce)	
Initial Date of Assessment	1st July 2022	
Last Reviewed	September 2024	

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

Key Targets	**Current Position**	**Controls and Plans**

	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	September 24	

Corporate Risk ID	Strategic Ambition	Type	Principle Risk: **CRR34**: Autism Assessment	Appetite	Initial Rating	October Rating	November 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 1566 (target 120) Longest wait of CYP having commenced assessment, 82 weeks (target 13) Activity - 31 completed assessments in Aug against ICB plan of 50 (plus 2 military assessment), YTD 255 against plan of 250. ■ 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) which ended on 31st Aug 24. The projected wait for assessment for a new referral added to the waiting list today is 39 months. Our commissioned capacity is now lower at 40 assessments per month which means the waiting list will grow more steeply. 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	October Rating	November Rating	Target Rating	Target Date
CRR61: ED 4-hour Standard	Person centred, integrated care, strong partnership	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	March 25

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%. Performance:

TOTAL ED PERFORMANCE INCL RIPON	Year	Month	Day	Non admitted breaches	Admitted Breach Number	TOTAL ED ATTENDANCE WITH RIPON	MAX ED Attendances	MIN ED attendance	AVERAGE ED attendance	Ripon MIU Attendance
64.27%	2022	September	30	669	544	3395	181	123	150	544
68.22%	2022	October	31	857	814	5258	169	122	144	785
66.22%	2022	November	30	875	857	5128	168	112	146	748
63.65%	2022	December	31	943	959	5235	187	114	145	735
77.82%	2023	January	31	385	643	4635	154	93	126	742
80.79%	2023	February	28	329	551	4580	181	102	138	721
78.45%	2023	March	31	461	688	5337	167	109	146	810
83.48%	2023	April	30	360	501	5219	169	121	147	806
81.56%	2023	May	31	461	610	5815	182	134	157	952
80.54%	2023	June	30	536	617	5926	188	133	165	988
81.95%	2023	July	31	522	532	5838	189	129	157	979
72.89%	2023	August	31	784	736	5607	177	130	152	902
65.56%	2023	September	30	1157	840	5799	185	123	161	982
69.87%	2023	October	31	809	890	5656	195	125	155	851
68.91%	2023	November	30	854	838	5443	194	131	157	734
67.10%	2023	December	31	920	931	5626	205	120	158	724
71.21%	2024	January	31	767	889	5751	187	125	161	775
71.97%	2024	February	29	778	713	5320	209	128	158	727
78.15%	2024	March	31	576	670	5702	195	128	160	750
72.51%	2024	April	30	725	815	5606	193	129	158	858
73.40%	2024	May	31	864	790	6219	197	137	167	1038
72.88%	2024	June	30	873	787	6121	202	143	170	1010
74.25%	2024	July	31	816	772	6168	196	127	165	1058
79.23%	2024	August	31	636	592	5913	181	120	156	1079
75.44%	2024	September	30	831	668	6103	202	142	169	1044
72.29%	2024	October	31	839	824	5987	209	133	164	915

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.

Corporate Risk ID	Strategic Ambition	Type	Principle Risk: CRR79 Stroke Provision	Appetite	Initial Rating	October Rating	November Rating	Target Rating	Target Date
CRR79: Stroke Provision	Person centred, integrated care, strong partnership	Clinical; Patient Safety	Risk to patient safety due to delayed treatment caused by lack of capacity.	Minimal	16	-	16	4	Dec 2024

Key Targets	Current Position	Controls and Plans to implemented
All eligible patients receiving HASU Care No patients requiring HASU are directly admitted to Harrogate for Emergency Care.	**New Risk** New risk entered onto the risk register.	To support the Trust's True North objective, several focused actions and plans are being implemented: 1. Limited control and mitigations possible as ongoing negotiations with WY and NY are not yet concluded. Proposed pilot with York for inpatients and walk-ins to be referred to York remains under negotiation. 2. Continue to monitor SSNAP data and datix's raised re direct admissions to Harrogate. Ensure datix reports submitted for all delays and non transfer is robust to understand root causes. Planned Audit with HDFT and YAS for last 12 weeks data to understand why these patients were directly admitted. This will commence 30/09/24.

Corporate Risk ID	Strategic Ambition	Type	Principle Risk: NEW Cardiology	Appetite	Initial Rating	October Rating	November Rating	Target Rating	Target Date
TBC: Cardiology	Person centred, integrated care, strong partnership	Clinical; Patient Safety	Cardiology: Risk to providing DGH urgent and emergency care services due to lack of 24/7 cover.	Minimal	12	-	12	3	Dec 2025

Key Targets	Current Position	Controls and Plans to implemented
24/7 cardiology cover	**New Risk** New risk entered onto the risk register. • Safety risk for acute patients on CCU – recruitment process for Cardiology Fellow • Staffing - Substantive post for Consultant back out to advert with R&R premia • Current medical workforce do not have the skillset for temporary pacing wires and pericardiocentesis – excellent links with LGI • Long waits for outpatient angios (30% waiting over 6 weeks) – using locum to reduce was 50% over 6 weeks – also review use of Cath lab • ECHO service reliant on outsourcing workload (12 months ago 70% patients waiting over 6 weeks – now 22% waiting over 6 weeks – Sanus cor delivered activity and bank) – now recruited to a vacant post (starting Jan 25) and plans to grow our own No weekend Consultant ward round or ECHO provision • Increasing demand on pacemaker service due to increasing aging patient profile • Not meeting GIRFT requirements with 7 day service and weekend cover/ on call - Cardiology strategy planning meeting scheduled for 7 November 24.	To support the Trust's True North objective, several focused actions and plans are being implemented: Wider range of recruitment activity and partnership working

	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	October Rating	November 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 reviewed and established the underlying pressure moving into 24/25, £20.1m. Following further scrutiny across the wider system, the system agreed to a higher efficiency % target and an allocation of further funding. This has resulted in a £5.2m deficit plan for 24/25 which includes a 6% efficiency target. There are a number of risks contained within this plan including • Continued ED boundary divert • Inflation above the levels included in planning • Recurrent delivery of the efficiency programme • ERF Funding is achieved/over delivered The Directorate highlighted a number of issues when signing budget plans for 24/25. A number of mitigations are being reviewed to manage these. As at July the Trust are £0.1m behind plan due to an improvement in Directorate run rates and recognition of income expected. A main driver of the position is the undelivered WRAP, £2.4m, high risk schemes remain at £12m. There was no progress made on WRAP in July. An area which continues to show improvement is agency spend which is now 1.3% against a 3.2% NHSE target.	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.

The current run rate is having a detrimental impact on the cash balance.
Cash support will be required throughout the year if the reduction in run rate is not delivered.
Current cash forecast highlights that this will be required in Qtr 3 (Oct-Dec).

Corporate Risk ID	Strategic Ambition	Type	Principle Risk:	Appetite	Initial Rating	October Rating	November 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	October Rating	November 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	September 24	

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

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

SAFER STAFFING REPORT OCTOBER 2024

Adult Inpatient, Emergency Department and Children and Young People Inpatient Ward, Safer Nursing Care Tool (SNCT) Bi-annual Safer Staffing Review.

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 of SNCT data collection: July 2024

SNCT review meetings: August 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 July 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

Safe, Effective, Caring, Responsive and Well- Led Care		
Measure and Improve -patient outcomes, people productivity and financial sustainability- -report investigate and act on incidents (including red flags) - -patient, carer and staff feedback-		
-implement Care Hours per Patient Day (CHPPD) - develop local quality dashboard for safe sustainable staffing		
Expectation 1	**Expectation 2**	**Expectation 3**
Right Staff 1.1 evidence based workforce planning 1.2 professional judgement 1.3 compare staffing with peers	**Right Skills** 2.1 mandatory training, development and education 2.2 working as a multi-professional team 2.3 recruitment and retention	**Right Place and Time** 3.1 productive working and eliminating waste 3.2 efficient deployment and flexibility 3.3 efficient employment and minimising agency

The scope for this Safer Nursing Care Tool (SNCT) data collection encompasses the adult in patient wards. This is the second 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, in respect of the enhanced care requirements.

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 July 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 and Wensleydale, our medical admissions ward and Cardiology and Respiratory ward. For these wards a ratio of 70:30 was used to take into account the additional registered nurse input required to manage the acutely unwell patients, which is recommended by the tool with regards to these 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 and dependency 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.

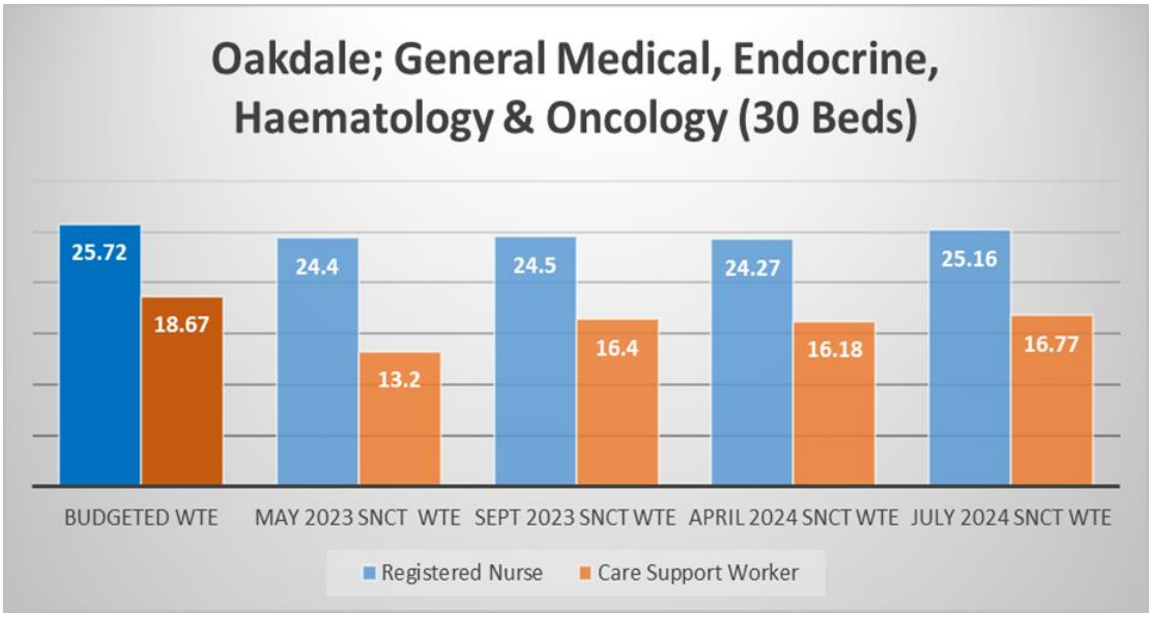
Harrogate and District NHS Foundation Trust

Results by Ward

Oakdale

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

SNCT Data since establishment uplift in April 2023



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

Discussions and data pack

See appendix 1

Recommendations

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

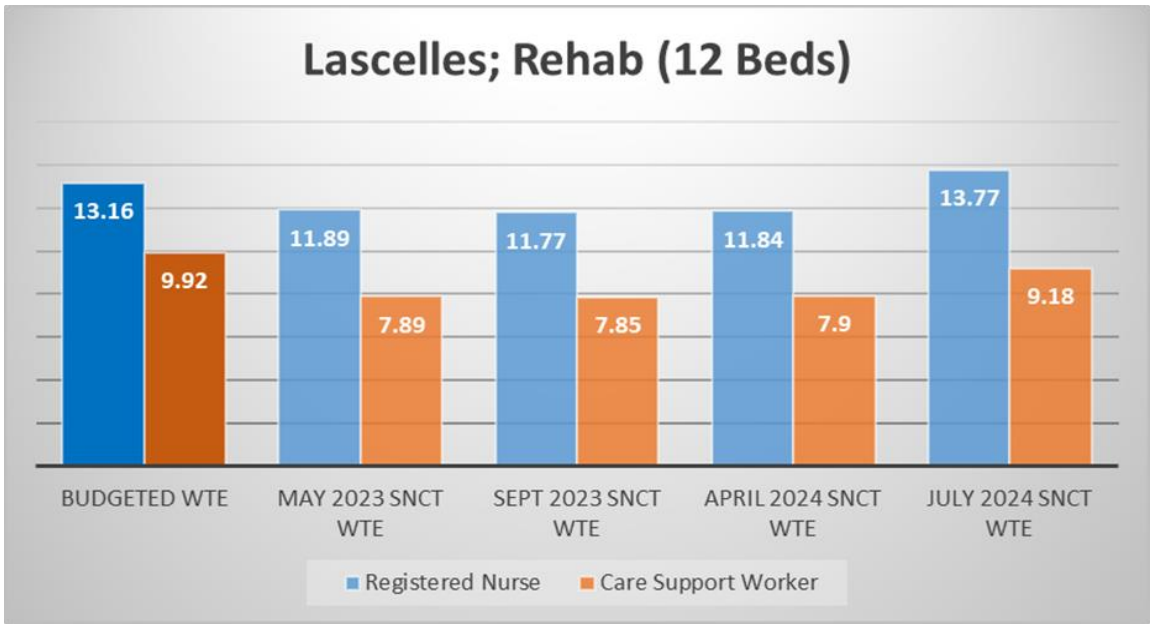
Any enhanced care requirements or unfilled shifts should be reviewed as part of the new safer staffing meetings using SafeCare. This is a safer staffing tool which measures the actual acuity and dependency of the patients on each ward against the availability of staff to ensure that we are deploying 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 January 2025.

Lascelles

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

SNCT Data since establishment uplift in April 2023



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)**		

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 and data pack

See appendix 2

Recommendations

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. This is being picked up by the directorate as part of a wider admin support review.

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 January 2025

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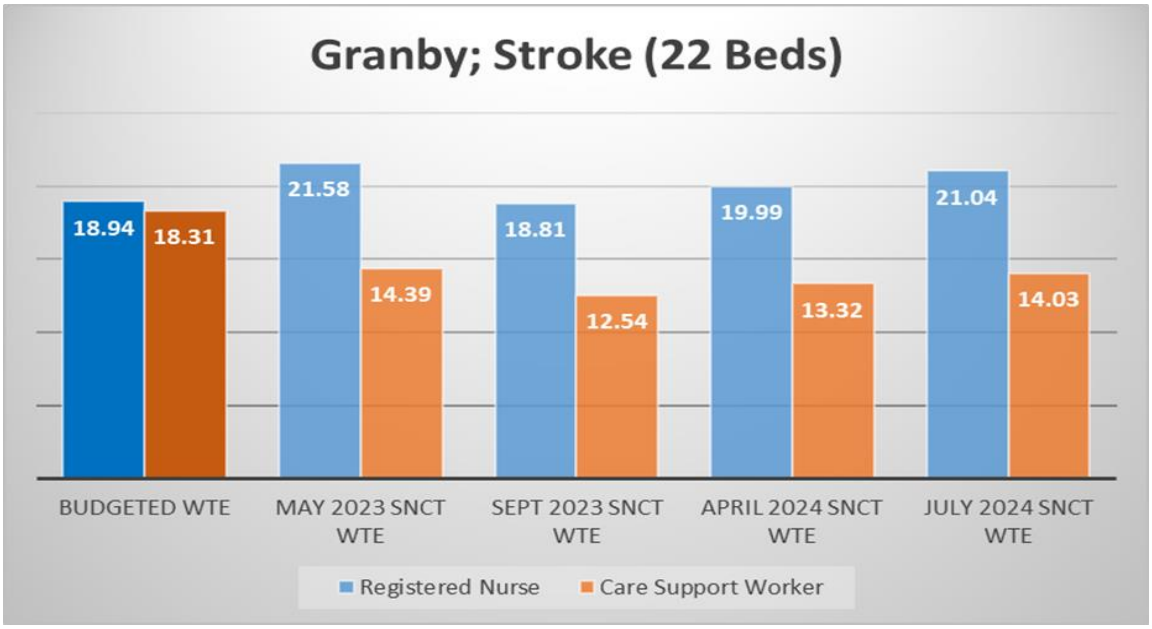
Granby

Granby is a 22 bedded Stroke & Neurology ward.

SNCT Data since establishment uplift in April 2023



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

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Discussion and data pack

See appendix 3

Recommendations

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

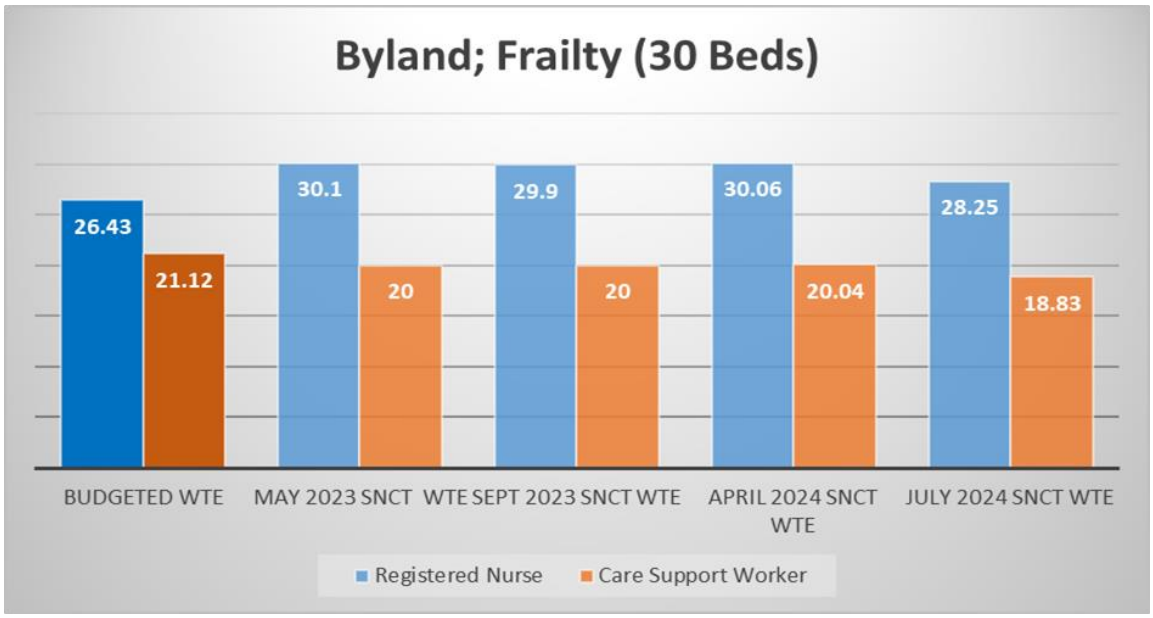
Any enhanced care requirements or unfilled shifts should be reviewed as part of the new safer staffing meetings using SafeCare. This is a safer staffing tool which measures the actual acuity and dependency of the patients on each ward against the availability of staff to ensure that we are deploying 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 January 2025.

Byland

Byland is a 30 bedded Frailty ward.

SNCT Data since establishment uplift in April 2023



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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 and data pack

See appendix 4

Recommendations

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

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 January 2025.

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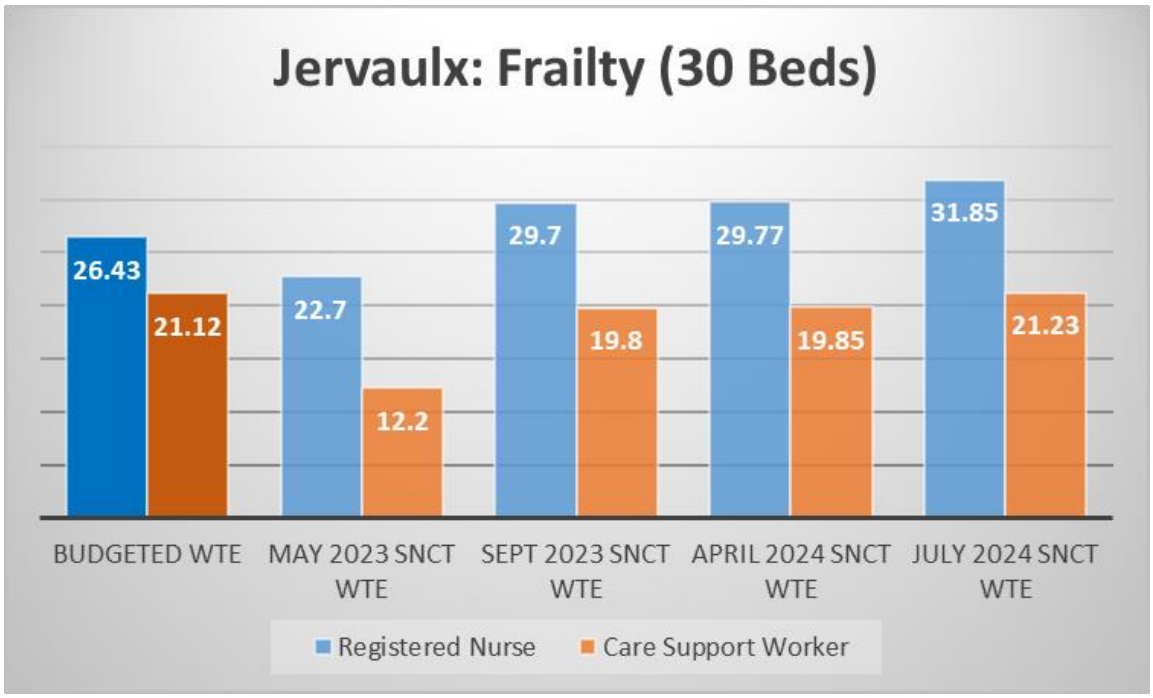
Jervaulx

Jervaulx is a 30 bedded Frailty ward.

SNCT Data since establishment uplift in April 2023



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 and data pack

See appendix 5

Recommendations

The SNCT outputs (data, quality metrics and professional judgement) **indicate no changes to the establishment as a result of this data collection.**

Ensure that the Ward team 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.

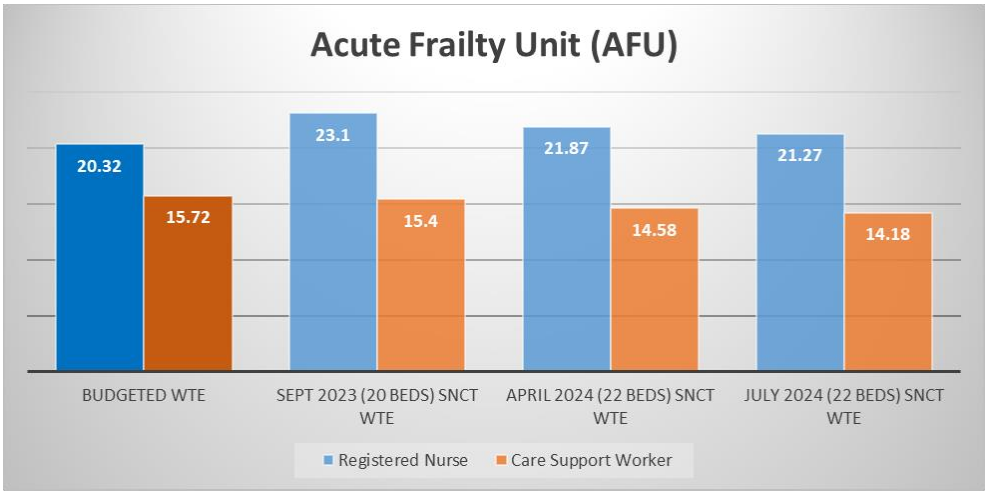
The directorate should build a business case to encompass all of the wards, Ward Clerk requirements.

Continue to collect twice yearly SNCT data, using the new levels of care SNCT tool. The next data collection will be in January 2025.

Acute Frailty Unit (AFU)

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.

SNCT Data since establishment uplift in April 2023



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The current staffing template for AFU (not including escalation 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 and data pack

See appendix 6

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 and CSW on the early shift.

Recommendations

The SNCT outputs (data, quality metrics and professional judgement) **indicate no changes to the establishment as a result of this data collection.**

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

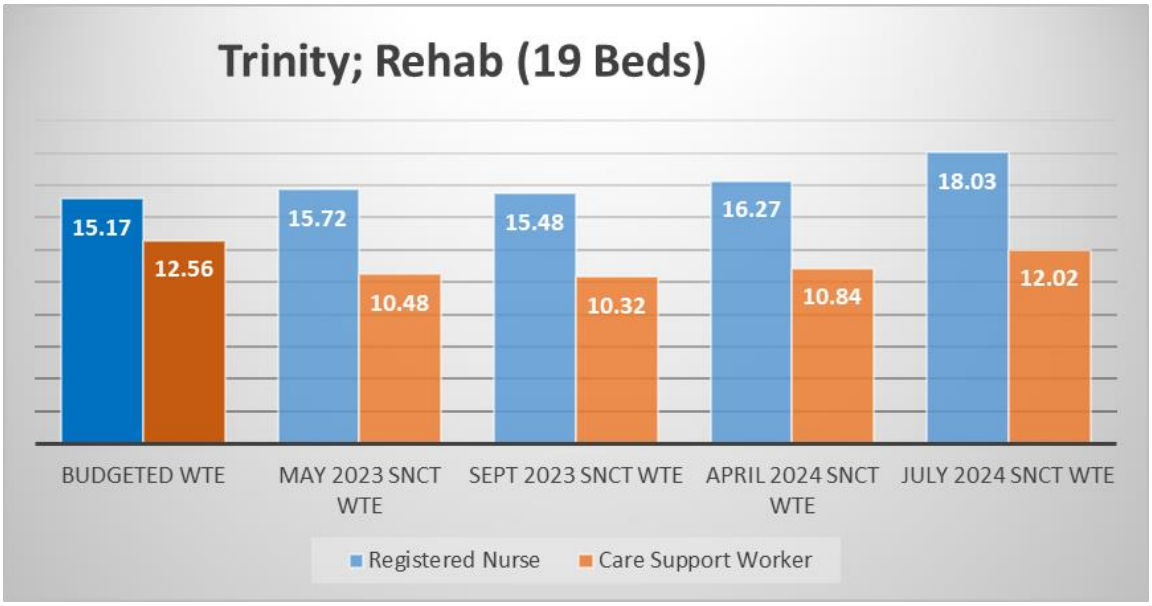
Any enhanced care requirements or unfilled shifts should be reviewed as part of the new safer staffing meetings using SafeCare. This is a safer staffing tool which measures the actual acuity and dependency of the patients on each ward against the availability of staff to ensure that we are deploying 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 January 2025.

Trinity

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

SNCT Data since establishment uplift in April 2023



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

See appendix 7

Recommendations

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

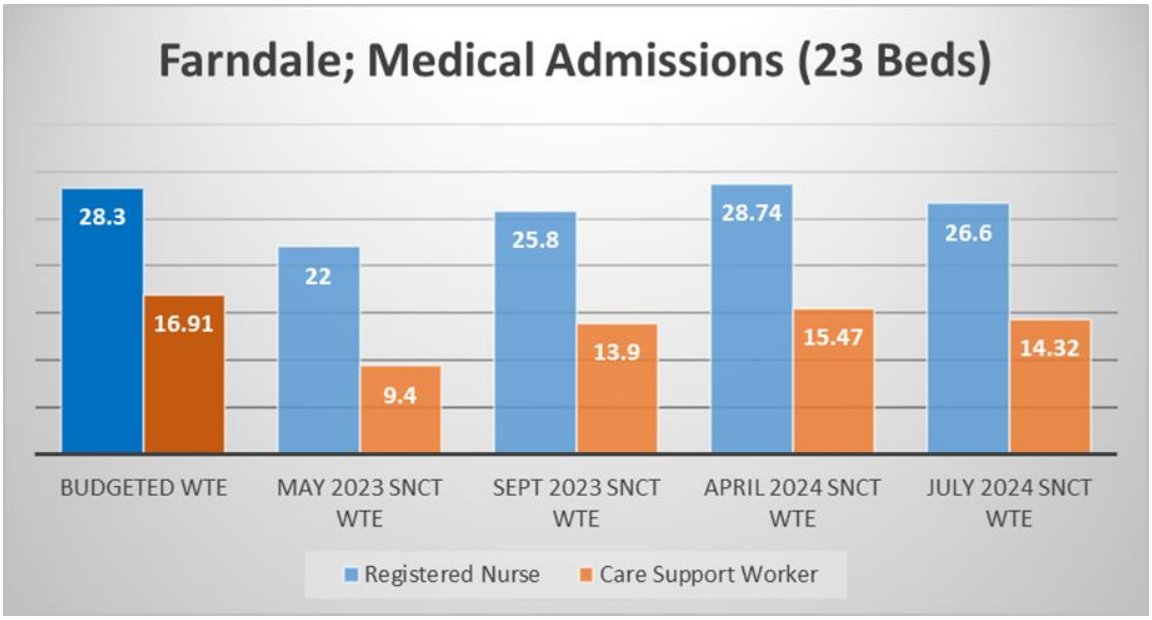
Any unfilled shifts should be reviewed as part of the new safer staffing meetings using SafeCare. This is a safer staffing tool which measures the actual acuity and dependency of the patients on each ward against the availability of staff to ensure that we are deploying the right staff with the right 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 January 2025.

Farndale

Farndale is a 23 bedded Medical Admissions ward.

SNCT Data and Changes in Nursing Establishment



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The current 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)**		

Budgeted Skill Mix

Band	WTE
7	1.0
6	6.44
5	20.86
3	0.0
2	16.91
2 Nutritional Assistant	1.4
2 Ward Clerk	2.07

Discussion and data pack

See appendix 8

Recommendations

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

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.

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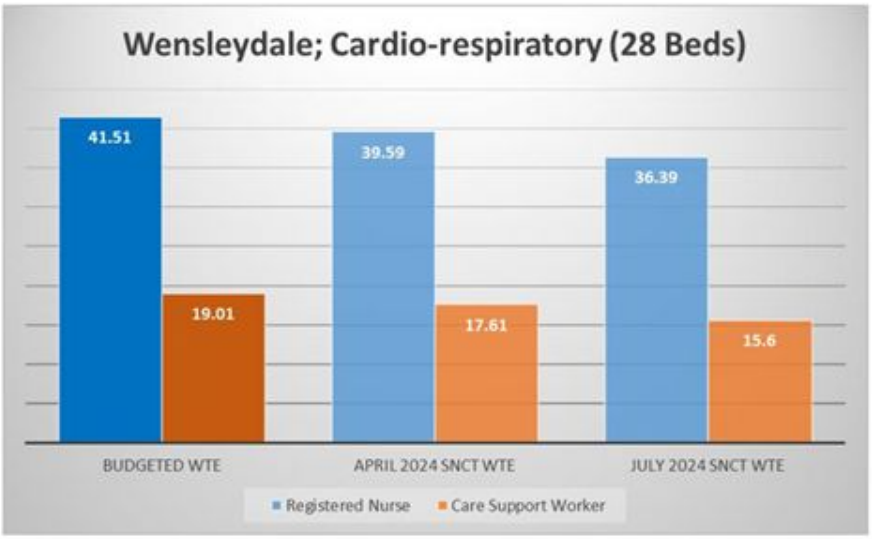
Wensleydale

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

SNCT Data since New Ward Budget Set in April 2023



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

See appendix 9

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Recommendations

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

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 January 2025.

Rowan

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.

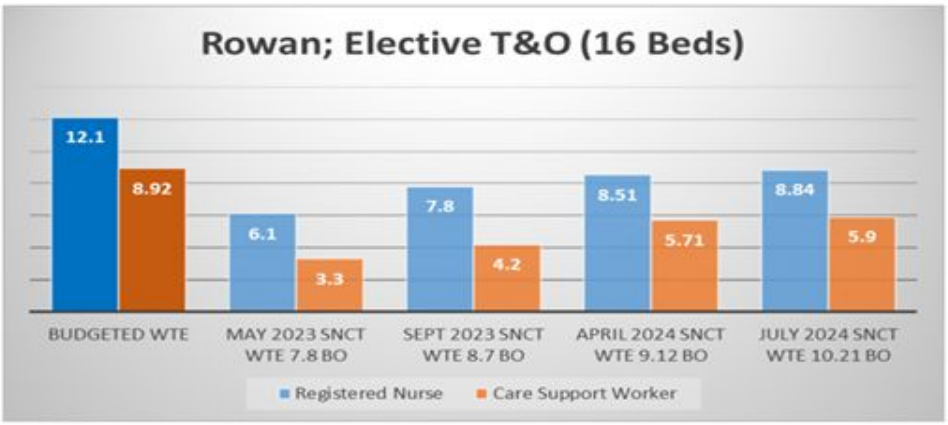
SNCT Data since New Ward Budget Set in April 2023

Budgeted WTE and SNCT establishment data

Rowan's data identifies that their full bed occupancy has not been utilised across the 7 day week. This data collection identifies utilisation of 10.21 beds, which is an increase on the 9.12 beds in April 2024.

	May 2023	September 2023	April 2024	July 2024
Bed Occupancy	7.8	8.7	9.12	10.21

The staffing template (above) shows the current staffing for Rowan and allows for a maximum of 16 patients.



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

See appendix 10

Recommendations

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

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.

Continue to collect twice yearly SNCT data, using the new levels of care SNCT tool. The next data collection will be in January 2025.

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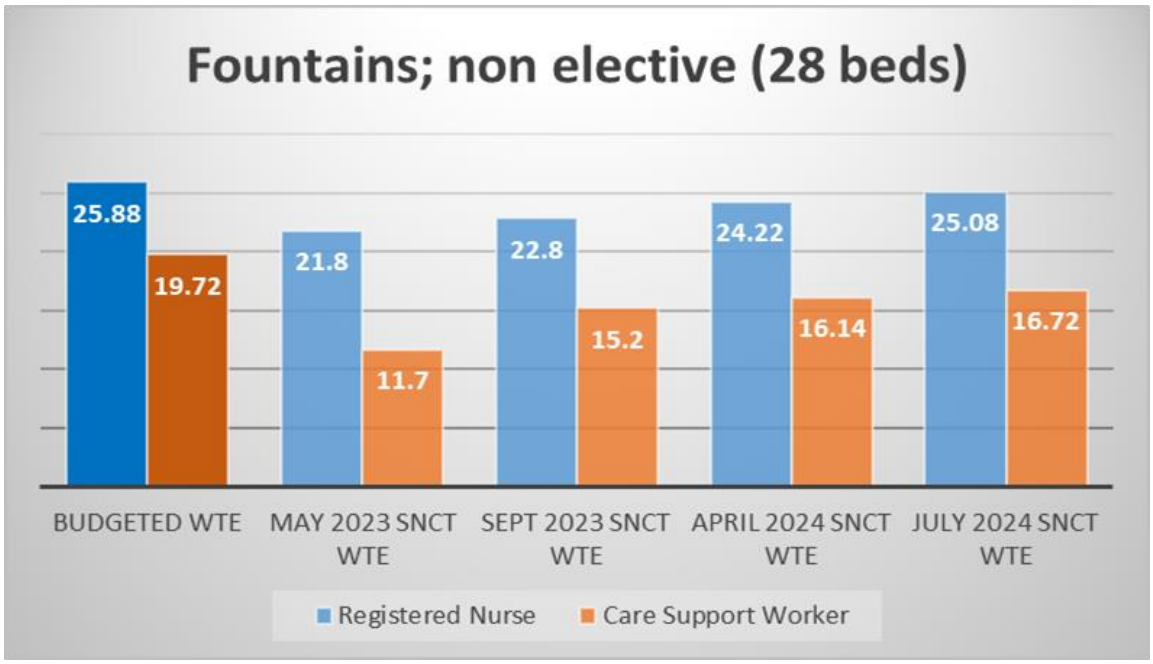
Fountains

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

SNCT Data since New Ward Budget Set in April 2023



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 and data pack

See appendix 11

Recommendations

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

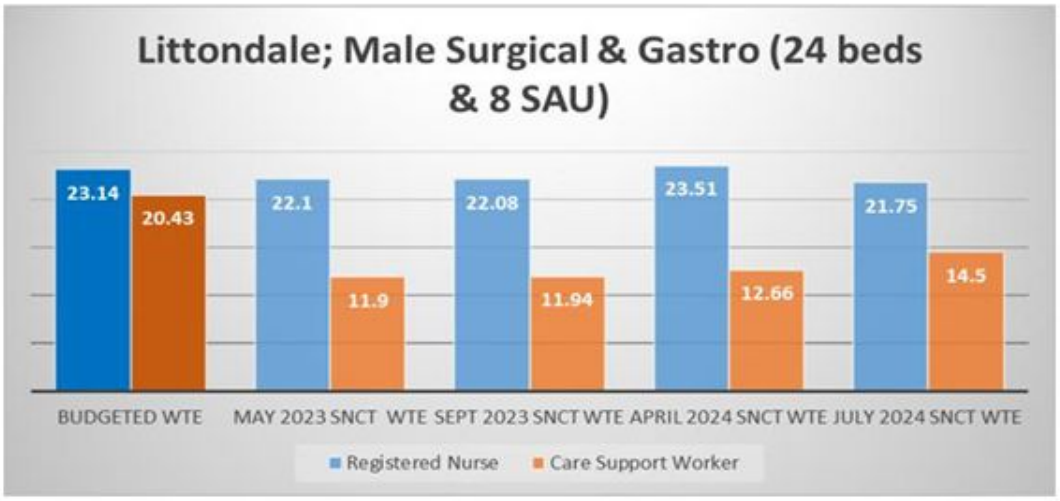
Any unfilled shifts should be reviewed as part of the new safer staffing meetings using SafeCare. This is a safer staffing tool which measures the actual acuity and dependency of the patients on each ward against the availability of staff to ensure that we are deploying the right staff with the right 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 January 2025.

Littondale

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

SNCT Data since New Ward Budget Set in April 2023



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 and data pack

See appendix 12

Recommendations

The SNCT data and triangulation supports moving Care Support Worker provision from Littondale to Nidderdale on the night shift.

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.

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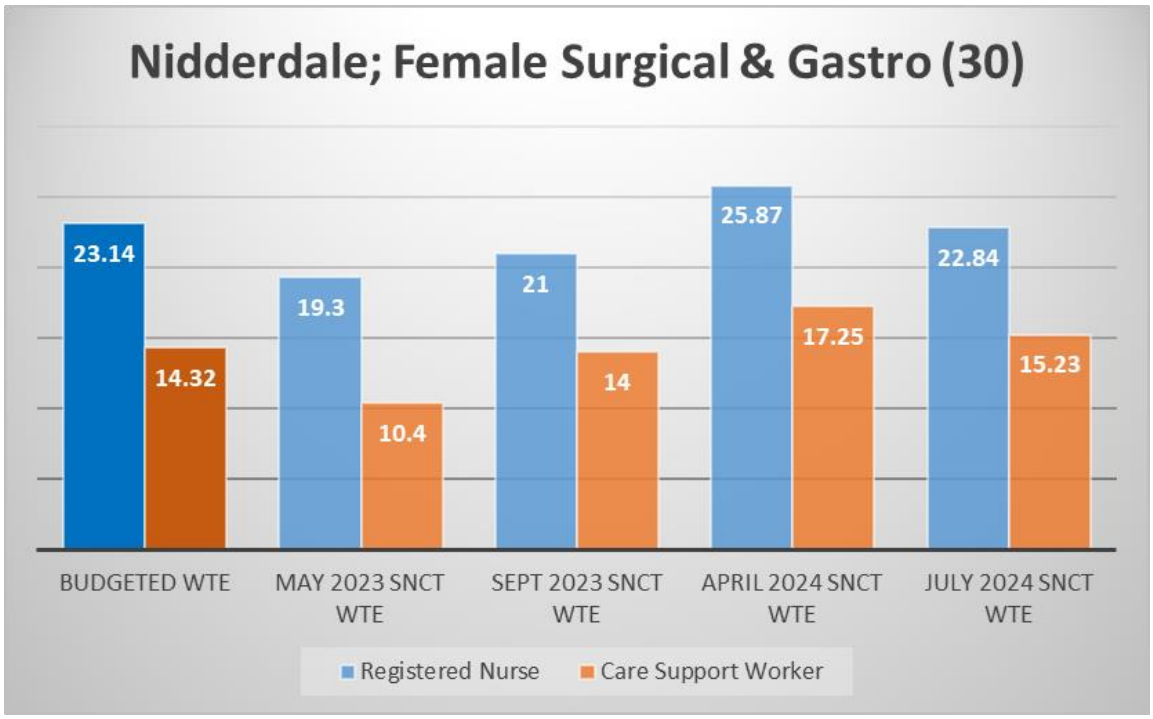
Nidderdale

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

SNCT Data since New Ward Budget Set in April 2023



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

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Discussion

See appendix 13

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 CSW will be moved from Littondale to Nidderdale for the Night shift, increasing the CSW establishment to 3. Following the next data collection, the directorate Tri will consider an increase on one RN on a night shift.

Recommendations

To consider increasing the RN and CSW requirements on a night shift. The CSW provision should be transferred from the Littondale establishment. The RN requirement will be monitored and confirmed at the next SNCT review meeting.

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.

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)**		

Harrogate and District NHS Foundation Trust

Emergency Department

Background

Following a National Institute of Clinical Excellence (NICE) endorsed Safer Nursing Care Tool (SNCT) review in 2023, significant investment supported the recommended nurse staffing establishments within the Emergency Department. Therefore ensuring that HDFT are delivering “the right staff, with the right skills, in the right place at the right time” The National Quality Board (NQB) (2018) and addressing the quality, safety and performance issues and align to the overall trust strategy; best quality, safest care and great start in life.

The latest SNCT data collection took place in June 2024 with triangulation of the results with quality data and professional judgement in August 2024.

Department Description

The Emergency Department (ED) is open 24 hours a day, 7 days a week delivering unscheduled care for acutely ill/injured adults and children. The department consists of two areas (ED1 and ED2). ED1 manages those patients presenting with major medical conditions, ED2 manages patients presenting with Minor Illness and injuries.

Management structure: The ED is led by a Triumvirate leadership structure consisting of a Clinical Lead, Service Manager and Matron. The matron is supported by 2 WTE Band 7 Department Managers who have 45 hours management time allocated per week. The workforce model ensures that there will be a band 7 Registered Nurse ‘in charge’ of each shift.

The NIC will consider staff experience, skill and competence when allocating staff to work areas, considering skill mix, workload, clinical priorities and patient dependency. The NIC is responsible for overseeing the team of Registered Nurses and Care Support Workers, ED reception clerks, patient flow in and out of the department (supported by a non-clinical patient flow coordinator and ED senior doctor: EPIC), and having an overview of patient acuity within the department. The NIC works closely with the EPIC and can escalate any concerns regarding prioritisation of patients to be seen. The NIC of each shift allocates staff to patient care areas on a shift basis:

- Streaming
- Triage
- Resuscitation room (2 enclosed cubicles and 1 curtained cubicle)
- Cubicle areas 1 -15 & ED2
- Fit 2 Sit
- YAS Rapid Initial Assessment Treatment

SNCT Raw Data

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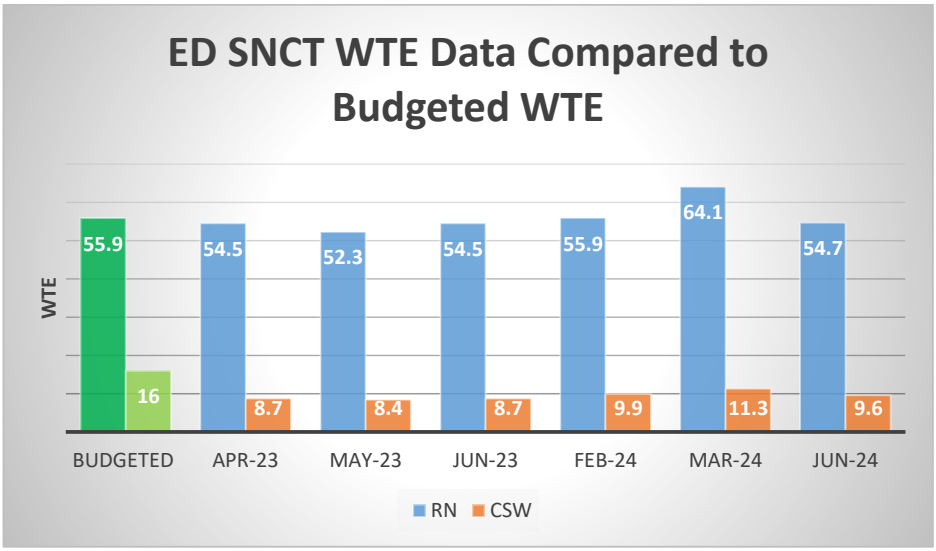

The current staffing template for the Emergency Department:

Area	Band	Early	Late	LD	Night
Nurse in Charge/Staff Base	**7**	0	0	1	1
Streaming	**6**	1	1	0	1
Streaming	**6/5**	0	0	1	1
Resus	**6**	0	0	1	1
Fit to Sit	**5**	0	0	1	1
Cubicles	**5**	1	1	2	3
Gynae & MH Room	**5**	1	1	0	1
YAS RIAT	**5**	0	0	1	1
YAS RIAT	**3**	0	0	1	1
Waiting Room RIAT	**3/2**	1	1	0	1
Cubicles	**2**	1	1	0	1

Budgeted Skill Mix

To note, the 6.0 wte band 2 CSW are in the process of being re-banded to band 3 due to an alignment of clinical skills and knowledge to the national job profiles.

Band	Budgeted	In Post	Vacancies
Band 7 Manager	2.0	2.0	0
Band 7 Clinical	5.35	5.35	0
Band 6 Clinical	12.4	12.4	0
Band 6 Practice Educator	1.8	1.8	0
Band 5	34.35	25.61	8.74
Band 3	10	6.73	3.27
Band 2	6.0	6.84	-0.84

Discussion

See appendix 14

Recommendations

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

Continue to collect bi annual SNCT data, using the new levels of care SNCT tool. The next data collection will be in January 2025.

Ensure effective rostering to meet the Key Performance Indicators and workforce model outlined in the Business Case.

Continue to strengthen the substantive workforce and reduce reliance on the temporary workforce with an aim of ‘zero use’ agency by the end of 2024.

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Children and Young People; Woodlands Ward

Background

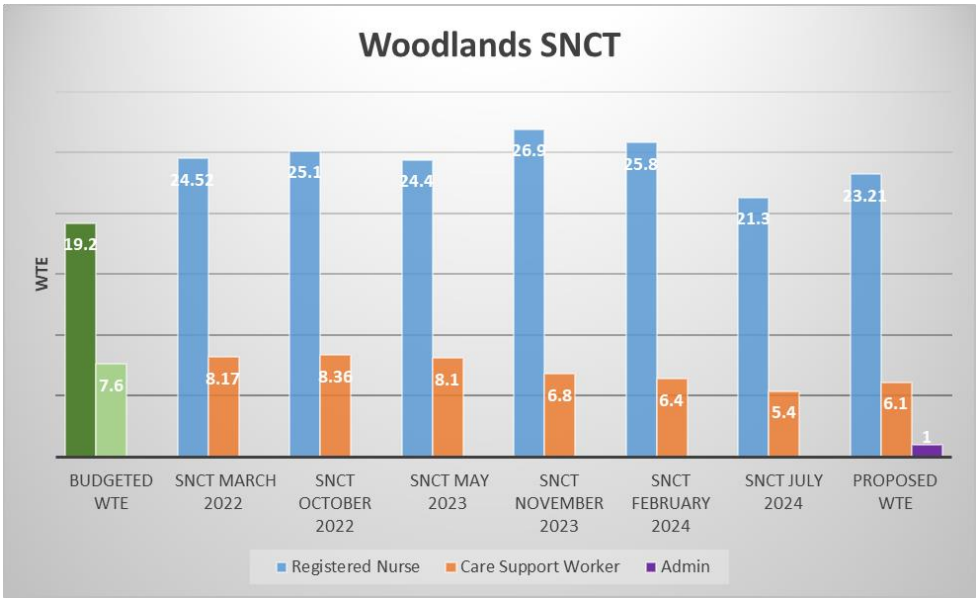
Following a National Institute of Clinical Excellence (NICE) endorsed Safer Nursing Care Tool (SNCT) (2021) review, undertaken biannually. The scope for this SNCT data collection encompasses the Children and Young People inpatient ward. To note, there is another review of Children's and Young People 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). Therefore, the results of this review are awaiting triangulation with this additional piece of work.

Data was collected in July 2024 with triangulation of the results with quality data and professional judgement in September 2024.

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). To note, since this data collection, there has been a Directorate change. Woodlands now sits within the PSC Directorate.

SNCT Raw Data



Harrogate and District NHS Foundation Trust

The current staffing template for Woodlands

Play Specialist	1.0 wte
Practice Education	0.2 wte
Admin	1.0 wte
Management Time	0.8 wte

Monday to Friday

	Early	Late	Night
RN	**4**	**3**	**3**
CSW	**1**	**1**	**1**

Saturday to Sunday

	Early	Late	Night
RN	**3**	**3**	**3**
CSW	**1**	**1**	**1**

Budgeted Skill Mix

	Budgeted WTE	Actual WTE	Vacancy
Band 7	1.0	1.0	0
Band 6	6.13	5.44	0.69
Band 5	12.14	9.91	2.23
Band 4	1.0	1.0	0
Band 3	0	0	0
Band 2	5.65	4.15	1.5
Band 2 ward clerk	1.0	1.0 LTS	0

Discussion

See appendix 15

Recommendations

The SNCT data and triangulation supports a slight increase in establishment. However, the actual requirement is still being worked through with the wider work being undertaken around the CAU and Children in ED workforce modelling.

Continue to collect bi annual SNCT data, using the SNCT tool. The next data collection will be in January 2025.

Ensure effective rostering to meet the Key Performance Indicators.

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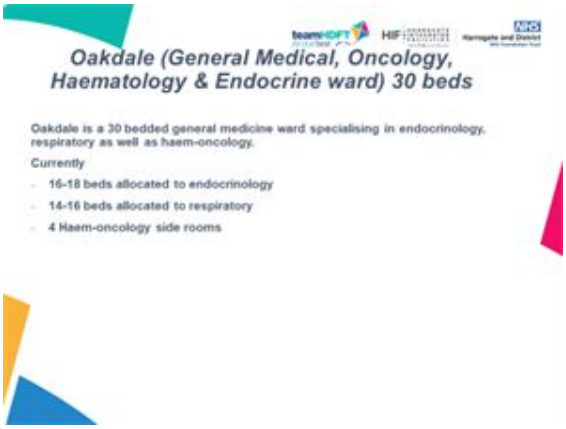
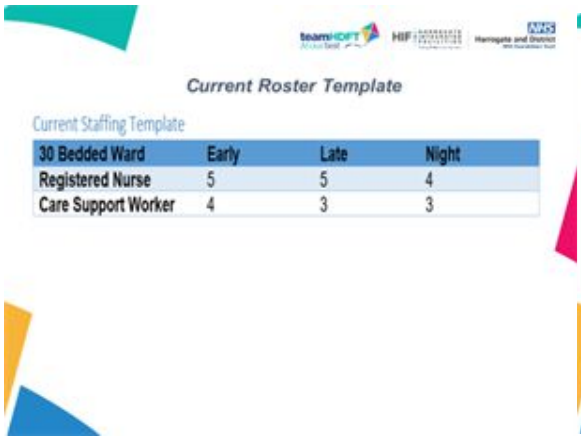
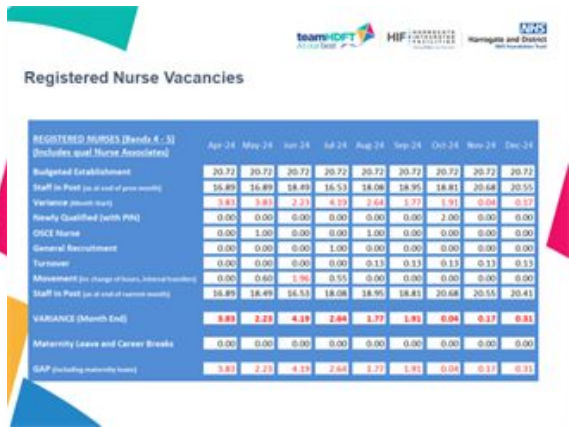
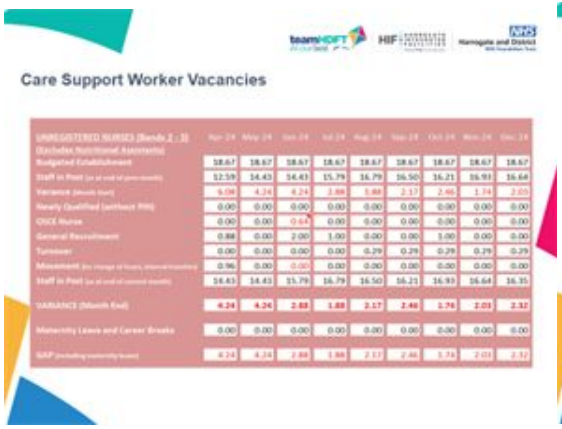
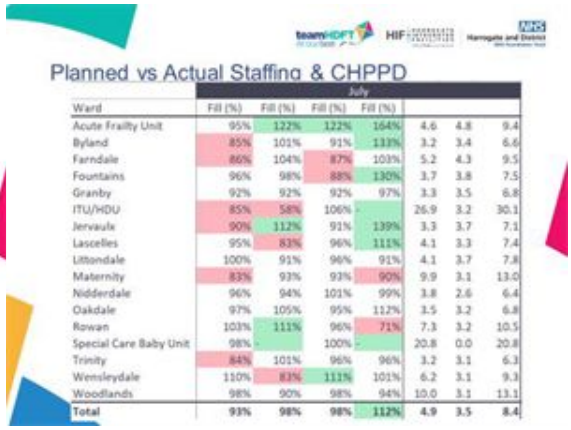
Appendix 1











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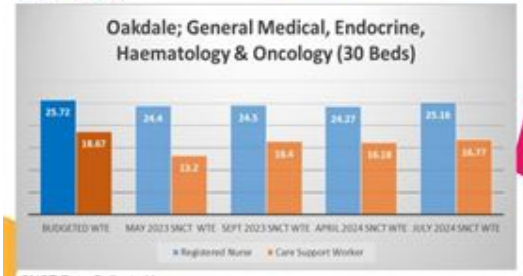
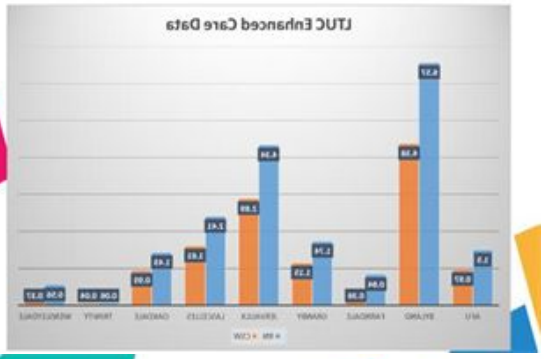
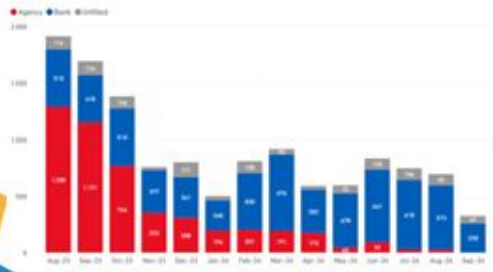
SNCT Results



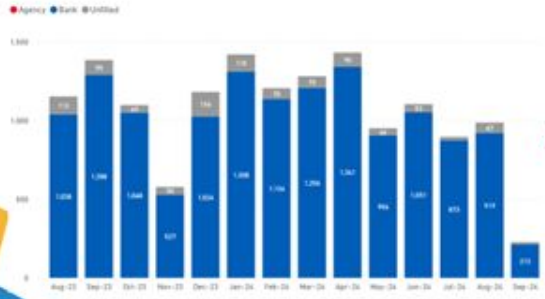
SNCT Data Collected by:
Arti Sivanandarajah



Temporary Staffing Registered Nurses (Hours)



Temporary Staffing Care Support Workers (Hours)



Oakdale Activity for July 2024

	Total in data collection period	Average per day
Admissions	20	0.64
Discharges	61	1.96
Transfers In	96	3.09
Transfers Out	43	1.38
Deaths	4	0.12
Ward Attenders	0	0

Quality Data

Quality indicators

Falls	8 (June = 10, May = 8)
Hospital acquired pressure ulcers	8 (June = 9, May = 5)
Medication incidents	3 (June = 3, May = 7)
Staffing Datix	2 (June = 2, May = 5)
Formal Complaints	0 (June = 0, May = 1)

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Appendix 2

Lascelles Safer Nursing Care Tool (SNCT)
July 2024 Data Collection

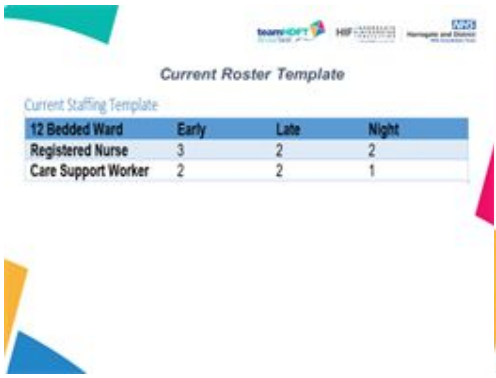
Matron: Tammy Gotts
Ward Manager: Annie Moran
ADoN: Charly Gill

Lascelles (Rehab) 12 beds

Lascelles is a mixed sex ward specialising in providing inpatient rehabilitation for adults living with a variety of neurological conditions such as head injuries, multiple sclerosis, Parkinson's, motor neurone disease, Guillain-Barre syndrome and patients who have suffered strokes. As this is a rehabilitation ward, the intensity of rehab available to the ward has a direct impact on the length of stay on the ward.

Patients on the ward often require assistance of two (or more) to support with the delivery of their care needs. Due to the complexity of the neurological conditions, the patient's remain on Lascelles for many months, which creates complex discharge planning. There will be a number of meetings required (goal planning, best interest meetings, discharge planning meetings) to determine the level of care input or care facility that is required on discharge. Multi-agencies are often essential (District Nurses, Continence Teams, Social Workers) and the allocation of funding for the required care packages can often take many weeks, extending the patient's admission.

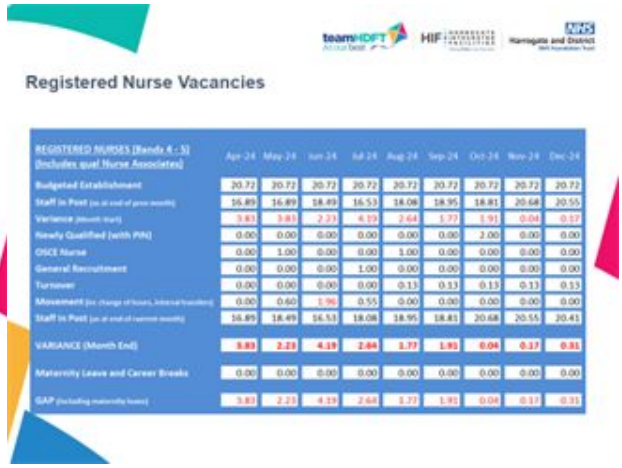
Patient care is allocated by the nurse in charge. The nurse in charge will have oversight of all patients and will support the CSW with personal care requirements of the patients.



Current Roster Template

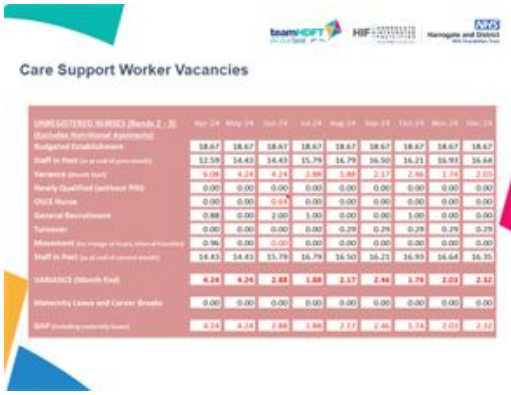
Current Staffing Template

12 Bedded Ward	Early	Late	Night
Registered Nurse	3	2	2
Care Support Worker	2	2	1



Registered Nurse Vacancies

REGISTERED NURSES (Bands 4 - 5) (Includes qual Nurse Associates)	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
Budgeted Establishment	20.72	20.72	20.72	20.72	20.72	20.72	20.72	20.72	20.72
Staff in Post (as at end of prev month)	16.89	16.89	18.49	16.53	18.08	18.95	18.81	20.68	20.55
Variance (Month End)	3.83	3.83	2.23	4.19	2.64	1.77	1.91	0.04	-0.17
Newly Qualified (with PIN)	0.00	0.00	0.00	0.00	0.00	0.00	2.00	0.00	0.00
OSCE Nurse	0.00	1.00	0.00	0.00	1.00	0.00	0.00	0.00	0.00
General Recruitment	0.00	0.00	0.00	1.00	0.00	0.00	0.00	0.00	0.00
Turnover	0.00	0.00	0.00	0.00	0.13	0.13	0.13	0.13	0.13
Movement (inc change of hours, internal transfers)	0.00	0.60	1.96	0.55	0.00	0.00	0.00	0.00	0.00
Staff in Post (as at end of current month)	16.89	18.49	16.53	18.08	18.95	18.81	20.68	20.55	20.41
VARIANCE (Month End)	3.83	2.23	4.19	2.64	1.77	1.91	0.04	-0.17	0.31
Maternity Leave and Career Breaks	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
GAP (including maternity leave)	3.83	2.23	4.19	2.64	1.77	1.91	0.04	-0.17	0.31



Care Support Worker Vacancies

UNREGISTERED NURSES (Bands 2 - 3) (Excludes Nutritional Assistants)	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
Budgeted Establishment	18.67	18.67	18.67	18.67	18.67	18.67	18.67	18.67	18.67
Staff in Post (as at end of prev month)	12.59	14.43	14.43	15.79	16.79	16.50	16.21	16.93	16.64
Variance (Month End)	6.08	4.24	4.24	2.88	1.88	2.17	2.46	1.74	2.03
Newly Qualified (without PIN)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
OSCE Nurse	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
General Recruitment	0.88	0.00	2.00	1.00	0.00	0.00	1.00	0.00	0.00
Turnover	0.00	0.00	0.00	0.00	0.29	0.29	0.29	0.29	0.29
Movement (inc change of hours, internal transfers)	0.96	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Staff in Post (as at end of current month)	14.43	14.43	15.79	16.79	16.50	16.21	16.93	16.64	16.35
VARIANCE (Month End)	4.24	4.24	2.88	1.88	2.17	2.46	1.74	2.03	2.32
Maternity Leave and Career Breaks	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
GAP (including maternity leave)	4.24	4.24	2.88	1.88	2.17	2.46	1.74	2.03	2.32

Planned vs Actual Staffing & CHPPD

	July						
	Day		Night		CHPPD		
Ward	RN Fill (%)	CSW Fill (%)	RN Fill (%)	CSW Fill (%)	RN	CSW	Overall
Acute Frailty Unit	95%	122%	122%	164%	4.6	4.8	9.4
Byland	85%	101%	91%	133%	3.2	3.4	6.6
Farndale	86%	104%	87%	103%	5.2	4.3	9.5
Fountains	96%	98%	88%	130%	3.7	3.8	7.5
Granby	92%	92%	92%	97%	3.3	3.5	6.8
ITU/HDU	85%	58%	106%	-	26.9	3.2	30.1
Jervaulx	90%	112%	91%	139%	3.3	3.7	7.1
Lascelles	95%	83%	96%	111%	4.1	3.3	7.4
Littondale	100%	91%	96%	91%	4.1	3.7	7.8
Maternity	83%	93%	93%	90%	9.9	3.1	13.0
Niddendale	96%	94%	101%	99%	3.8	2.6	6.4
Oakdale	97%	105%	95%	112%	3.5	3.2	6.8
Rowan	103%	111%	96%	71%	7.3	3.2	10.5
Special Care Baby Unit	98%	-	100%	-	20.8	0.0	20.8
Trinity	84%	101%	96%	96%	3.2	3.1	6.3
Wensleydale	110%	83%	111%	101%	6.2	3.1	9.3
Woodlands	98%	90%	98%	94%	10.0	3.1	13.1
Total	93%	98%	98%	112%	4.9	3.5	8.4

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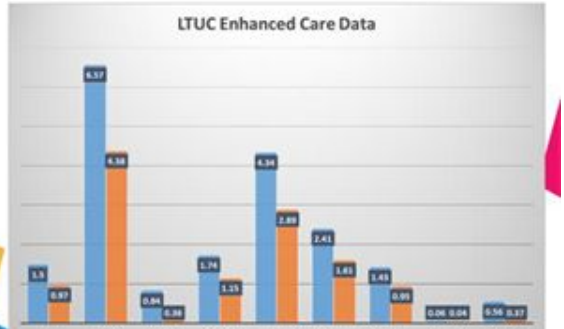
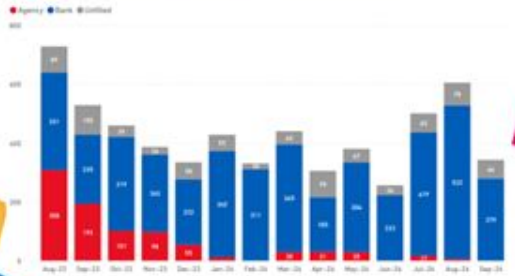
SNCT Results

SNCT Data Collected by:
Annie Moran

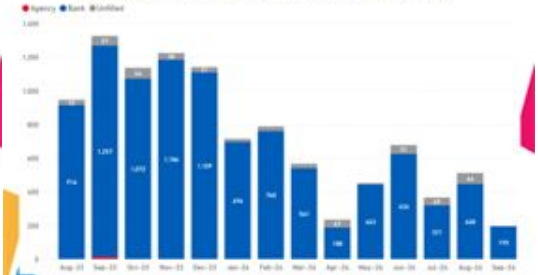
Enhanced Care



Temporary Staffing Registered Nurses (Hours)



Temporary Staffing Care Support Workers (Hours)



Lascelles Activity for July 2024

	Total in data collection period	Average per day
Admissions	0	0
Discharges	8	0.25
Transfers In	10	0.32
Transfers Out	2	0.06
Deaths	0	0
Ward Attenders	0	0

Datix during the month of July

Quality indicators

Falls	4 (June = 3, May = 2)
Hospital acquired pressure ulcers	1 (June = 3, May = 1)
Medication incidents	0 (June = 1, May = 2)
Staffing Datix	0 (June = 0, May = 0)
Formal Complaints	0 (June = 0, May = 0)

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Appendix 3

Granby Safer Nursing Care Tool (SNCT) July 2024 Data Collection

Matron: Tammy Gotts
Ward Manager: Martine Hartley
ADoN: Charly Gill

Granby (Stroke & Neurology ward) 22 beds

Description of ward

Current Roster Template

Current Staffing Template

22 Bedded Ward	Early	Late	Night
Registered Nurse	3	3	3
Care Support Worker	3	3	3

Additional RN on a Monday, Thursday and Friday Early; MDT responsibilities.

Registered Nurse Vacancies

REGISTERED NURSES (Bands 4 - 5) (Includes qual Nurse Associates)	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
Budgeted Establishment	14.24	14.24	14.24	14.24	14.24	14.24	14.24	14.24	14.24
Staff in Post (as at end of prev month)	9.08	9.41	10.41	10.41	11.41	11.41	11.41	12.41	12.41
Variance (Month End)	5.16	4.83	3.83	3.83	2.83	2.83	2.83	1.83	1.83
Newly Qualified (with PIN)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
OSCE Nurse	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
General Recruitment	0.00	1.00	0.00	1.00	0.00	0.00	1.00	0.00	0.00
Turnover	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Movement (inc change of hours, internal transfers)	-0.33	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Staff in Post (as at end of current month)	9.41	10.41	10.41	11.41	11.41	11.41	12.41	12.41	12.41
VARIANCE (Month End)	4.83	3.83	3.83	2.83	2.83	2.83	1.83	1.83	1.83
Maternity Leave and Career Breaks	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
GAP (including maternity leave)	4.83	3.83	3.83	2.83	2.83	2.83	1.83	1.83	1.83

Care Support Worker Vacancies

UNREGISTERED NURSES (Bands 2 - 3) (Excludes Nutritional Assistants)	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
Budgeted Establishment	16.91	16.91	16.91	16.91	16.91	16.91	16.91	16.91	16.91
Staff in Post (as at end of prev month)	15.07	16.99	16.39	15.11	15.11	15.04	14.97	15.91	15.84
Variance (Month End)	1.84	0.08	0.52	1.80	1.80	1.87	1.94	1.00	1.07
Newly Qualified (without PIN)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
OSCE Nurse	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
General Recruitment	2.88	0.00	0.00	0.00	0.00	0.00	1.00	0.00	0.00
Turnover	0.00	0.00	0.40	0.00	0.07	0.07	0.07	0.07	0.07
Movement (inc change of hours, internal transfers)	-0.96	-0.60	-0.88	0.00	0.00	0.00	0.00	0.00	0.00
Staff in Post (as at end of current month)	16.99	16.39	15.11	15.11	15.04	14.97	15.91	15.84	15.77
VARIANCE (Month End)	0.08	0.52	1.80	1.80	1.87	1.94	1.00	1.07	1.14
Maternity Leave and Suspension	1.53	1.53	0.53	0.53	0.53	0.53	0.53	0.53	0.53
GAP (including maternity leave)	1.45	2.06	2.34	2.34	2.40	2.47	1.54	1.60	1.67

Planned vs Actual Staffing & CHPPD

	April						
	Day		Night		CHPPD		
Ward	RN Fill (%)	CSW Fill (%)	RN Fill (%)	CSW Fill (%)	RN	CSW	Overall
Acute Frailty Unit	98%	117%	126%	153%	4.8	4.6	9.4
Byland	91%	108%	96%	130%	3.5	3.6	7.0
Fountains	93%	89%	94%	109%	3.9	3.5	7.4
Farndale	93%	108%	97%	100%	5.7	4.4	10.2
Granby	89%	100%	96%	117%	3.5	4.1	7.6
Jervaulx	88%	110%	95%	125%	3.4	3.6	7.0
Lascelles	93%	71%	96%	96%	4.4	3.1	7.5
Littondale	101%	85%	97%	76%	4.2	3.4	7.6
Nidderdale	95%	83%	112%	101%	3.8	2.3	6.1
Oakdale	100%	113%	95%	131%	3.6	3.6	7.2
Rowan	92%	43%	93%	57%	7.5	2.9	10.5
Trinity	90%	100%	96%	96%	3.3	3.0	6.3
Wensleydale	109%	84%	111%	107%	6.1	3.1	9.2
Total	96%	96%	101%	111%	4.5	3.4	7.9

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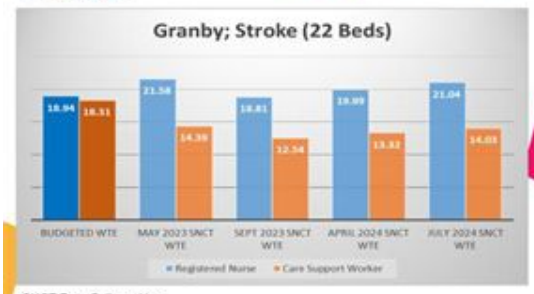
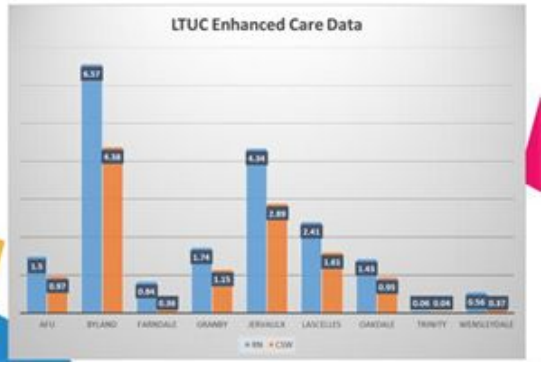
SNCT Results

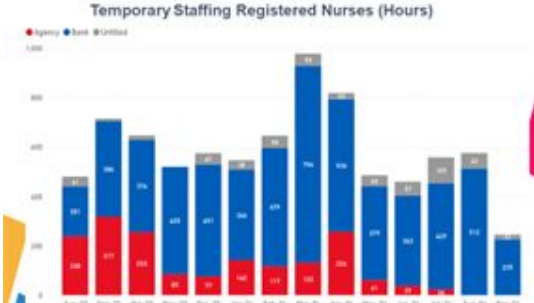


SNCT Data Collected by:
Martine Hartley
Lucy Marsh (not trained)

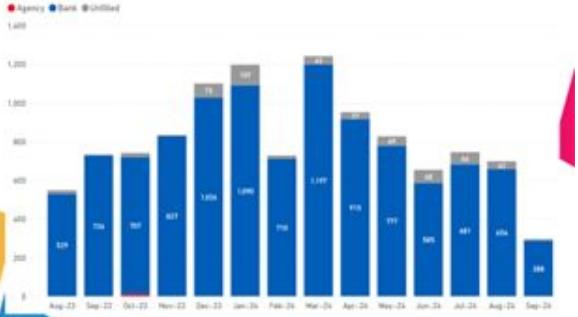
Enhanced Care



Temporary Staffing Registered Nurses (Hours)



Temporary Staffing Care Support Workers (Hours)



Granby Activity for July 2024

	Total in data collection period	Average per day
Admissions	23	0.74
Discharges	41	1.32
Transfers In	34	1.09
Transfers Out	12	0.38
Deaths	1	0.03
Ward Attenders	0	0

Datix during month of July

Quality indicators

Falls	**1** (June = 5, May = 4)
Hospital acquired pressure ulcers	**3** (June = 3, May = 4)
Medication incidents	**1** (June = 6, May = 6)
Staffing Datix	**0** (June = 0, May = 3)
Formal Complaints	**1** (June = 1, May = 0)

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Appendix 4

Byland Safer Nursing Care Tool (SNCT)
July 2024 Data Collection

Matron: Jo Burns
Ward Manager: Biju Varughese
ADoN: Charly Gill

Byland (Frailty) 30 beds

Byland ward is a 30 bedded elderly care ward.

There are four bays of six and six single rooms, three of which are en-suite.

The ward is an "L" shaped ward. Along the entry corridor is the ward office, kitchen, linen room, staff room, treatment room and two single rooms out of sight of the main staff base and around the corner from the main ward area.

The staff base is at the apex of the "L" and the dirty utility is immediately adjacent to the staffroom. There is some visibility of bay 1 and 2 and side rooms 2 and 3 are visible to the nurses' station. None of the bays have patient bathroom facilities, shared facilities are located opposite each bay.

The ward is led by an experienced Ward Manager and an experienced Matron. There are also experienced Band 6 Ward Sisters.

Due to the high number of elderly care patients with dementia and delirium, the risk of falls, pressure ulcers and absconding patients is high. The ward requests a daily CSW to support with the enhanced care needs of patients.

Current Roster Template

Current Staffing Template

30 Bedded Ward	Early	Late	Night
Registered Nurse	5	5	4
Care Support Worker	4	4	3

Registered Nurse Vacancies

REGISTERED NURSES (Bands 4 - 5) (Includes qual Nurse Associates)	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
Budgeted Establishment	21.43	21.43	21.43	21.43	21.43	21.43	21.43	21.43	21.43
Staff in Post (as at end of prev month)	18.23	19.03	19.03	20.63	21.09	22.98	23.86	24.74	24.63
Variance (Month Start)	3.20	2.40	2.40	0.80	0.34	1.55	2.43	3.31	3.20
Newly Qualified (with PIN)	0.00	0.00	0.00	0.00	0.00	0.00	1.00	0.00	0.00
OSCE Nurse	1.00	0.00	2.00	0.00	1.00	0.00	0.00	0.00	2.00
General Recruitment	0.00	0.00	1.00	0.00	1.00	1.00	0.00	0.00	0.00
Turnover	0.00	0.00	0.40	0.00	0.12	0.12	0.12	0.12	0.12
Movement (inc change of hours, internal transfers)	0.20	0.00	1.00	0.47	0.00	0.00	0.00	0.00	0.00
Staff in Post (as at end of current month)	19.03	19.03	20.63	21.09	22.98	23.86	24.74	24.63	26.51
VARIANCE (Month End)	2.40	2.40	0.80	0.34	1.55	2.43	3.31	3.20	5.08
Maternity Leave and Career Breaks	0.40	3.04	3.04	3.04	3.04	3.04	3.04	3.04	3.04
GAP (including maternity leave)	2.80	5.44	3.84	3.38	1.49	0.61	0.27	0.16	2.04

Care Support Worker Vacancies

UNREGISTERED NURSES (Bands 2 - 3) (Excludes Nutritional Assistants)	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
Budgeted Establishment	19.72	19.72	19.72	19.72	19.72	19.72	19.72	19.72	19.72
Staff in Post (as at end of prev month)	13.89	15.89	16.41	17.41	18.21	19.00	18.83	19.66	19.49
Variance (Month Start)	5.83	3.83	3.31	2.31	1.51	0.72	0.89	0.06	0.23
Newly Qualified (without PIN)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
OSCE Nurse	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
General Recruitment	2.00	0.52	2.00	1.00	0.96	0.00	1.00	0.00	0.00
Turnover	0.00	0.00	0.00	0.00	0.17	0.17	0.17	0.17	0.17
Movement (inc change of hours, internal transfers)	0.00	0.00	-1.00	-0.20	0.00	0.00	0.00	0.00	0.00
Staff in Post (as at end of current month)	15.89	16.41	17.41	18.21	19.00	18.83	19.66	19.49	19.32
VARIANCE (Month End)	4.03	3.31	2.31	1.51	0.72	0.89	0.06	0.23	0.40
Maternity Leave and Career Breaks	0.60	0.00	0.00	0.60	0.60	0.60	0.60	0.60	0.60
GAP (including maternity leave)	4.63	3.31	2.31	2.11	1.32	1.49	0.66	0.83	1.00

Planned vs Actual Staffing & CHPPD

	July						
	Day		Night		CHPPD		
Ward	RN Fill (%)	CSW Fill (%)	RN Fill (%)	CSW Fill (%)	RN	CSW	Overall
Acute Frailty Unit	95%	122%	122%	164%	4.6	4.8	9.4
Byland	85%	101%	91%	133%	3.2	3.4	6.6
Farndale	86%	104%	87%	103%	5.2	4.3	9.5
Fountains	96%	98%	88%	130%	3.7	3.8	7.5
Granby	92%	92%	92%	97%	3.3	3.5	6.8
ITU/HDU	85%	58%	106%		26.9	3.2	30.1
Jervaulx	90%	112%	91%	139%	3.3	3.7	7.1
Lascelles	95%	83%	96%	111%	4.1	3.3	7.4
Littondale	100%	91%	96%	91%	4.1	3.7	7.8
Maternity	83%	93%	93%	90%	9.9	3.1	13.0
Nidderdale	96%	94%	101%	99%	3.8	2.6	6.4
Oakdale	97%	105%	95%	112%	3.5	3.2	6.8
Rowan	103%	111%	96%	71%	7.3	3.2	10.5
Special Care Baby Unit	98%		100%		20.8	0.0	20.8
Trinity	84%	101%	96%	96%	3.2	3.1	6.3
Wensleydale	110%	83%	111%	101%	6.2	3.1	9.3
Woodlands	98%	90%	98%	94%	10.0	3.1	13.1
Total	93%	98%	98%	112%	4.9	3.5	8.4

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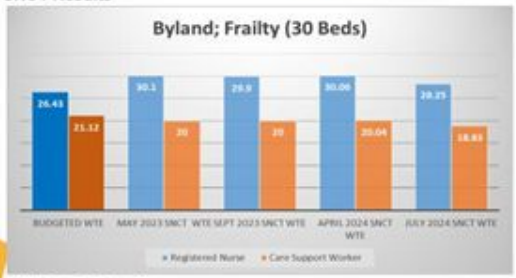
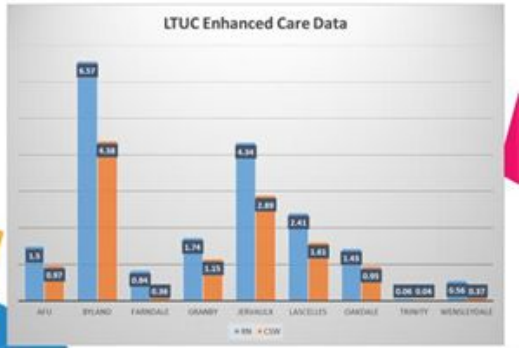
SNCT Results



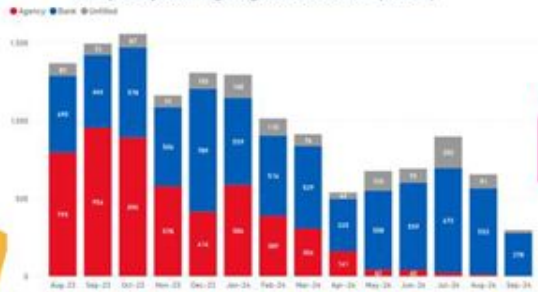
SNCT Data Collected by:

Sheeba Sojan.
Biju Varughese (? Not on the sheet). Thomson Joseph (not trained)
Lisamma Anthony (not trained). Maria Kumsy (not trained)
Sheeba Sojan (not trained). Megan Jae Munoz (not trained)
Maria Kumar (not trained). Anju Alex (not trained)

Enhanced Care



Temporary Staffing Registered Nurses (Hours)



Temporary Staffing Care Support Workers (Hours)

Byland Activity for July 2024

	Total in data collection period	Average per day
Admissions	4	0.12
Discharges	58	1.87
Transfers In	74	2.38
Transfers Out	7	0.22
Deaths	7	0.22
Ward Attenders	0	0

Datix during the month of July

Quality indicators

Falls	**5** (June = 6, May = 7)
Hospital acquired pressure ulcers	**14** (June = 22, May = 16)
Medication incidents	**2** (June = 3, May = 4)
Staffing Datix	**3** (June = 2, May = 1)
Formal Complaints	**1** (June =1, May = 0)

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Appendix 5

Jervaulx Safer Nursing Care Tool (SNCT)
July 2024 Data Collection

Matron: Jo Burns
Ward Manager: Hannah Dickinson
ADoN: Charly Gill

Jervaulx (Frailty) 30 beds

Jervaulx ward is a 30 bedded elderly care ward. There are four bays of six and six single rooms, three of which are en-suite.

The ward is an "L" shaped ward. Along the entry corridor is the ward office, kitchen, linen room, staff room, and two single rooms out of sight of the main staff base and around the corner from the main ward area. At the bottom of the ward there is a treatment room where the new Omnicell medication machine is located and where all medication is prepared and stored appropriately.

The staff base is at the apex of the "L". Bay 1 and 2 are visible to the staff base as are the single rooms 2 and 3. None of the bays have patient bathroom facilities, shared facilities are located opposite each bay.

The ward is led by an experienced Ward Manager and Matron, there are also experienced Band 6 Ward Sisters.

Due to the high number of elderly care patients with dementia and delirium, the risk of falls, pressure ulcers and absconding patients is high. The ward requests a daily CSW to support with the enhanced care needs of patients.

Current Roster Template

Current Staffing Template

30 Bedded Ward	Early	Late	Night
Registered Nurse	5	5	4
Care Support Worker	4	4	3

Registered Nurse Vacancies

REGISTERED NURSES (Bands 4 - 5) (Includes qual Nurse Associates)	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
Budgeted Establishment	21.43	21.43	21.43	21.43	21.43	21.43	21.43	21.43	21.43
Staff in Post (as at end of prev month)	14.97	14.23	14.63	18.63	18.63	20.96	22.89	22.63	22.76
Variance (Month Start)	6.46	7.20	6.80	2.80	2.80	0.47	1.46	1.40	1.33
Newly Qualified (with PIN)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
OSCE Nurse	0.00	0.00	1.00	0.00	2.00	0.00	0.00	0.00	0.00
General Recruitment	0.00	0.00	1.00	0.00	0.40	2.00	0.00	0.00	0.00
Turnover	0.00	0.00	0.00	0.00	0.07	0.07	0.07	0.07	0.07
Movement (inc change of hours, internal transfers)	0.75	0.40	2.00	0.00	0.00	0.00	0.00	0.00	0.00
Staff in Post (as at end of current month)	14.23	14.63	18.63	18.63	20.96	22.89	22.83	22.76	22.69
VARIANCE (Month End)	7.20	6.80	2.80	2.80	0.47	1.46	1.40	1.33	1.26
Maternity Leave and Career Breaks	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
GAP (including maternity leave)	8.20	7.80	3.80	3.80	1.47	0.46	0.40	0.33	0.26

Care Support Worker Vacancies

UNREGISTERED NURSES (Bands 2 - 3) (Excludes Nutritional Assistants)	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
Budgeted Establishment	19.72	19.72	19.72	19.72	19.72	19.72	19.72	19.72	19.72
Staff in Post (as at end of prev month)	19.72	20.71	20.71	20.31	20.18	22.02	21.85	21.69	21.53
Variance (Month Start)	0.01	0.99	0.99	0.59	0.46	2.30	2.13	1.97	1.81
Newly Qualified (without PIN)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
OSCE Nurse	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
General Recruitment	1.00	0.00	0.00	0.00	2.00	0.00	0.00	0.00	0.00
Turnover	0.00	0.40	0.00	0.00	0.16	0.16	0.16	0.16	0.16
Movement (inc change of hours, internal transfers)	0.00	0.40	0.40	0.13	0.00	0.00	0.00	0.00	0.00
Staff in Post (as at end of current month)	20.71	20.71	20.31	20.18	22.02	21.85	21.69	21.53	21.36
VARIANCE (Month End)	0.99	0.99	0.59	0.46	2.30	2.13	1.97	1.81	1.64
Maternity Leave and Career Breaks	2.47	2.47	1.19	0.60	0.60	0.60	0.60	0.60	0.60
GAP (including maternity leave)	1.47	1.47	0.59	0.14	1.70	1.53	1.37	1.21	1.04

Planned vs Actual Staffing & CHPPD

	July						
	Day		Night		CHPPD		
Ward	RN Fill (%)	CSW Fill (%)	RN Fill (%)	CSW Fill (%)	RN	CSW	Overall
Acute Frailty Unit	95%	122%	122%	164%	4.6	4.8	9.4
Byland	85%	101%	91%	133%	3.2	3.4	6.6
Farndale	86%	104%	87%	103%	5.2	4.3	9.5
Fountains	96%	98%	86%	130%	3.7	3.8	7.5
Granby	92%	92%	92%	97%	3.3	3.5	6.8
ITU/HDU	85%	58%	106%	-	26.9	3.2	30.1
Jervaulx	90%	112%	91%	139%	3.3	3.7	7.1
Lascelles	95%	83%	96%	111%	4.1	3.3	7.4
Littondale	100%	91%	96%	91%	4.1	3.7	7.8
Maternity	83%	93%	93%	90%	9.9	3.1	13.0
Nidderdale	96%	94%	101%	99%	3.8	2.6	6.4
Oakdale	97%	105%	95%	112%	3.5	3.2	6.8
Rowan	103%	111%	96%	71%	7.3	3.2	10.5
Special Care Baby Unit	98%		100%	-	20.8	0.0	20.8
Trinity	84%	101%	96%	96%	3.2	3.1	6.3
Wensleydale	110%	83%	111%	101%	6.2	3.1	9.3
Woodlands	98%	90%	98%	94%	10.0	3.1	13.1
Total	93%	98%	98%	112%	4.9	3.5	8.4

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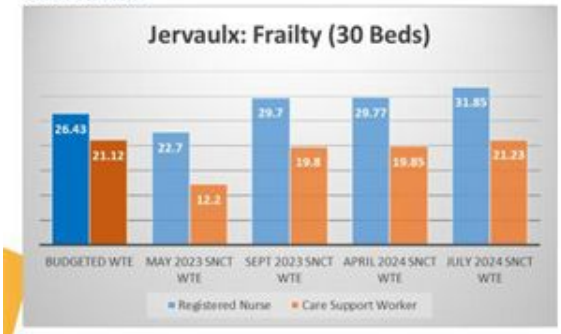
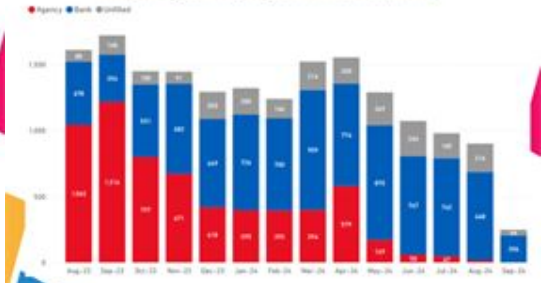
SNCT Results

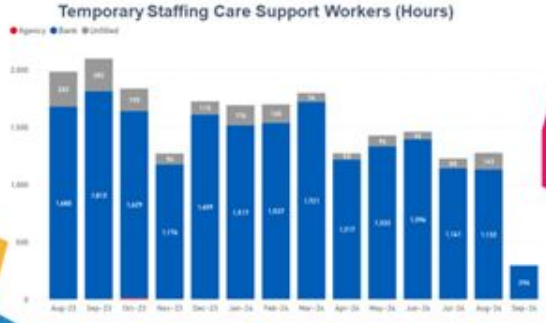


SNCT Data Collected by:
Hannah Rushton

Temporary Staffing Registered Nurses (Hours)



Temporary Staffing Care Support Workers (Hours)



Jervaulx Activity for July 2024

	Total in data collection period	Average per day
Admissions	1	0.03
Discharges	31	1
Transfers In	59	1.90
Transfers Out	19	0.61
Deaths	5	0.16
Ward Attenders	0	0

Datix during the month of July

Quality indicators

Falls	**4** (June = 4, May = 5)
Hospital acquired pressure ulcers	**17** (June = 10, May = 9)
Medication incidents	**5** (June = 5, May = 8)
Staffing Datix	**0** (June = 1, May = 3)
Formal Complaints	**0** (June = 0, May = 0)

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Appendix 6

Acute Frailty Safer Nursing Care Tool (SNCT)
July 2024 Data Collection

Matron: Jo Burns
Ward Manager: Sarah McDaniel
ADoN: Charly Gill

Acute Frailty Unit (AFU)18 beds 2 assessment beds

AFU is an acute frailty admissions unit designed to be 18 bedded unit with 2 frailty to assessment beds.

AFU has 3x bays can have up to 4 patients in each but very tight due to size so keep 3 patients in 2x bays then 1x4 to keep numbers of patients at 18. The ward has 8 side rooms; used for infections patients and direct admissions.

The ward is long, with side rooms at lower end of ward out of direct view of the main ward. The ward also has 2x Frailty to assess beds for in essence day case patients that can be turned around following treatment or Physiotherapy input to prevent admission to hospital

However, since winter 2023/24 the ward has had to utilise escalation beds. AFU have had a total of 23 open beds (including the assessment beds). Therefore, additional staffing has been resources through temporary staffing.

Current Roster Template

Acute Frailty Unit

Current Staffing Template

18 Bedded Ward	Early	Late	Night
Registered Nurse	4	4	3
Care Support Worker	3	3	2

Budgeted WTE and SNCT establishment data

To note the April and July 2024 SNCT data included escalation beds (up to 24 bed in total). Following the September 2023 SNCT data collection, the RN establishment was reduced (removal of 1 RN each night shift). This staffing template (shown above) is for 18 beds and 2 assessment beds (20). Therefore, when escalation beds are opened an additional RN and CSW resource is required.

Registered Nurse Vacancies

REGISTERED NURSES (Bands 4 - 5) (Includes qual Nurse Associates)	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
Budgeted Establishment	14.94	14.94	14.94	14.94	14.94	14.94	14.94	14.94	14.94
Staff in Post (as at end of prev month)	12.80	13.80	12.61	13.61	13.61	14.61	14.61	15.25	15.25
Variance (Month Start)	2.14	1.14	2.33	1.33	1.33	0.33	0.33	0.31	0.31
Newly Qualified (with PIN)	0.00	0.00	0.00	0.00	0.00	0.00	0.64	0.00	0.00
OSCE Nurse	0.00	0.00	1.00	0.00	1.00	0.00	0.00	0.00	1.00
General Recruitment	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Turnover	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Movement (inc change of hours, internal transfers)	1.00	1.19	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Staff in Post (as at end of current month)	13.80	12.61	13.61	13.61	14.61	14.61	15.25	15.25	16.25
VARIANCE (Month End)	1.14	2.33	1.33	1.33	0.33	0.33	0.31	0.31	1.31
Maternity Leave and Career Breaks	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
GAP (including maternity leave and Career Break)	1.14	2.33	1.33	1.33	0.33	0.33	0.31	0.31	1.31

Care Support Worker Vacancies

UNREGISTERED NURSES (Bands 2 - 3) (Excludes Nutritional Assistants)	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
Budgeted Establishment	14.32	14.32	14.32	14.32	14.32	14.32	14.32	14.32	14.32
Staff in Post (as at end of prev month)	11.01	13.92	13.40	13.78	13.78	13.47	13.16	13.85	13.54
Variance (Month Start)	3.31	0.40	0.92	0.54	0.54	0.85	1.16	0.47	0.78
Newly Qualified (without PIN)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
OSCE Nurse	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
General Recruitment	2.00	0.00	0.00	0.00	0.00	0.00	1.00	0.00	0.00
Turnover	0.00	0.44	0.00	0.00	0.31	0.31	0.31	0.31	0.31
Movement (inc change of hours, internal transfers)	0.91	0.09	0.38	0.00	0.00	0.00	0.00	0.00	0.00
Staff in Post (as at end of current month)	13.92	13.40	13.78	13.78	13.47	13.16	13.85	13.54	13.24
VARIANCE (Month End)	0.40	0.92	0.54	0.54	0.85	1.16	0.47	0.78	1.08
Maternity Leave and Career Breaks	0.64	0.55	0.55	0.00	0.00	0.00	0.00	0.00	0.00
GAP (including maternity leave)	1.04	1.47	1.09	0.54	0.85	1.16	0.47	0.78	1.08

Planned vs Actual Staffing & CHPPD

	July						
	Day		Night		CHPPD		
Ward	RN Fill (%)	CSW Fill (%)	RN Fill (%)	CSW Fill (%)	RN	CSW	Overall
Acute Frailty Unit	95%	122%	122%	164%	4.6	4.8	9.4
Byland	85%	101%	91%	133%	3.2	3.4	6.6
Farndale	86%	104%	87%	103%	5.2	4.3	9.5
Fountains	96%	98%	88%	130%	3.7	3.8	7.5
Granby	92%	92%	92%	97%	3.3	3.5	6.8
ITU/HDU	85%	58%	106%	-	26.9	3.2	30.1
Jervaulx	90%	112%	91%	139%	3.3	3.7	7.1
Lascelles	95%	83%	96%	111%	4.1	3.3	7.4
Littondale	100%	91%	96%	91%	4.1	3.7	7.8
Maternity	83%	93%	93%	90%	9.9	3.1	13.0
Nidderdale	96%	94%	101%	99%	3.8	2.6	6.4
Oakdale	97%	105%	95%	112%	3.5	3.2	6.8
Rowan	103%	111%	96%	71%	7.3	3.2	10.5
Special Care Baby Unit	98%	-	100%	-	20.8	0.0	20.8
Trinity	84%	101%	96%	96%	3.2	3.1	6.3
Wensleydale	110%	83%	111%	101%	6.2	3.1	9.3
Woodlands	98%	90%	98%	94%	10.0	3.1	13.1
Total	93%	98%	98%	112%	4.9	3.5	8.4

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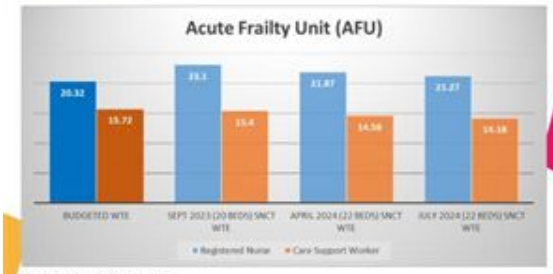
SNCT Results

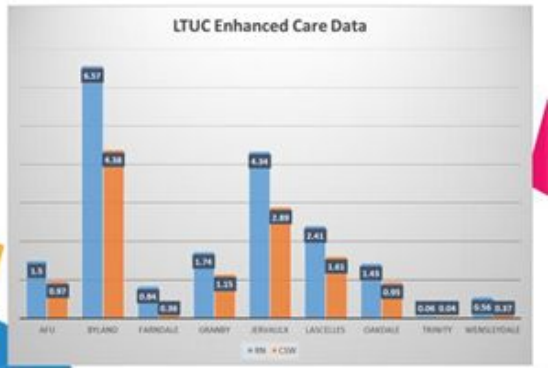
Acute Frailty Unit (AFU)



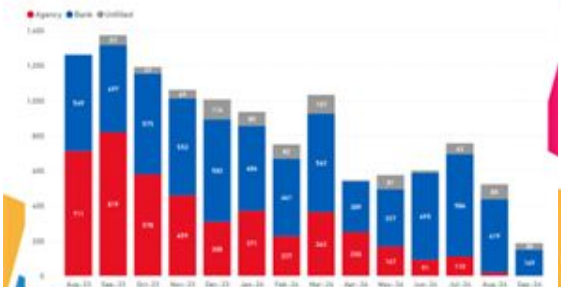
SNCT Data Collected by:
Sarah McDaniel
S. Thankappan (not trained), Prudence Anwuli (not trained), Anju Alex (not trained).

Enhanced Care

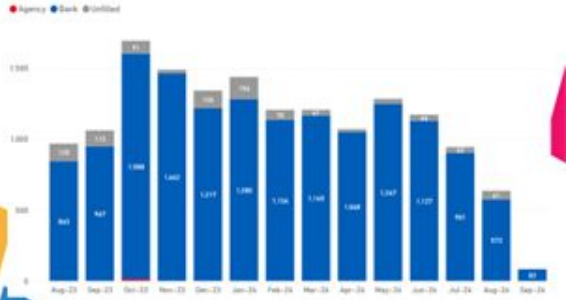
LTUC Enhanced Care Data



Temporary Staffing Registered Nurses (Hours)



Temporary Staffing Care Support Workers (Hours)



AFU Activity for July 2024

	Total in data collection period	Average per day
Admissions	177	5.70
Discharges	73	2.35
Transfers In	30	0.96
Transfers Out	86	2.77
Deaths	8	0.25
Ward Attenders	1	0.03

Datix during the month of July

Quality indicators

Falls	2 (June = 15, May = 7)
Hospital acquired pressure ulcers	8 (June = 2, May = 7)
Medication incidents	5 (June = 5, May = 3)
Staffing Datix	4 (June = 1, May = 0)
Formal Complaints	0 (June = 1, May = 0)

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Appendix 7

Trinity Safer Nursing Care Tool (SNCT)
July 2024 Data Collection

Matron: Jo Burns
Ward Manager: Julie Bates
ADoN: Charly Gill

Trinity (Rehab) 19 beds

Description of Ward

Trinity Ward is a 19 bedded elderly rehabilitation ward with 2 palliative care beds included in this number.

The ward is located within Ripon Community Hospital and is the only 24 hour facility at the Ripon site.

The layout of the ward consists 1x7 bedded male bay and a side room located in the male bay, a 9 bedded female bay and 1 side room located in the female bay. There is also a palliative care area containing 1 bed that can be male or female. Due to the historic nature of the building not all the beds are visible from the nurses station which is located at the entrance to the ward.

The ward also has a day room for patients which is also used as a meeting room for MDT and other meetings. There is also a garden for patient and staff use.

The ward is predominantly nurse led with medical cover provided by a consultant, ACP's and GPs. ACPs visit Monday and Friday morning and a frailty consultant and an ACP visit on a Wednesday when the main MDT is held. 2 local GPs cover the ward and these visit Monday, Wednesday and Friday. The Ward manager also has a site co-ordinator role.

Enhanced care is generally managed within the existing numbers. Very mobile confused patients are excluded from Trinity due to the number of entrances and exits and the close proximity of the ward to the road.

Length of stay on the ward can be from 3 days to weeks depending on the individual patient needs. Patients who come to Trinity usually require a minimum of assistance of 2 people to mobilise. We are also involved in many complex discharge processes.

Current Roster Template

Current Staffing Template

19 Bedded Ward	Early	Late	Night
Registered Nurse	3	3	2
Care Support Worker	3	2	2

Additional RN Early on a Wednesday for MDT

Registered Nurse Vacancies

REGISTERED NURSES (Bands 6 - 5) (Includes qual Nurse Associates)	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
Budgeted Establishment	11.53	11.53	11.53	11.53	11.53	11.53	11.53	11.53	11.53
Staff in Post (as at end of prev month)	6.33	7.33	7.33	8.33	9.33	10.33	10.33	10.33	11.05
Variance (month start)	5.20	4.20	4.20	3.20	2.20	1.20	1.20	1.20	0.48
Newly Qualified (with PIN)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.72	0.00
OSCE Nurse	1.00	0.00	0.00	0.00	1.00	0.00	0.00	0.00	0.00
General Recruitment	0.00	0.00	1.00	1.00	0.00	0.00	0.00	0.00	0.00
Turnover	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Movement (inc. change of hours, internal transfers)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Staff in Post (as at end of current month)	7.33	7.33	8.33	9.33	10.33	10.33	10.33	11.05	11.05
VARIANCE (Month End)	4.20	4.20	3.20	2.20	1.20	1.20	1.20	0.48	0.48
Maternity Leave and Career Breaks	0.00	0.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
GAP (including maternity leave)	4.20	4.20	4.20	3.20	2.20	2.20	2.20	1.48	1.48

Care Support Worker Vacancies

UNREGISTERED NURSES (Bands 2 - 3) (Excludes Nutritional Assistants)	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
Budgeted Establishment	12.56	12.56	12.56	12.56	12.56	12.56	12.56	12.56	12.56
Staff in Post (as at end of prev month)	11.99	11.99	11.12	10.84	10.84	11.77	11.70	13.10	13.03
Variance (month start)	0.57	0.57	1.44	1.72	1.72	0.79	0.86	-0.54	-0.47
Newly Qualified (without PIN)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
OSCE Nurse	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
General Recruitment	0.00	0.00	0.72	0.00	1.00	0.00	1.48	0.00	0.00
Turnover	0.00	0.87	0.00	0.00	0.07	0.07	0.07	0.07	0.07
Movement (inc. change of hours, internal transfers)	0.00	0.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00
Staff in Post (as at end of current month)	11.99	11.12	10.84	10.84	11.77	11.70	13.10	13.03	12.96
VARIANCE (Month End)	0.57	1.44	1.72	1.72	0.79	0.86	0.54	0.47	0.40
Maternity Leave and Career Breaks	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
GAP (including maternity leave)	0.57	1.44	1.72	1.72	0.79	0.86	0.54	0.47	0.40

Planned vs Actual Staffing & CHPPD

	July						
Ward	Fill (%)	Fill (%)	Fill (%)	Fill (%)			
Acute Frailty Unit	95%	122%	122%	164%	4.6	4.8	9.4
Byland	85%	101%	91%	133%	3.2	3.4	6.6
Farndale	86%	104%	87%	103%	5.2	4.3	9.5
Fountains	96%	98%	88%	130%	3.7	3.8	7.5
Granby	92%	92%	92%	97%	3.3	3.5	6.8
ITU/HDU	85%	58%	106%	-	26.9	3.2	30.1
Jervaulx	90%	112%	91%	139%	3.3	3.7	7.1
Lascelles	95%	83%	96%	111%	4.1	3.3	7.4
Littondale	100%	91%	96%	91%	4.1	3.7	7.8
Maternity	83%	93%	93%	90%	9.9	3.1	13.0
Nidderdale	96%	94%	101%	99%	3.8	2.6	6.4
Oakdale	97%	105%	95%	112%	3.5	3.2	6.8
Rowan	103%	111%	96%	71%	7.3	3.2	10.5
Special Care Baby Unit	98%	-	100%	-	20.8	0.0	20.8
Trinity	84%	101%	96%	96%	3.2	3.1	6.3
Wensleydale	110%	83%	111%	101%	6.2	3.1	9.3
Woodlands	98%	90%	98%	94%	10.0	3.1	13.1
Total	93%	98%	98%	112%	4.9	3.5	8.4

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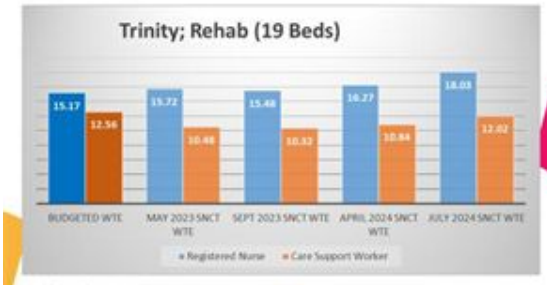
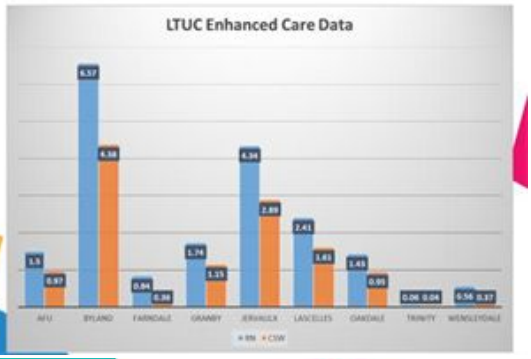
SNCT Results

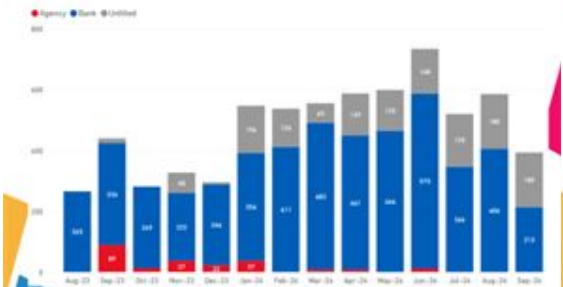


SNCT Data Collected by:
Julie Bates
L Stockdale (not trained) Rob Ulley (not trained) Mary Templado (not trained)
T Cason (not trained) Rachel Templado (not trained) Judith Wilson (not trained)

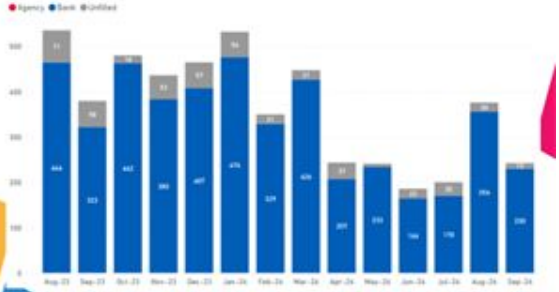
Enhanced Care



Temporary Staffing Registered Nurses (Hours)



Temporary Staffing Care Support Workers (Hours)



Trinity Activity for July 2024

	Total in data collection period	Average per day
Admissions	1	0.03
Discharges	28	0.90
Transfers In	23	0.74
Transfers Out	0	0
Deaths	1	0.03
Ward Attenders	0	0

Datix during the month of July

Quality indicators

Falls	**0** (June = 3, May = 3)
Hospital acquired pressure ulcers	**9** (June = 4, May = 3)
Medication incidents	**1** (June = 1, May = 2)
Staffing Datix	**1** (June = 0, May = 0)
Formal Complaints	**0** (June = 0, May = 0)

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Appendix 8

Farndale Safer Nursing Care Tool
(SNCT)
July 2024 Data Collection

Matron: Rebecca Heseltine
Ward Manager: Clare Pemberton
ADoN: Charly Gill

Farndale (Medical Admissions Ward) 23 beds

Description of ward

- Farndale is a 23 bedded admissions unit with high turnover of patients and high acuity for medical admissions.
- 17 of these beds are side rooms for infectious patients.
- Farndale is able to accept patients on telemetry/requiring cardiac monitoring, and the nurses are skilled to care for patients requiring acute NIV.

Current Roster Template

The budget for Farndale was increased following the last SNCT establishment review.

The SNCT data below has been calculated on a side room factor (for wards where there are 75% or more side rooms).

Budgeted Staffing Template

23 Bedded Ward	Early	Late	Night
Registered Nurse	5	5	5
Care Support Worker	3	3	3

Registered Nurse Vacancies

REGISTERED NURSES (Bands 5 - 6) (Includes qual Nurse Associates)	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
Budgeted Establishment	15.46	15.46	15.46	15.46	15.46	15.46	15.46	15.46	15.46
Staff in Post (as at end of prev month)	16.97	15.97	13.07	13.07	14.07	15.93	16.79	17.26	17.70
Variance (Month Start)	1.51	0.51	-2.39	-2.39	-1.39	0.47	1.33	1.80	2.24
Newly Qualified (with PIN)	1.00	0.00	0.00	0.00	1.00	0.00	1.00	0.00	0.00
OSCE Nurse	1.00	0.00	0.00	1.00	1.00	0.00	0.00	0.00	1.00
General Recruitment	1.00	0.00	0.00	0.00	0.00	1.00	0.00	0.58	0.00
Turnover	0.00	1.00	0.00	0.00	0.14	0.14	0.14	0.14	0.14
Movement (inc change of hours, internal transfers)	-4.00	1.91	0.00	0.00	0.00	0.00	0.42	0.00	0.00
Staff in Post (as at end of current month)	15.97	13.07	13.07	14.07	15.93	16.79	17.26	17.70	18.56
VARIANCE (Month End)	**0.51**	**-2.39**	**-2.39**	**-1.39**	**0.47**	**1.33**	**1.80**	**2.24**	**3.10**
Maternity Leave and Career Breaks	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
GAP (including maternity leave)	0.51	-2.39	-2.39	-1.39	0.47	1.33	1.80	2.24	3.10

Care Support Worker Vacancies

UNREGISTERED NURSES (Bands 2 - 3) (Excludes Nutritional Assistants)	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
Budgeted Establishment	16.91	16.91	16.91	16.91	16.91	16.91	16.91	16.91	16.91
Staff in Post (as at end of prev month)	15.65	14.85	15.85	15.26	17.48	17.33	17.18	16.63	16.48
Variance (Month Start)	1.26	2.06	1.06	1.65	0.57	0.42	0.27	0.28	0.43
Newly Qualified (without PIN)	0.00	0.00	0.00	0.00	0.00	0.00	0.40	0.00	0.00
OSCE Nurse	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
General Recruitment	0.00	1.00	0.00	2.00	0.00	0.00	0.00	0.00	0.00
Turnover	0.80	0.00	0.00	0.00	0.15	0.15	0.15	0.15	0.15
Movement (inc change of hours, internal transfers)	0.00	0.00	0.60	0.23	0.00	0.00	0.00	0.00	0.00
Staff in Post (as at end of current month)	14.85	15.85	15.26	17.48	17.33	17.18	16.63	16.48	16.33
VARIANCE (Month End)	**2.06**	**1.06**	**1.65**	**0.57**	**0.42**	**0.27**	**0.28**	**0.43**	**0.58**
Maternity Leave and Career Breaks	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
GAP (including maternity leave)	2.06	1.06	1.65	0.57	0.42	0.27	0.28	0.43	0.58

Planned vs Actual Staffing & CHPPD

	July						
	Day		Night		CHPPD		
Ward	RN Fill (%)	CSW Fill (%)	RN Fill (%)	CSW Fill (%)	RN	CSW	Overall
Acute Frailty Unit	95%	122%	122%	164%	4.6	4.8	9.4
Byland	85%	101%	91%	133%	3.2	3.4	6.6
Farndale	86%	104%	87%	103%	5.2	4.3	9.5
Fountains	96%	98%	88%	130%	3.7	3.8	7.5
Granby	92%	92%	92%	97%	3.3	3.5	6.8
ITU/HDU	85%	58%	106%	-	26.9	3.2	30.1
Jervaulx	90%	112%	91%	139%	3.3	3.7	7.1
Lascelles	95%	83%	96%	111%	4.1	3.3	7.4
Littondale	100%	91%	96%	91%	4.1	3.7	7.8
Maternity	83%	93%	93%	90%	9.9	3.1	13.0
Nidderdale	96%	94%	101%	99%	3.8	2.6	6.4
Oakdale	97%	105%	95%	112%	3.5	3.2	6.8
Rowan	103%	111%	96%	71%	7.3	3.2	10.5
Special Care Baby Unit	98%	-	100%	-	20.8	0.0	20.8
Trinity	84%	101%	96%	96%	3.2	3.1	6.3
Wensleydale	110%	83%	111%	101%	6.2	3.1	9.3
Woodlands	98%	90%	98%	94%	10.0	3.1	13.1
Total	93%	98%	98%	112%	4.9	3.5	8.4

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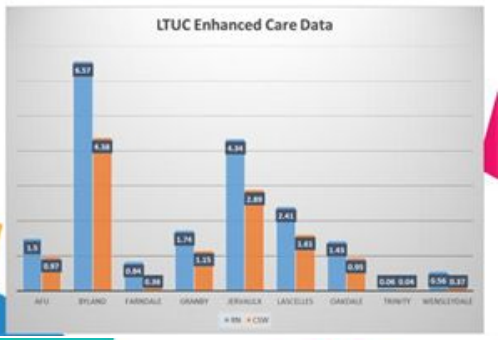
SNCT Results

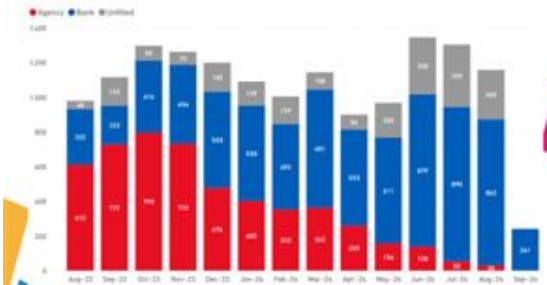
SNCT Data Collected by:

Clare Pemberton
S. Jones (not trained). C. Warren (not trained). Aswathy Valsala (not trained).
Callum Stewart (not trained).

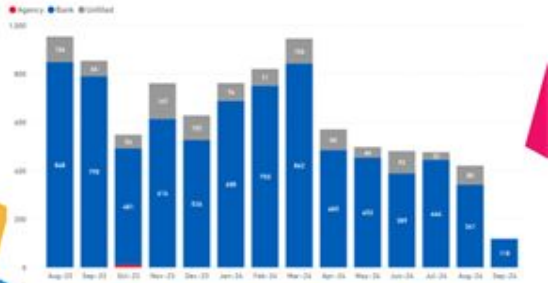
Enhanced Care



Temporary Staffing Registered Nurses (Hours)



Temporary Staffing Care Support Workers (Hours)



Farndale Activity for July 2024

	Total in data collection period	Average per day
Admissions	394	12.70
Discharges	163	5.25
Transfers In	10	0.32
Transfers Out	183	5.90
Deaths	5	0.16
Ward Attenders	0	0

Datix during month of July

Quality indicators

Falls	**2** (June = 5, May = 11)
Hospital acquired pressure ulcers	**5** (June = 2, May = 4)
Medication incidents	**2** (June = 8, May = 11)
Staffing Datix	**1** (June = 3, May = 6)
Formal Complaints	**0** (June = 0, May = 0)

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Appendix 9

Wensleydale Safer Nursing Care Tool
(SNCT)
July 2024 Data Collection

Matron: Rebecca Heseltine/Simon Brazier
Ward Manager: Rachael Dealhoy
ADoN: Charly Gill

Wensleydale (Cardio-respiratory ward with MECU) 28 beds

Wensleydale is a 28 bedded acute cardiology and respiratory ward, incorporating an 8 bedded Coronary Care Unit and Medical Enhanced Care Unit. The acuity is high due to this area with a high turnover of patients. The linear ward has recently been refurbished and incorporated digital technology for the nurse call system which enables all staff to identify who needs assistance at any time via hand held devices.

The ward has recruited a full time clinical educator to develop all staff training especially in CCU and MECU, also we are introducing of Nasal Highflow patients and increased medical needs.

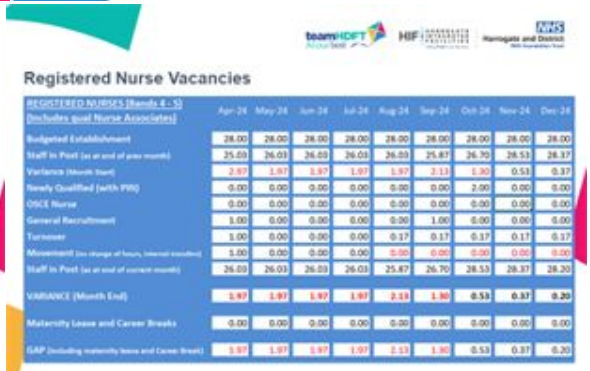
The ward has 7 day ward clerk and nutritional support workers to enable clinical staff more time with patient care,

Current Roster Template

Current Staffing Template

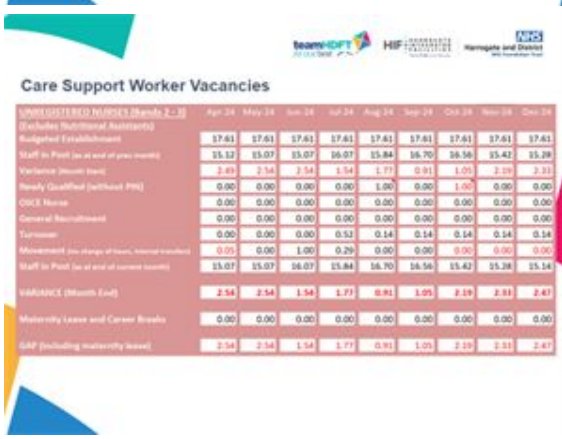
This is a new Cardio-respiratory ward with MECU & CCU beds. We now have two data collections and therefore any changes can now be made.

28 Bedded Ward	Early	Late	Night
Registered Nurse	7	7	7
Care Support Worker	3	3	3



Registered Nurse Vacancies

REGISTERED NURSES (Bands 4 - 5) (Includes qual Nurse Associates)	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
Budgeted Establishment	28.00	28.00	28.00	28.00	28.00	28.00	28.00	28.00	28.00
Staff in Post (as at end of prev month)	25.03	26.03	26.03	26.03	26.03	25.87	26.70	28.53	28.37
Variance (Month Start)	2.97	1.97	1.97	1.97	1.97	2.13	1.30	0.53	0.37
Newly Qualified (with PIN)	0.00	0.00	0.00	0.00	0.00	0.00	2.00	0.00	0.00
OSCE Nurse	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
General Recruitment	1.00	0.00	0.00	0.00	0.00	1.00	0.00	0.00	0.00
Turnover	1.00	0.00	0.00	0.00	0.17	0.17	0.17	0.17	0.17
Movement (inc change of hours, internal transfers)	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Staff in Post (as at end of current month)	26.03	26.03	26.03	26.03	25.87	26.70	28.53	28.37	28.20
VARIANCE (Month End)	1.97	1.97	1.97	1.97	2.13	1.30	0.53	0.37	0.20
Maternity Leave and Career Breaks	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
GAP (including maternity leave and Career Breaks)	1.97	1.97	1.97	1.97	2.13	1.30	0.53	0.37	0.20



Care Support Worker Vacancies

UNREGISTERED NURSES (Bands 2 - 3) (Excludes Nutritional Assistants)	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
Budgeted Establishment	17.61	17.61	17.61	17.61	17.61	17.61	17.61	17.61	17.61
Staff in Post (as at end of prev month)	15.12	15.07	15.07	16.07	15.84	16.70	16.56	15.42	15.28
Variance (Month Start)	2.49	2.54	2.54	1.54	1.77	0.91	1.05	2.19	2.33
Newly Qualified (without PIN)	0.00	0.00	0.00	0.00	1.00	0.00	1.00	0.00	0.00
OSCE Nurse	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
General Recruitment	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Turnover	0.00	0.00	0.00	0.53	0.14	0.14	0.14	0.14	0.14
Movement (inc change of hours, internal transfers)	0.05	0.00	1.00	0.29	0.00	0.00	0.00	0.00	0.00
Staff in Post (as at end of current month)	15.07	15.07	16.07	15.84	16.70	16.56	15.42	15.28	15.14
VARIANCE (Month End)	2.54	2.54	1.54	1.77	0.91	1.05	2.19	2.33	2.47
Maternity Leave and Career Breaks	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
GAP (including maternity leave)	2.54	2.54	1.54	1.77	0.91	1.05	2.19	2.33	2.47

Planned vs Actual Staffing & CHPPD

	July						
	Day		Night		CHPPD		
Ward	RN Fill (%)	CSW Fill (%)	RN Fill (%)	CSW Fill (%)	RN	CSW	Overall
Acute Frailty Unit	95%	122%	122%	164%	4.6	4.8	9.4
Byland	85%	101%	91%	133%	3.2	3.4	6.6
Farndale	86%	104%	87%	103%	5.2	4.3	9.5
Fountains	96%	98%	88%	130%	3.7	3.8	7.5
Granby	92%	92%	92%	97%	3.3	3.5	6.8
ITU/HDU	85%	58%	106%	-	26.9	3.2	30.1
Jervaulx	90%	112%	91%	139%	3.3	3.7	7.1
Lascelles	95%	83%	96%	111%	4.1	3.3	7.4
Littondale	100%	91%	96%	91%	4.1	3.7	7.8
Maternity	83%	93%	93%	90%	9.9	3.1	13.0
Nidderdale	96%	94%	101%	99%	3.8	2.6	6.4
Oakdale	97%	105%	95%	112%	3.5	3.2	6.8
Rowan	103%	111%	96%	71%	7.3	3.2	10.5
Special Care Baby Unit	98%	-	100%	-	20.8	0.0	20.8
Trinity	84%	101%	96%	96%	3.2	3.1	6.3
Wensleydale	110%	83%	111%	101%	6.2	3.1	9.3
Woodlands	98%	90%	98%	94%	10.0	3.1	13.1
Total	93%	98%	98%	112%	4.9	3.5	8.4

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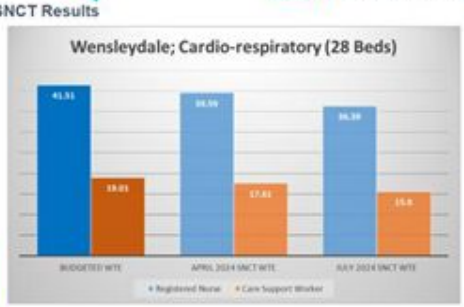
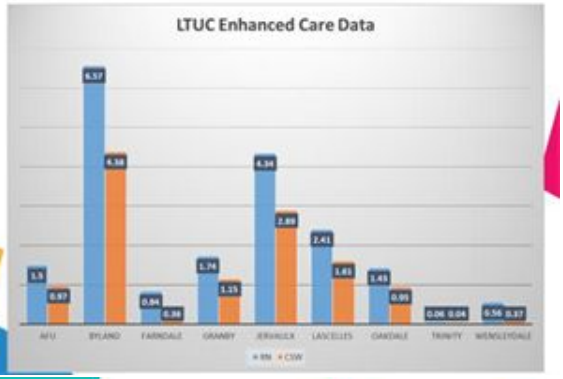
SNCT Results

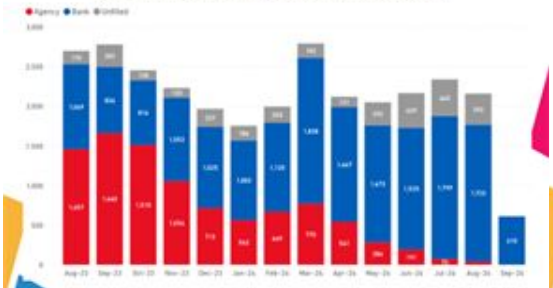


SNCT Data Collected by:
RaTrael Deahoy, Maria Cartwright, Joona Juby (not trained), R. Vickerman (not trained), R. Jandrew (not trained), Ronu Raju (not trained), Bobby Sisay (not trained), S. Rish (not trained / no record), Lucia Wightman (not trained)

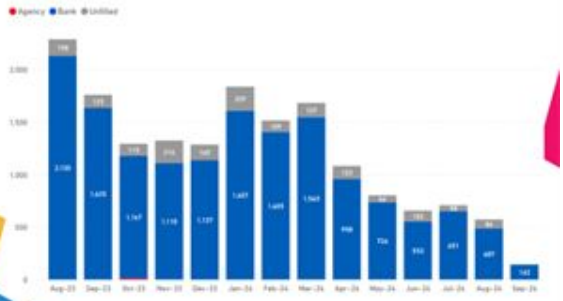
Enhanced Care



Temporary Staffing Registered Nurses (Hours)



Temporary Staffing Care Support Workers (Hours)



Wensleydale Activity for July 2024

	Total in data collection period	Average per day
Admissions	116	3.74
Discharges	126	4.06
Transfers In	86	2.77
Transfers Out	60	1.93
Deaths	8	0.25
Ward Attenders	0	0

Datix during month of July

Quality indicators

Falls	1 (June = 5, May = 4)
Hospital acquired pressure ulcers	5 (June = 10, May = 4)
Medication incidents	3 (June = 5, May = 6)
Staffing Datix	0 (June = 3, May = 4)
Formal Complaints	1 (June = 1, May = 0)

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Appendix 10

Rowan Safer Nursing Care Tool
(SNCT)
July 2024 Data Collection

Matron: Jonathan Slack
Ward Manager: Jemma Waddington
ADoN: Julie Walker

Rowan 16 Beds

Description of Ward

Rowan is an Elective orthopaedic ward with 16 beds but has 20 physical bed spaces which we have created for the orthopaedic LLP Lists at weekend.
If escalation beds these are used, a 3rd RN is required to ensure quality, safety and performance.
Turn around of patients can be fast patients aim discharge 1-2 days post surgery.
The quantity of admissions varies, from week to week, but from October, this activity will increase.
There is a dedicated treatment room where patients return to be reviewed as ward attenders if they have wound problems and they are dealt with by the ward nurses and reviewed by Ortho Registrar.

Current Roster Template

Current Staffing Template

30 Bedded Ward	Early	Late	Night
Registered Nurse	2	2	2
Care Support Worker	2	2	1

Registered Nurse Vacancies

REGISTERED NURSES (Bands 4 - 5) (Includes qual Nurse Associates)	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
Budgeted Establishment	8.10	8.10	8.10	8.10	8.10	8.10	8.10	8.10	8.10
Staff in Post (as at end of prev month)	10.88	10.47	10.35	9.35	8.36	8.36	8.36	8.36	8.36
Variance (Month End)	2.78	2.37	2.25	1.25	0.26	0.26	0.26	0.26	0.26
Newly Qualified (with PIN)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
OSCE Nurse	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
General Recruitment	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Turnover	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Movement (no change of hours, internal transfers)	0.41	0.12	1.00	0.99	0.00	0.00	0.00	0.00	0.00
Staff in Post (as at end of current month)	10.47	10.35	9.35	8.36	8.36	8.36	8.36	8.36	8.36
VARIANCE (Month End)	2.37	2.25	1.25	0.26	0.26	0.26	0.26	0.26	0.26
Maternity Leave and Career Breaks	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
GAP (including maternity leave)	1.37	2.25	1.25	0.26	0.26	0.26	0.26	0.26	0.26

Care Support Worker Vacancies

UNREGISTERED NURSES (Bands 2 - 3) (Excludes Nutritional Assistants)	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
Budgeted Establishment	8.92	8.92	8.92	8.92	8.92	8.92	8.92	8.92	8.92
Staff in Post (as at end of prev month)	5.19	6.19	6.19	6.19	6.60	6.51	6.41	6.32	6.23
Variance (Month End)	3.73	2.73	2.73	2.73	2.32	2.41	2.51	2.60	2.69
Newly Qualified (without PIN)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
OSCE Nurse	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
General Recruitment	0.00	0.00	0.00	1.00	0.00	0.00	0.00	0.00	0.00
Turnover	0.00	0.00	0.59	0.00	0.09	0.09	0.09	0.09	0.09
Movement (no change of hours, internal transfers)	1.00	0.00	0.59	0.59	0.00	0.00	0.00	0.00	0.00
Staff in Post (as at end of current month)	6.19	6.19	6.19	6.60	6.51	6.41	6.32	6.23	6.13
VARIANCE (Month End)	2.73	2.73	2.73	2.32	2.41	2.51	2.60	2.69	2.79
Maternity Leave and Career Breaks	0.00	0.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
GAP (including maternity leave)	2.73	2.73	3.73	3.32	3.41	3.51	3.60	3.69	3.79

Planned vs Actual Staffing & CHPPD

	July						
	Day		Night		CHPPD		
Ward	RN Fill (%)	CSW Fill (%)	RN Fill (%)	CSW Fill (%)	RN	CSW	Overall
Acute Frailty Unit	95%	122%	122%	164%	4.6	4.8	9.4
Byland	85%	101%	91%	133%	3.2	3.4	6.6
Farndale	86%	104%	87%	103%	5.2	4.3	9.5
Fountains	96%	98%	88%	130%	3.7	3.8	7.5
Granby	92%	92%	92%	97%	3.3	3.5	6.8
ITU/HDU	85%	58%	106%	-	26.9	3.2	30.1
Jervaulx	90%	112%	91%	139%	3.3	3.7	7.1
Lascelles	95%	83%	96%	111%	4.1	3.3	7.4
Littondale	100%	91%	96%	91%	4.1	3.7	7.8
Maternity	83%	92%	93%	90%	9.9	3.1	13.0
Nidderdale	96%	94%	101%	99%	3.8	2.6	6.4
Oakdale	97%	109%	95%	112%	3.5	3.2	6.8
Rowan	103%	111%	96%	71%	7.3	3.2	10.5
Special Care Baby Unit	98%	-	100%	-	20.8	0.0	20.8
Trinity	84%	101%	96%	96%	3.2	3.1	6.3
Wensleydale	110%	83%	111%	101%	6.2	3.1	9.3
Woodlands	98%	90%	98%	94%	10.0	3.1	13.1
Total	93%	98%	98%	112%	4.9	3.5	8.4

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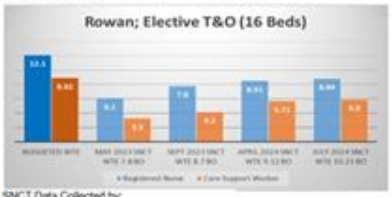
SNCT Raw Data

Budgeted WTE and SNCT establishment data

Rowan's data identifies that their full bed occupancy has not been utilised across the 7 day week. This data collection identifies utilisation of 10.21 beds, which is an increase on the 9.12 beds in April 2024.

	May 2023	September 2023	April 2024	July 2024
Bed Occupancy	7.8	8.7	9.12	10.21

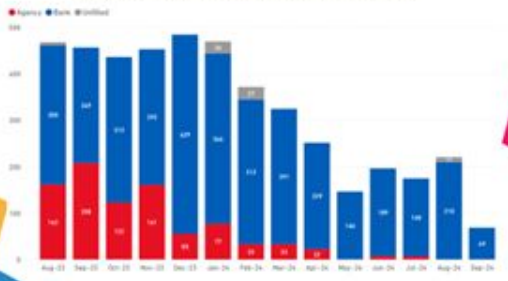
The staffing template (above) shows the current staffing for Rowan and allows for a maximum of 16 patients.



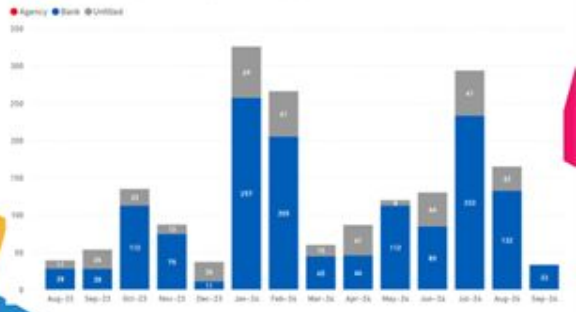
SNCT Data Collected by:
S. Shaw, Jomma Waddington, Jas Kaur, Dalia Roney
D. Dave (not trained / no record)

Enhanced Care

Temporary Staffing Registered Nurses (Hours)



Temporary Staffing Care Support Workers (Hours)



Rowan Activity for July 2024

	Total in data collection period	Average per day
Admissions	117	3.77
Discharges	52	1.67
Transfers In	5	0.16
Transfers Out	66	2.12
Deaths	0	0
Ward Attenders	27	0.87

Datix during month of July

Quality indicators

Falls	1 (June = 0, May = 2)
Hospital acquired pressure ulcers	1 (June = 0, May = 1)
Medication incidents	0 (June = 2, May = 3)
Staffing Datix	0 (June = 0, May = 0)
Formal Complaints	0 (June = 0, May = 0)

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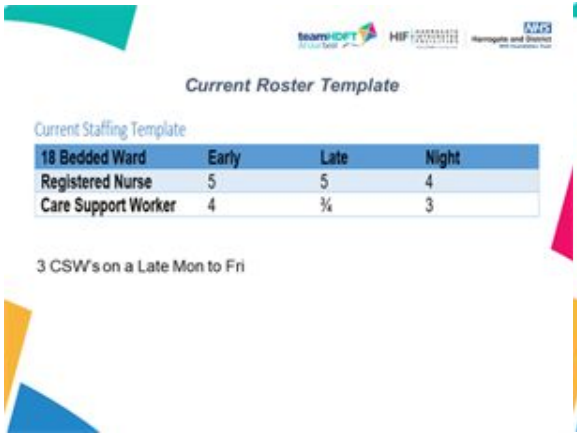
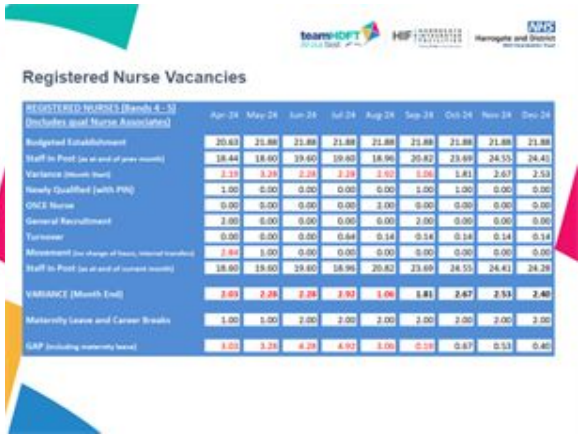
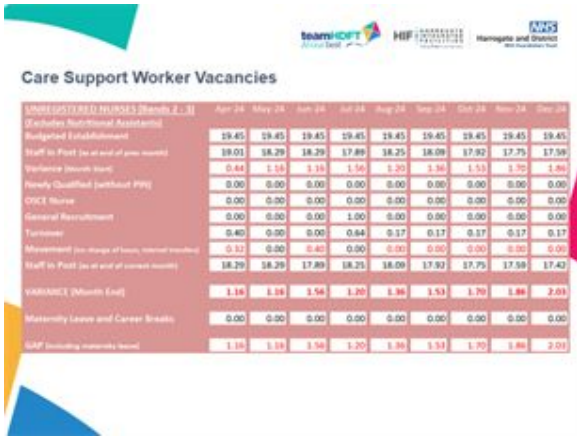
Appendix 11







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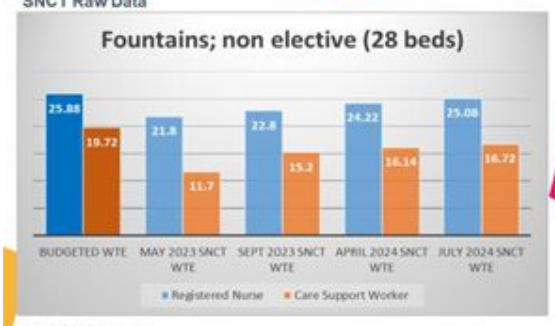
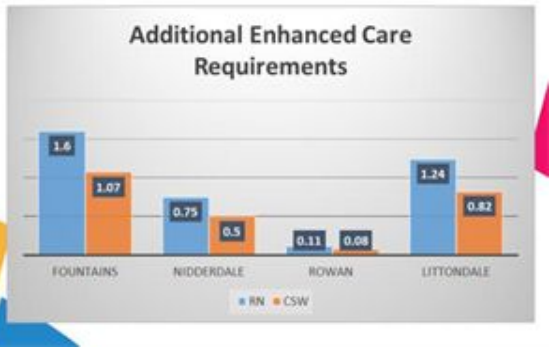
SNCT Raw Data

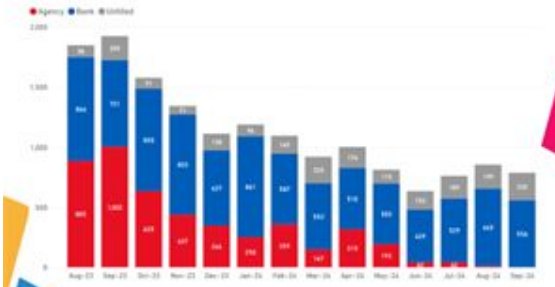


SNCT Data Collected by:
Mevludo Haradinaj, D. Matthew, D. Benn

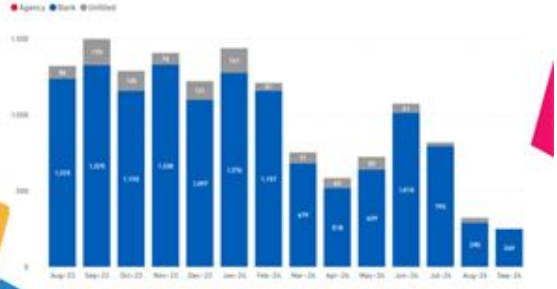
Enhanced Care



Temporary Staffing Registered Nurses (Hours)



Temporary Staffing Care Support Workers (Hours)



Fountains Activity for July 2024

	Total in data collection period	Average per day
Admissions	123	3.96
Discharges	69	2.22
Transfers In	25	0.80
Transfers Out	76	2.45
Deaths	5	0.16
Ward Attenders	0	0

Datix during month of July

Quality indicators

Falls	**3** (June = 3, May = 1)
Hospital acquired pressure ulcers	**9** (June = 13, May = 10)
Medication incidents	**9** (June = 4, May = 6)
Staffing Datix	**1** (June = 0, May = 2)
Formal Complaints	**0** (June = 0, May = 0)

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Appendix 12

Littondale Safer Nursing Care Tool
(SNCT)
July 2024 Data Collection

Matron: Lesley Danby
Ward Manager: Rachel Latimer
ADoN: Julie Walker

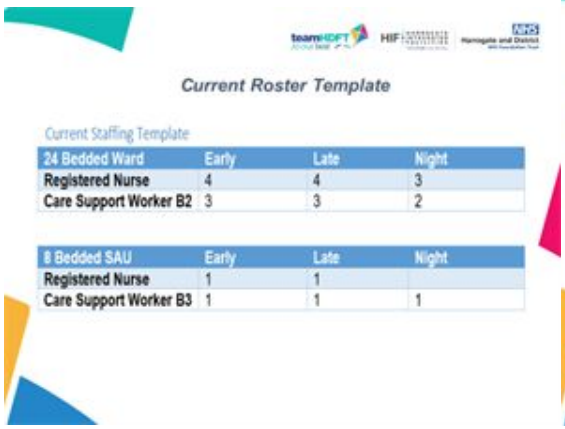
Littondale 24 beds & 8 Assessment beds

Description of Ward

Littondale is a 24 bedded male surgical and gastroenterology ward, which houses a surgical assessment unit (8 beds).

The ward is a "T" shaped ward. With four adjacent bays and one double side room and six single rooms, all of which are not in sight of the main staff base. Single room 1 and 2 are opposite bay 3 and 4 and single room 8 and 9 are opposite bay 6. Room 5 is opposite the central staff base but visibility is still limited. The double side room is adjacent to room 6 at the far end of the ward. Two single rooms one with ensuite are on the entry corridor to the main ward. The bathrooms, staff base, linen room, and storage room face the bays. Other rooms include the ward office, dirty utility room, ward kitchen, treatment room, doctors' office, quiet room, therapy storage and staff room, which are all located a distance away from the main patient areas along the entry corridor.

The ward is led by an experienced Ward Manager and Matron, with experienced Band 6 Ward Sisters.

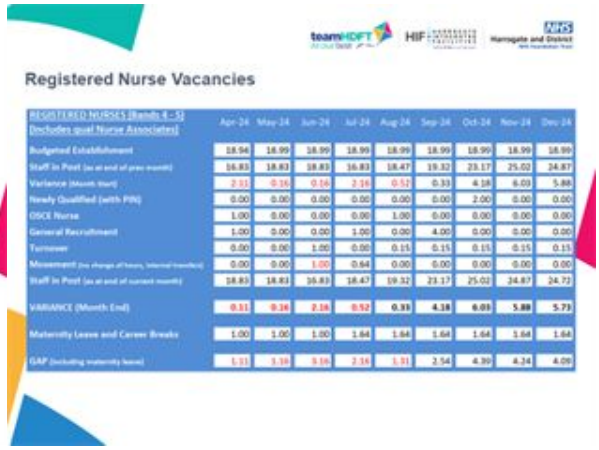


Current Roster Template

Current Staffing Template

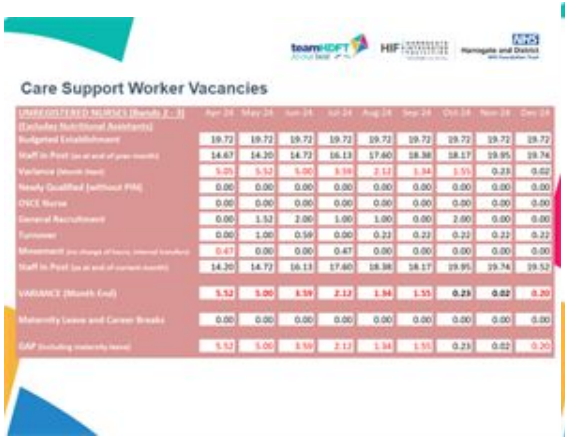
24 Bedded Ward	Early	Late	Night
Registered Nurse	4	4	3
Care Support Worker B2	3	3	2

8 Bedded SAU	Early	Late	Night
Registered Nurse	1	1	
Care Support Worker B3	1	1	1



Registered Nurse Vacancies

REGISTERED NURSES (Bands 4 - 5) (Includes qual Nurse Associates)	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
Budgeted Establishment	18.94	18.99	18.99	18.99	18.99	18.99	18.99	18.99	18.99
Staff in Post (as at end of prev month)	16.83	16.83	16.83	16.83	16.47	19.32	23.17	25.02	24.87
Variance (Month End)	-2.11	-2.16	-2.16	-2.16	-2.52	0.33	4.18	6.03	5.88
Newly Qualified (with PIN)	0.00	0.00	0.00	0.00	0.00	0.00	2.00	0.00	0.00
OSCE Nurse	1.00	0.00	0.00	0.00	1.00	0.00	0.00	0.00	0.00
General Recruitment	1.00	0.00	0.00	1.00	0.00	4.00	0.00	0.00	0.00
Turnover	0.00	0.00	1.00	0.00	0.15	0.15	0.15	0.15	0.15
Movement (inc change of hours, internal transfers)	0.00	0.00	-1.00	0.64	0.00	0.00	0.00	0.00	0.00
Staff in Post (as at end of current month)	16.83	16.83	16.83	16.47	19.32	23.17	25.02	24.87	24.72
VARIANCE (Month End)	-2.11	-2.16	-2.16	-2.52	0.33	4.18	6.03	5.88	5.73
Maternity Leave and Career Breaks	1.00	1.00	1.00	1.64	1.64	1.64	1.64	1.64	1.64
GAP (including maternity leave)	-1.11	-1.16	-1.16	-2.16	-1.91	2.54	4.39	4.24	4.09



Care Support Worker Vacancies

UNREGISTERED NURSES (Bands 2 - 3) (Excludes Nutritional Assistants)	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
Budgeted Establishment	19.72	19.72	19.72	19.72	19.72	19.72	19.72	19.72	19.72
Staff in Post (as at end of prev month)	14.67	14.20	14.72	16.13	17.60	18.38	18.17	19.95	19.74
Variance (Month End)	-5.05	-5.52	-5.00	-3.59	-2.12	-1.34	-1.55	0.23	0.02
Newly Qualified (without PIN)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
OSCE Nurse	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
General Recruitment	0.00	1.52	2.00	1.00	1.00	0.00	2.00	0.00	0.00
Turnover	0.00	1.00	0.59	0.00	0.22	0.22	0.22	0.22	0.22
Movement (inc change of hours, internal transfers)	0.47	0.00	0.00	0.47	0.00	0.00	0.00	0.00	0.00
Staff in Post (as at end of current month)	14.20	14.72	16.13	17.60	18.38	18.17	19.95	19.74	19.52
VARIANCE (Month End)	-5.52	-5.00	-3.59	-2.12	-1.34	-1.55	0.23	0.02	-0.20
Maternity Leave and Career Breaks	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
GAP (including maternity leave)	-5.52	-5.00	-3.59	-2.12	-1.34	-1.55	0.23	0.02	-0.20

Planned vs Actual Staffing & CHPPD

	July						
	Day		Night		CHPPD		
Ward	RN Fill (%)	CSW Fill (%)	RN Fill (%)	CSW Fill (%)	RN	CSW	Overall
Acute Frailty Unit	95%	122%	122%	164%	4.6	4.8	9.4
Byland	85%	101%	91%	133%	3.2	3.4	6.6
Farndale	86%	104%	87%	103%	5.2	4.3	9.5
Fountains	96%	98%	88%	130%	3.7	3.8	7.5
Granby	92%	92%	92%	97%	3.3	3.5	6.8
ITU/HDU	85%	58%	106%		26.9	3.2	30.1
Jervaulx	90%	112%	91%	139%	3.3	3.7	7.1
Lascelles	95%	83%	96%	111%	4.1	3.3	7.4
Littondale	100%	91%	96%	91%	4.1	3.7	7.8
Maternity	83%	93%	93%	90%	9.9	3.1	13.0
Nidderdale	96%	94%	101%	99%	3.8	2.6	6.4
Oakdale	97%	105%	95%	112%	3.5	3.2	6.8
Rowan	103%	111%	96%	71%	7.3	3.2	10.5
Special Care Baby Unit	98%		100%		20.8	0.0	20.8
Trinity	84%	101%	96%	96%	3.2	3.1	6.3
Wensleydale	110%	83%	111%	101%	6.2	3.1	9.3
Woodlands	98%	90%	98%	94%	10.0	3.1	13.1
Total	93%	98%	98%	112%	4.9	3.5	8.4

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SNCT Raw Data

Budgeted WTE and SNCT establishment data

Littondale budgeted establishment (RN 23.14 and CSW 20.72) is to staff the 24 bedded ward and the 8 bedded Surgical Assessment Unit (SAU).

The SNCT Data in the table below shows the WTE required to staff the 24 inpatient beds.

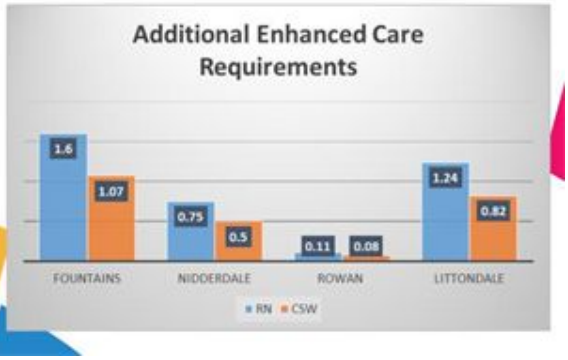
SAU requires one RN and one Band 3 CSW each day.

The data suggests a deficit in RN's within the overall establishment.

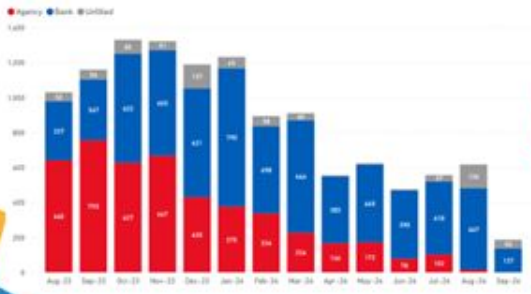
This data needs triangulation to consider the ward (bed base of 24) requirements.

SNCT Data Collected by:
Rachel Latimer, Sridhan Park
V. Franklin (not trained), M. Thomas (not trained), C. Hernandez (not trained)
H Cowanah (?) (not trained), E. Lambert (not trained)

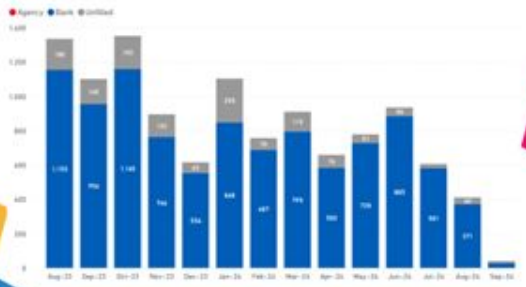
Enhanced Care



Temporary Staffing Registered Nurses (Hours)



Temporary Staffing Care Support Workers (Hours)



Littondale Activity for July 2024

	Total in data collection period	Average per day
Admissions	56	1.80
Discharges	86	2.77
Transfers In	93	3
Transfers Out	59	1.90
Deaths	3	0.09
Ward Attenders	0	0

Datix during month of July

Quality indicators

Falls	**2** (June = 1, May = 3)
Hospital acquired pressure ulcers	**2** (June = 0, May = 2)
Medication incidents	**3** (June = 3, May = 6)
Staffing Datix	**0** (June = 0, May = 0)
Formal Complaints	**0** (June = 0, May = 1)

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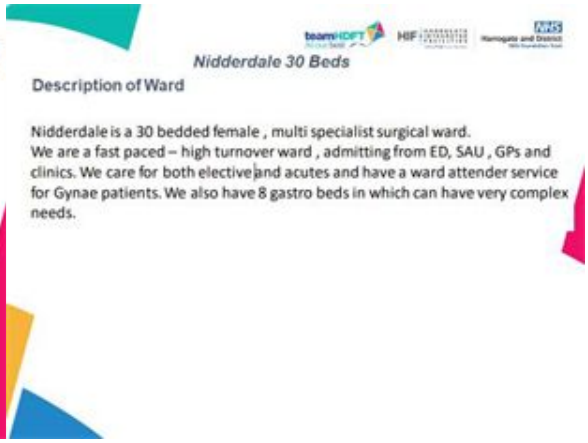
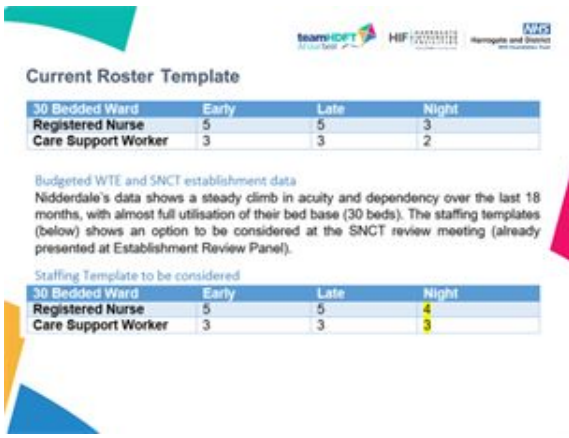
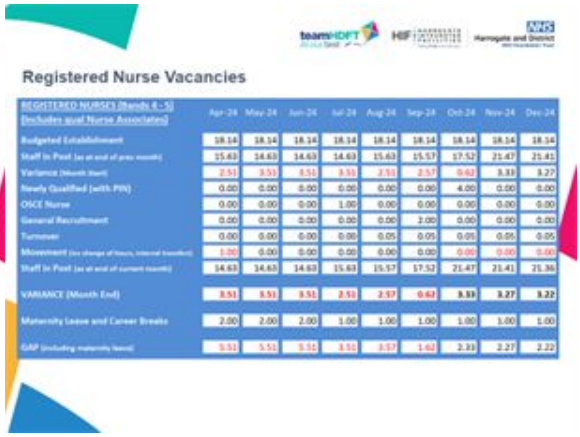
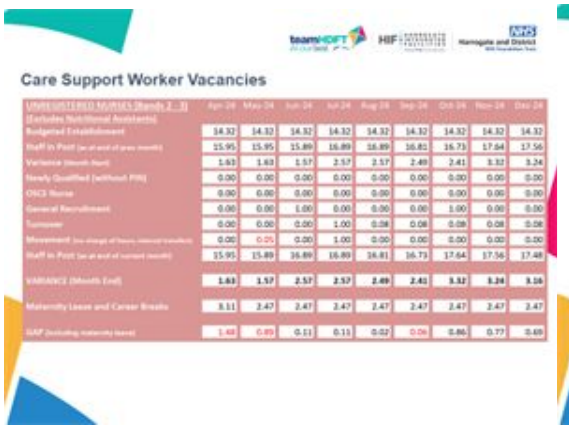
Appendix 13









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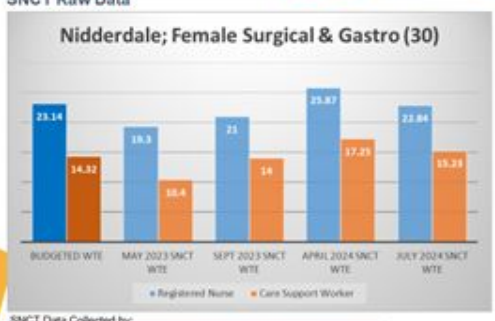
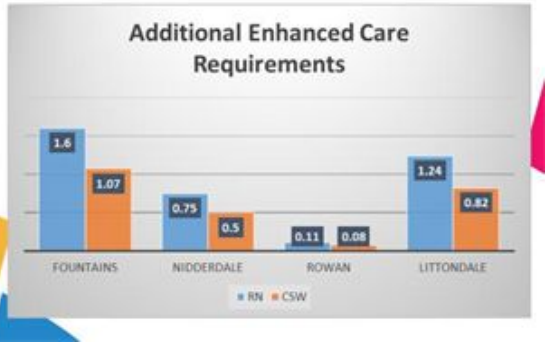
SNCT Raw Data

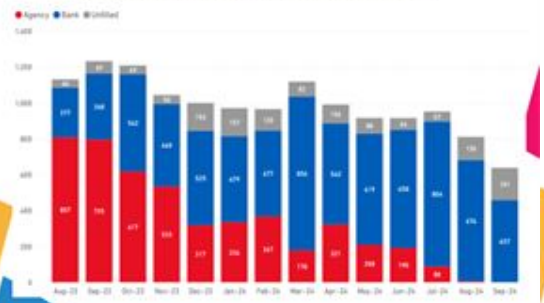


SNCT Data Collected by:
Rachel Little
Priyanka Thankan (not trained); D. Ashton (not trained / no record); E. Jones (not trained)

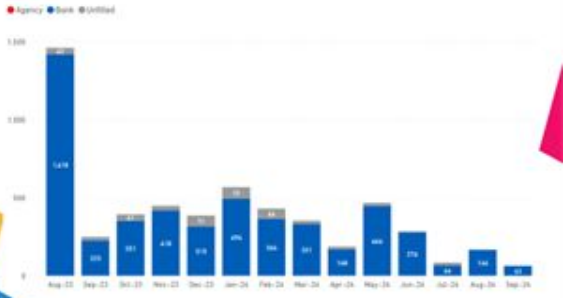
Enhanced Care



Temporary Staffing Registered Nurses (Hours)



Temporary Staffing Care Support Workers (Hours)



Nidderdale Activity for July 2024

	Total in data collection period	Average per day
Admissions	131	4.22
Discharges	129	4.16
Transfers in	99	3.19
Transfers Out	98	3.16
Deaths	3	0.09
Ward Attenders	59	1.90

Datix during month of July

Quality indicators

Falls	**1** (June = 3, May = 4)
Hospital acquired pressure ulcers	**2** (June = 0, May = 0)
Medication incidents	**0** (June = 2, May = 8)
Staffing Datix	**1** (June =1, May = 6)
Formal Complaints	**0** (June = 0, May = 1)

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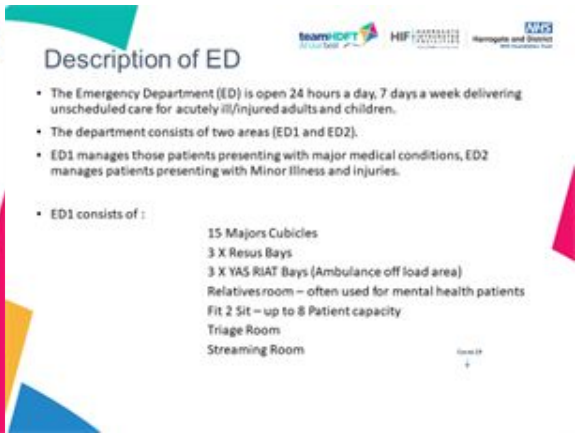
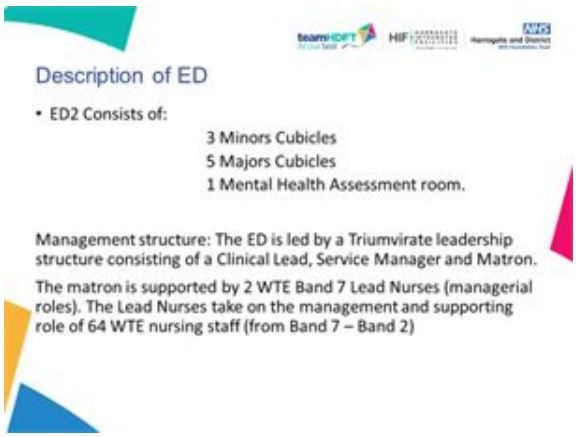
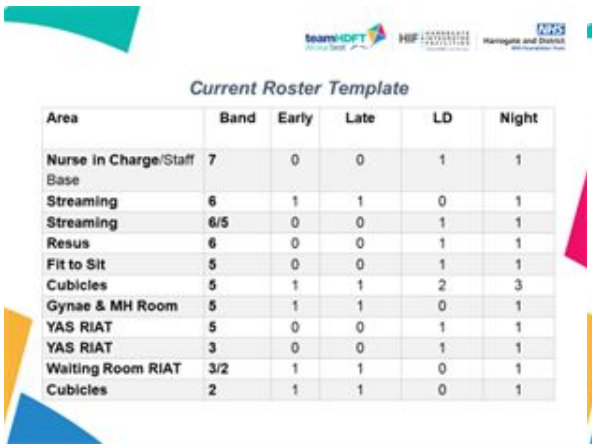
Appendix 14

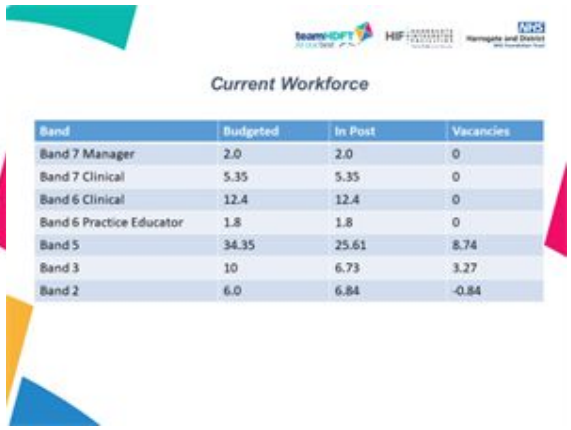






Current Roster Template

Area	Band	Early	Late	LD	Night
Nurse in Charge/Staff Base	7	0	0	1	1
Streaming	6	1	1	0	1
Streaming	6/5	0	0	1	1
Resus	6	0	0	1	1
Fit to Sit	5	0	0	1	1
Cubicles	5	1	1	2	3
Gynae & MH Room	5	1	1	0	1
YAS RIAT	5	0	0	1	1
YAS RIAT	3	0	0	1	1
Waiting Room RIAT	3/2	1	1	0	1
Cubicles	2	1	1	0	1



Current Workforce

Band	Budgeted	In Post	Vacancies
Band 7 Manager	2.0	2.0	0
Band 7 Clinical	5.35	5.35	0
Band 6 Clinical	12.4	12.4	0
Band 6 Practice Educator	1.8	1.8	0
Band 5	34.35	25.61	8.74
Band 3	10	6.73	3.27
Band 2	6.0	6.84	-0.84

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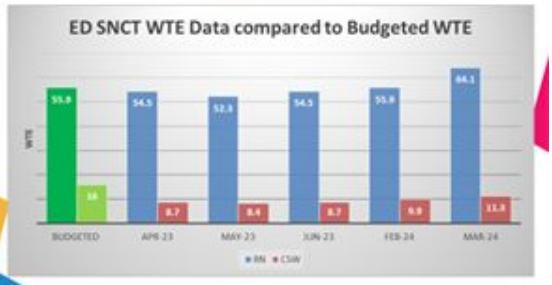
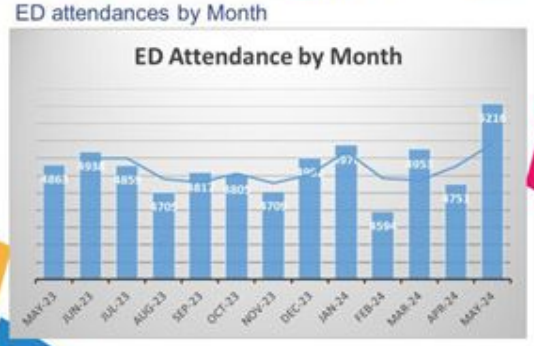
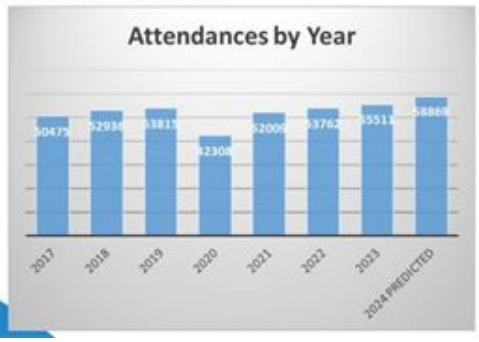
ED SNCT Data over time compared to current budgeted WTE



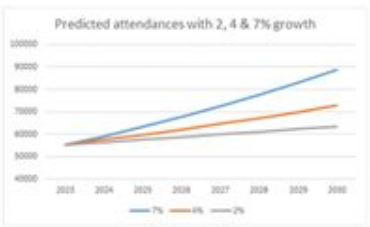
ED attendances by Month



ED Attendances by Year



ED Predicted Attendances



4 Hour Performance Data

Performance Data:12 Hour DTA Breaches

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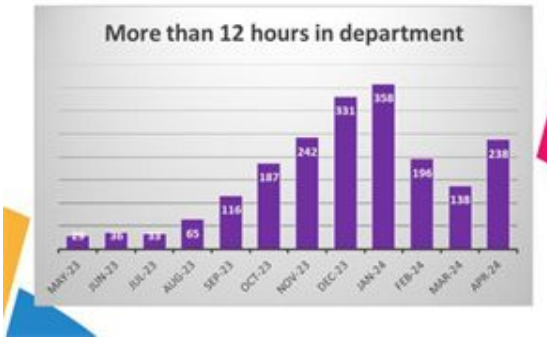

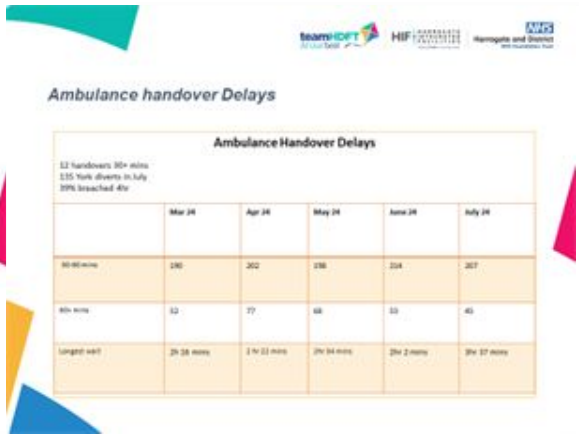

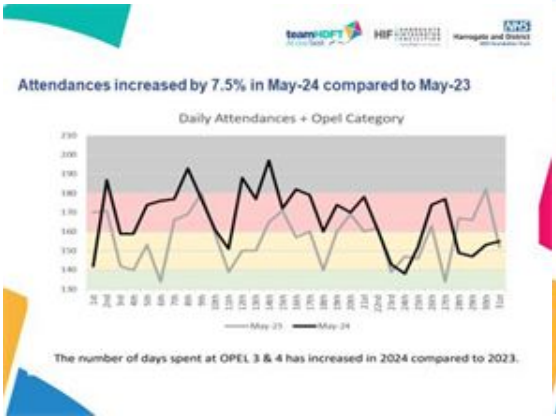

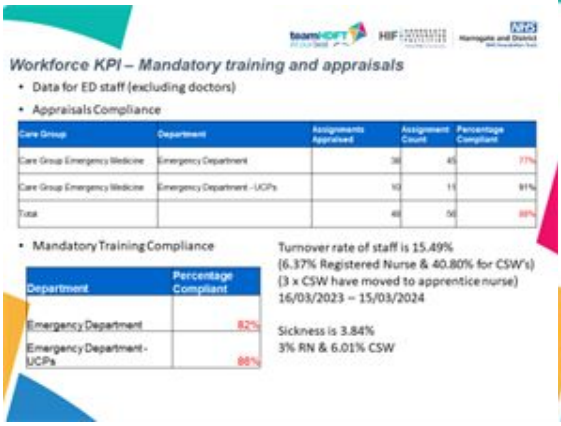

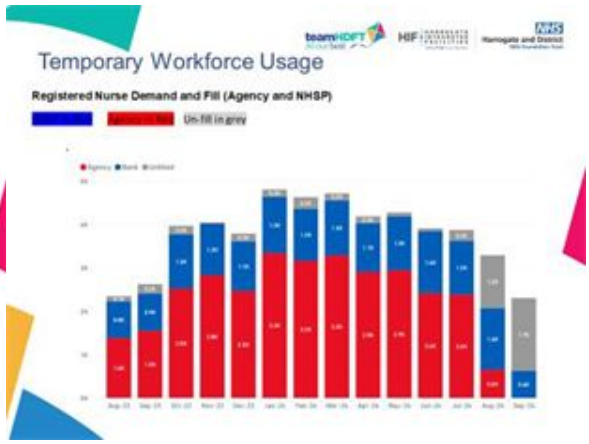

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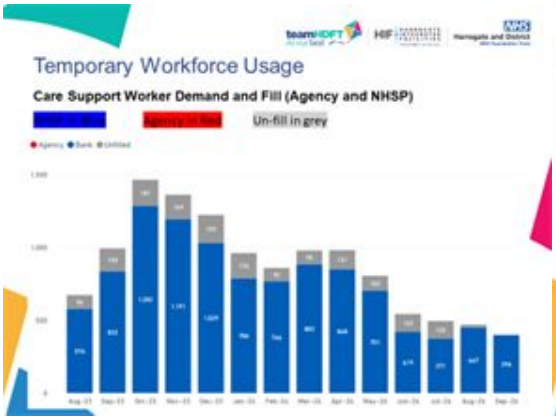
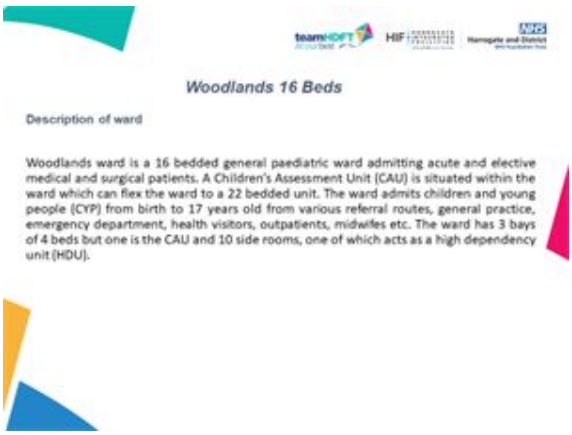


Appendix 15



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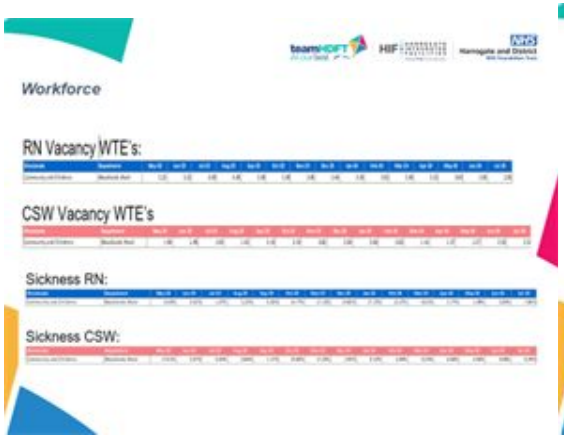

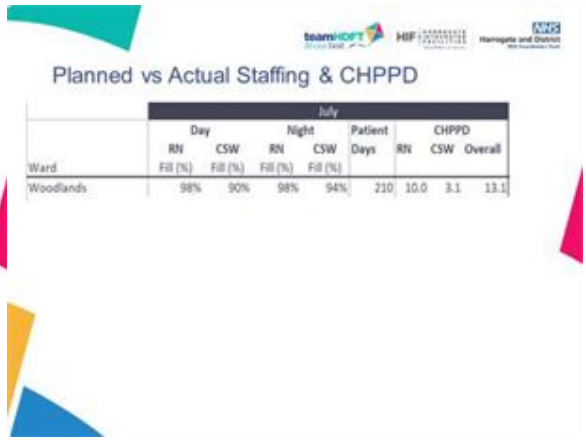

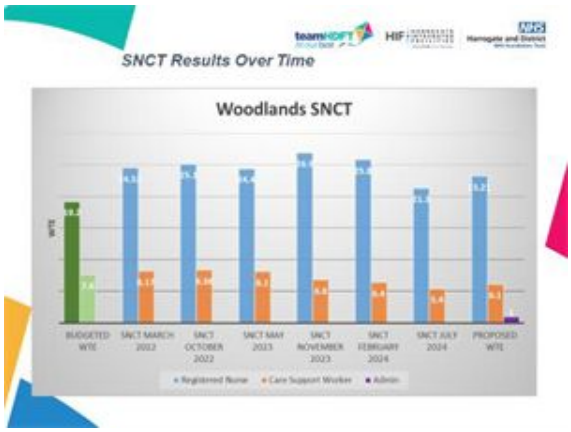

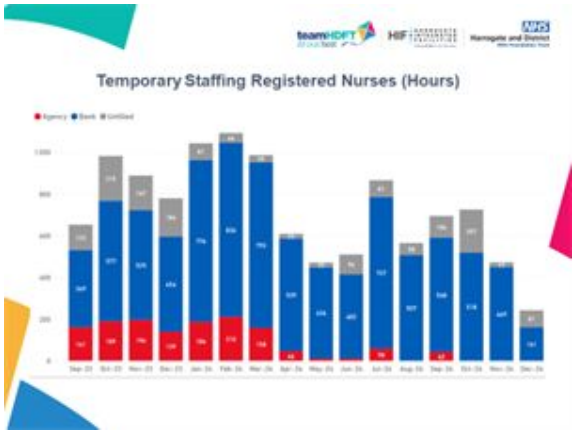

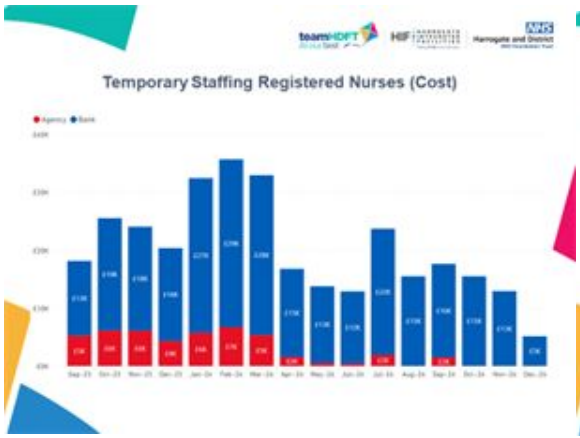

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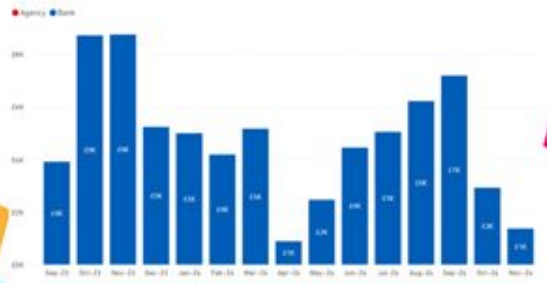
Temporary Staffing Care Support Workers (Cost)



Woodlands Activity for July 2024

	Total in data collection period	Average per day
Admissions	265	8.54
Discharges	278	8.96
Transfers In	7	0.22
Transfers Out	0	0
Deaths	0	0
Ward Attenders	48	1.54

Woodlands Activity for 2024

Month	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
May	295	302	3	2	0	21
June	305	306	3	2	0	41
July	265	278	7	0	0	48
August	210	216	3	3	0	35
September	245	251	5	0	0	39

Datix during month of July

Quality indicators

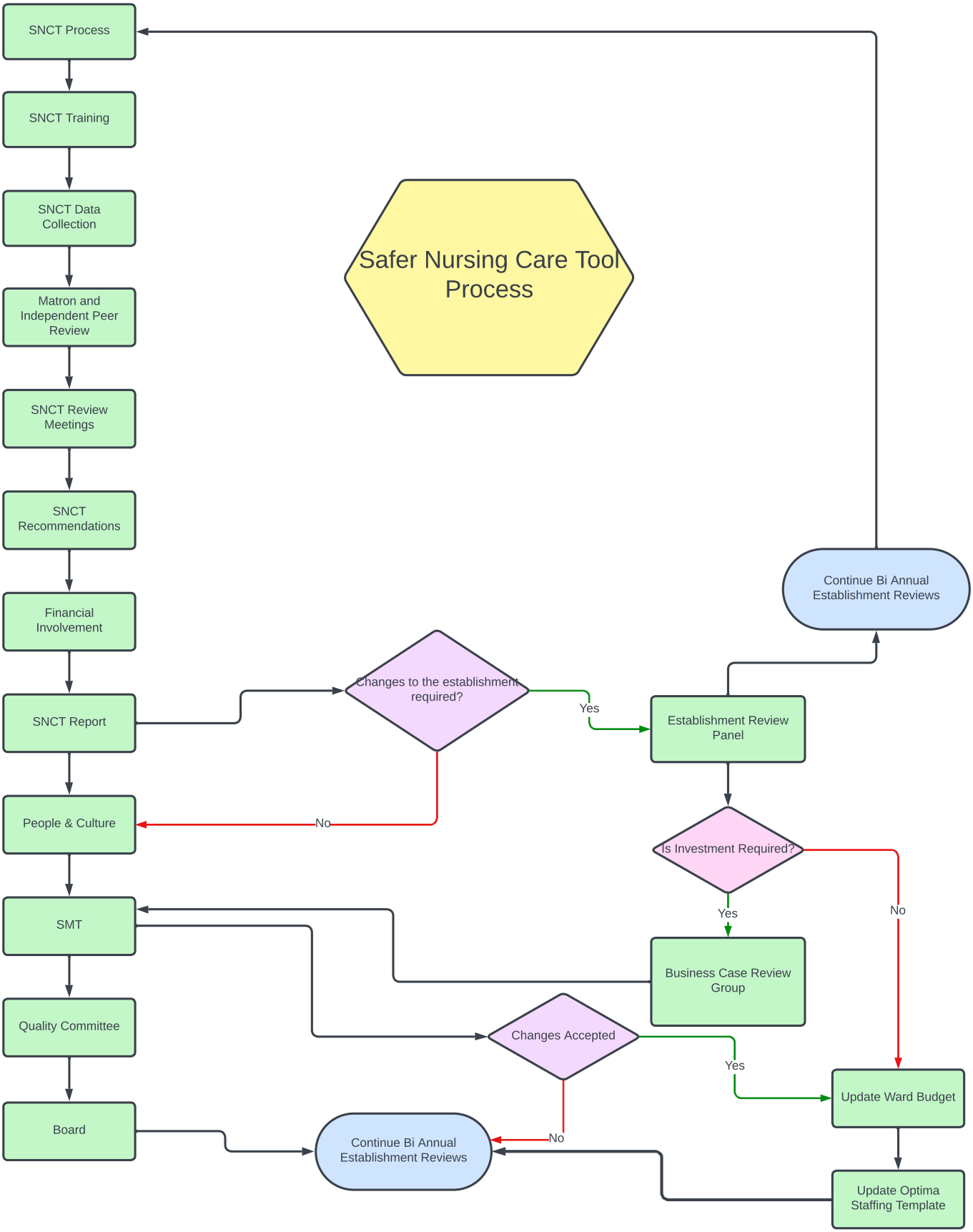
Falls	0
Hospital acquired pressure ulcers	0
Medication incidents	1 (Paracetamol prescribed and was given and signed for at 0640 and given again at 0924).
Staffing Datix	2
Formal Complaints	1 (Pt's mother travelled from Leeds to collect a prescription from the ward and was told it would not be ready until the following day).

Proposed required establishment

	Early	Late	Night
RN	4	4	3
CSW	1	1	1
MD	30 hours (0.8WTE)		
Practice Educator	37.5 (1.0 WTE)		
Play Specialist	37.5 (1.0 WTE)		
Ward Clerk	37.5 (1.0WTE)		

Proposed changes to establishment - if any

	Current £	Current WTE	Proposed £	Proposed WTE	£ Variance	WTE Variance
B2			£27,400	1.00	-£27,400	-1.00
B2	£215,200	6.65	£198,900	6.10	£16,300	0.55
B3		0.00			£0	0.00
B4	£36,700	1.00	£36,800	1.00	-£100	0.00
B5	£602,600	12.14	£709,007	14.13	-£106,407	-1.99
B6	£338,700	6.13	£394,875	7.08	-£56,175	-0.95
B7	£57,600	1.00	£57,700	1.00	-£100	0
Total	£1,250,800	26.92	£1,424,682	30.31	-£173,882	-3.39


Safer Nursing Care Tool Process
SNCT Process
SNCT Training
SNCT Data Collection
Matron and Independent Peer Review
SNCT Review Meetings
SNCT Recommendations
Financial Involvement
SNCT Report
People & Culture
SMT
Quality Committee
Board
Changes to the establishment required?
Yes
No
Establishment Review Panel
Continue Bi Annual Establishment Reviews
Is Investment Required?
Yes
No
Business Case Review Group
Changes Accepted
Yes
No
Update Ward Budget
Update Optima Staffing Template
Continue Bi Annual Establishment Reviews

Harrogate and District NHS Foundation Trust

4

Board Meeting Held in Public
Wednesday 27th November 2024

Title:	Learning from Deaths Quarterly Report Q2: Jul-Sep 2024
Responsible Director:	Executive Medical Director
Author:	Deputy Medical Director for Quality and Safety

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

Harrogate and District NHS Foundation Trust

Board Meeting Held in Public

Wednesday 27th November 2024

Learning from Deaths Quarter 2 Report

Executive Medical Director

1.0 Executive Summary

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

SHMI remains around the expected level and compares favourably with regional and national peer organisations.

19 cases have undergone a structured judgement review since the last report, 13 of which were from deaths in the Q2 period. Our new Datix SJR module is now live and enables better oversight and interrogation of SJR themes.

Harrogate and District NHS Foundation Trust

2.0 Introduction

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

3.0 Findings

3.1 Crude Mortality Data

The crude mortality rate for admissions gives a long-term view of trust mortality. In total, 175 deaths were recorded in Q2, slightly up from 171 in the preceding Q1 and also compared to Q2 in 23/24 which had 168 deaths. This data is not risk-adjusted so takes no account of the unique characteristics of individual admissions. Comparison with the national mortality rate is also shown where data is available (shown in the darker blue line in Figures 1 and 2). This demonstrates that the peaks and troughs we see in HDFT are often mirrored at the national level. Figure 2 gives a "zoomed in" view of data from the last 2 years. Note that the 12 month rolling mortality has generally declined since 20210 (apart from the impact of the Covid pandemic). It should be remembered that the denominator for this data is the number of hospital episodes, so as we increase elective work (including endoscopies), the percentage of deaths would be expected to fall.

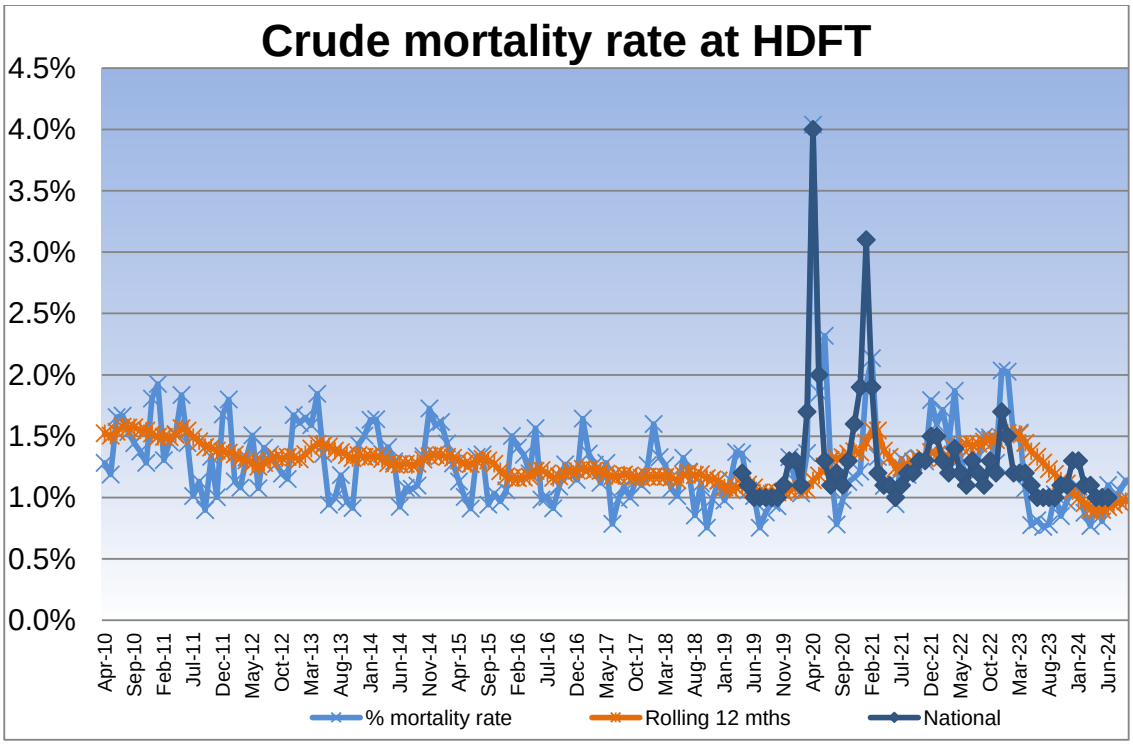


Figure 1: Crude mortality rates over the last 14 years (%deaths per hospital episode)

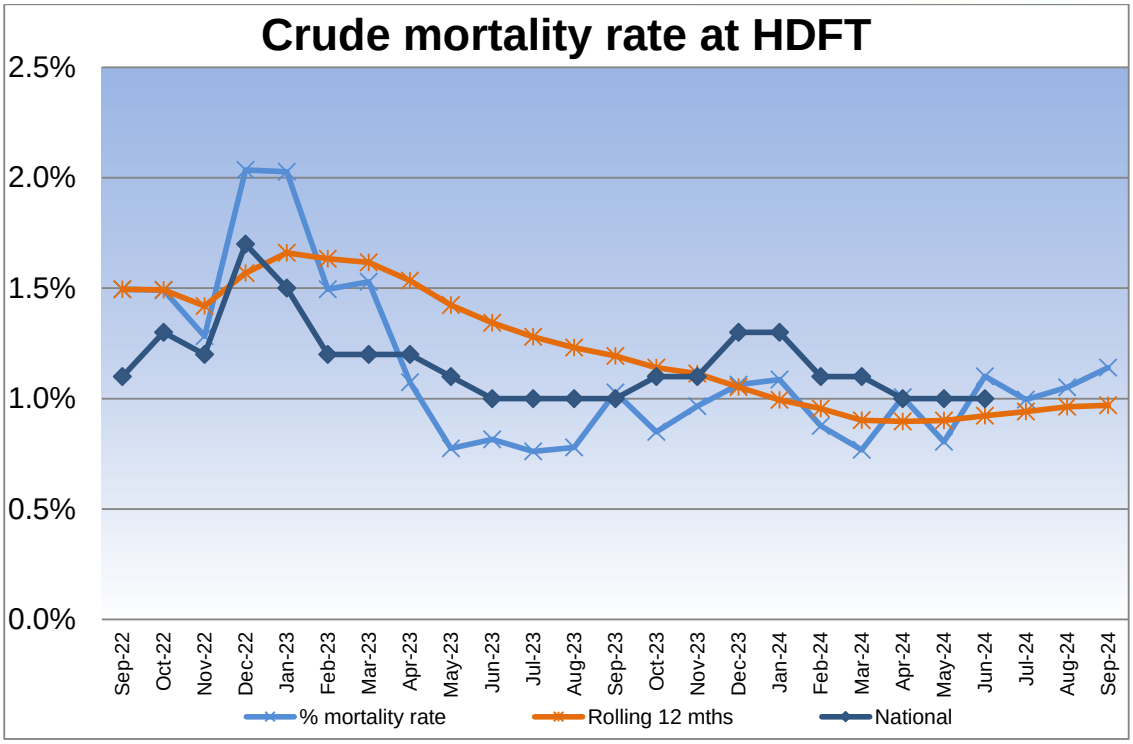


Figure 2: Expanded crude mortality rates over the last 2 years (%deaths per hospital episode)

3.2 Standardised Hospital Mortality Index (SHMI)

Figure 3 shows a decline in SHMI from a peak in April 2022.

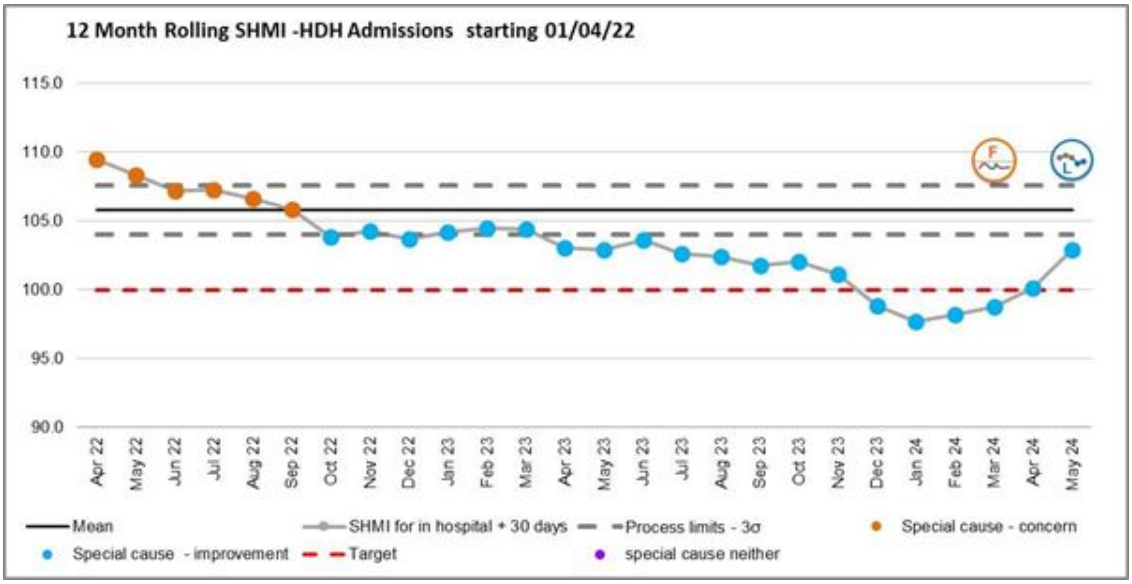


Figure 3: HDFT SHMI since April 2022

Figures 4 and 5 demonstrate the observed and expected death predicted by the SHMI model, with Figure 6 demonstrating the difference between these two values. The number of observed deaths rose to a peak in March 2023 whereas the expected numbers peaked in November 2023.

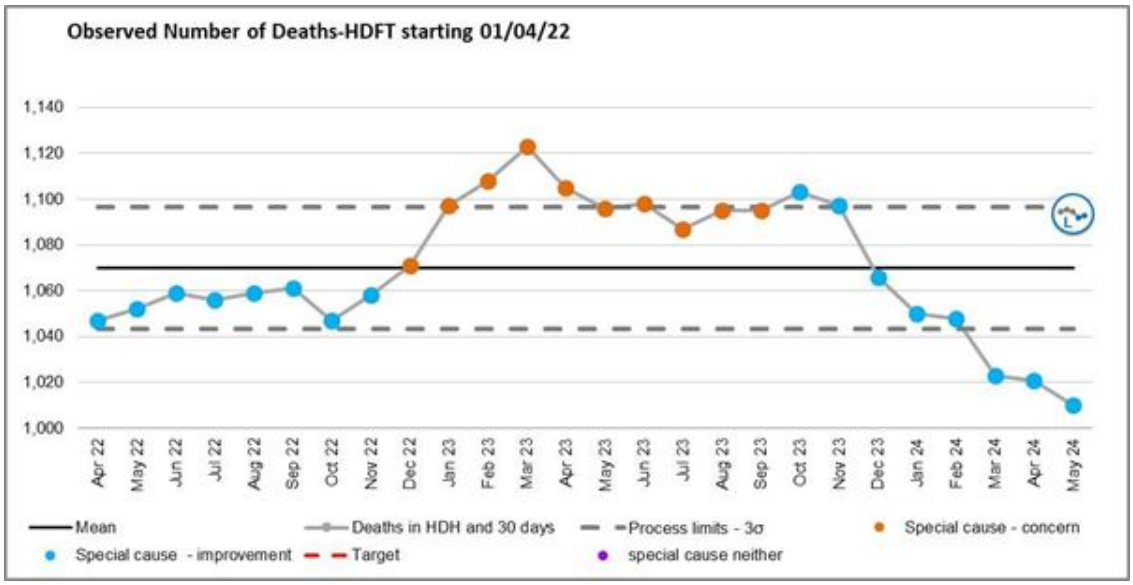


Figure 4: Observed deaths included into SHMI

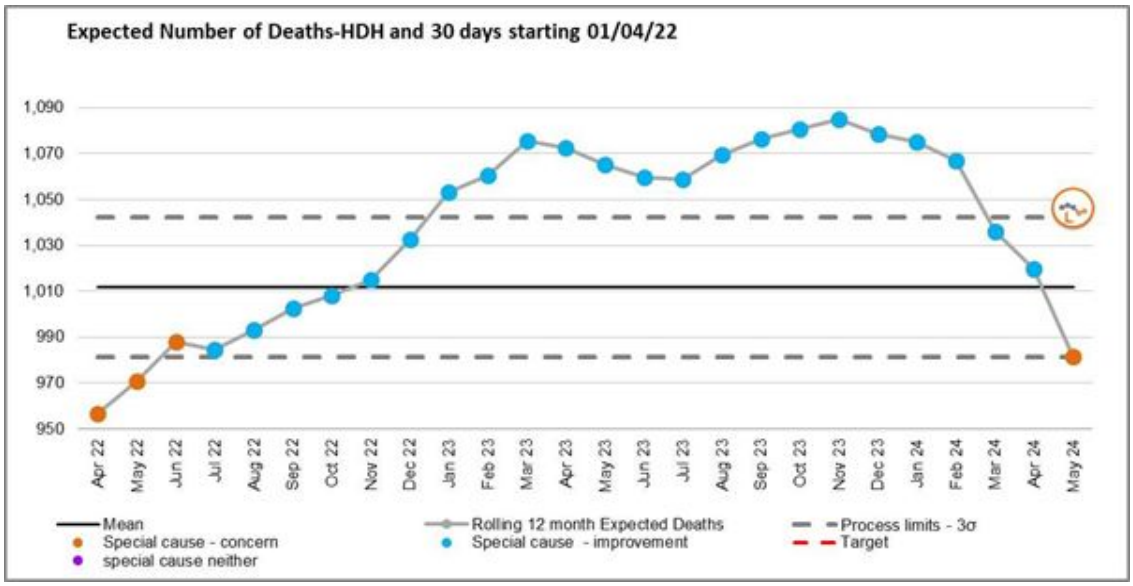


Figure 5: Expected deaths as predicted by SHMI.

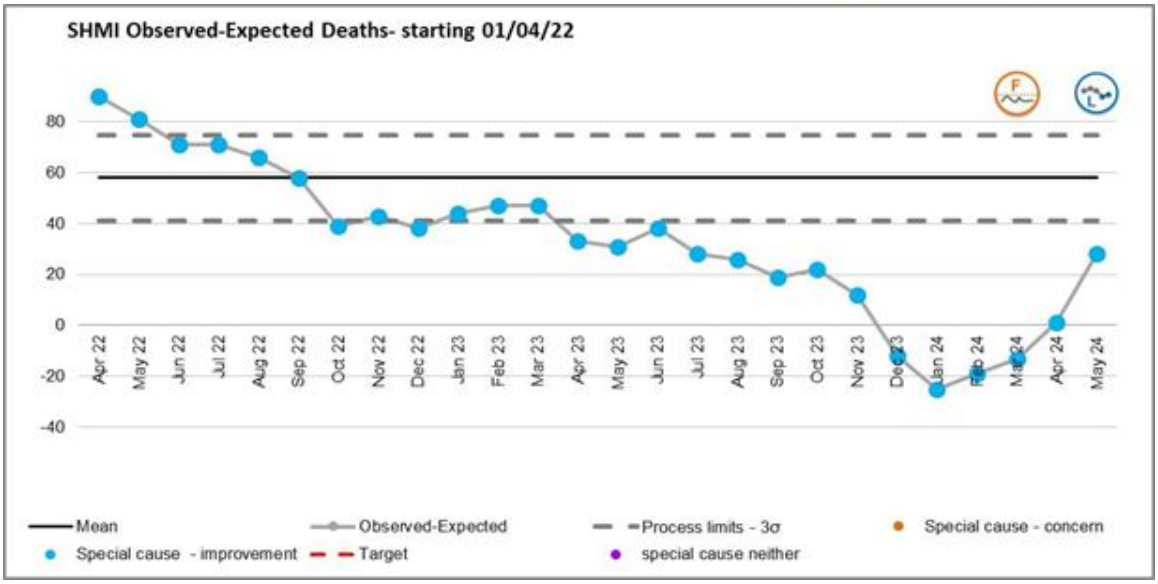


Figure 6: Observed-Expected Deaths, as predicted by SHMI

Figures 7 and 8 demonstrate our 12 month rolling SHMI against that of national peer and regional trusts:

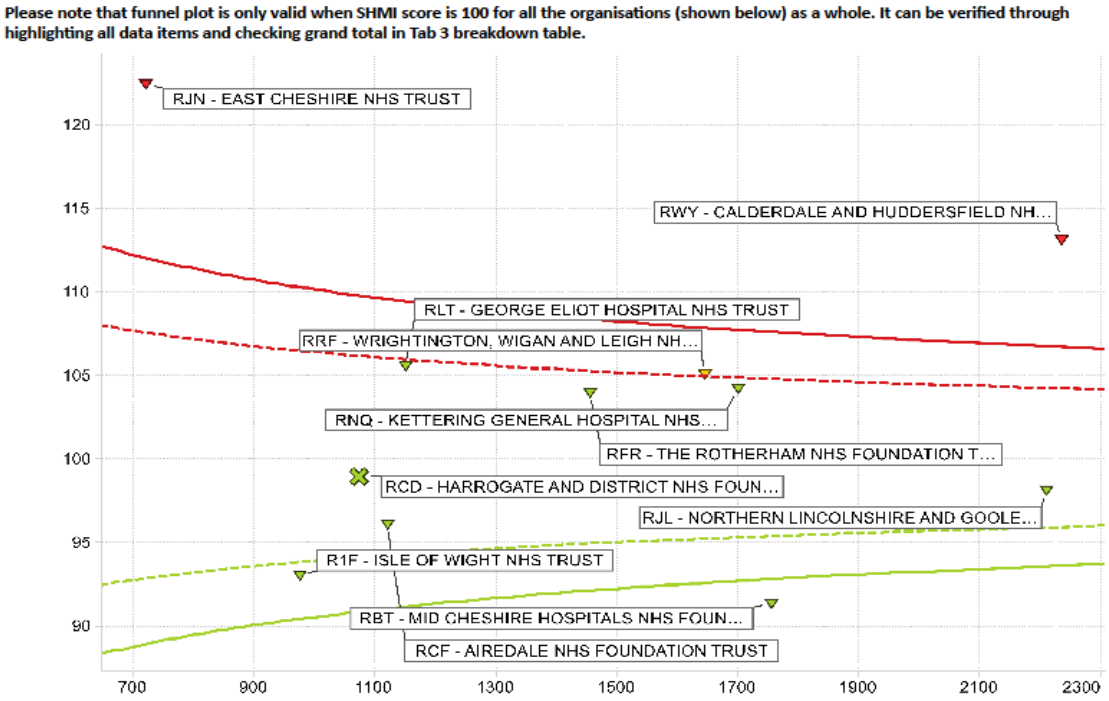


Figure 7: SHMI data for national peer organisations

Please note that funnel plot is only valid when SHMI score is 100 for all the organisations (shown below) as a whole. It can be verified through highlighting all data items and checking grand total in Tab 3 breakdown table.

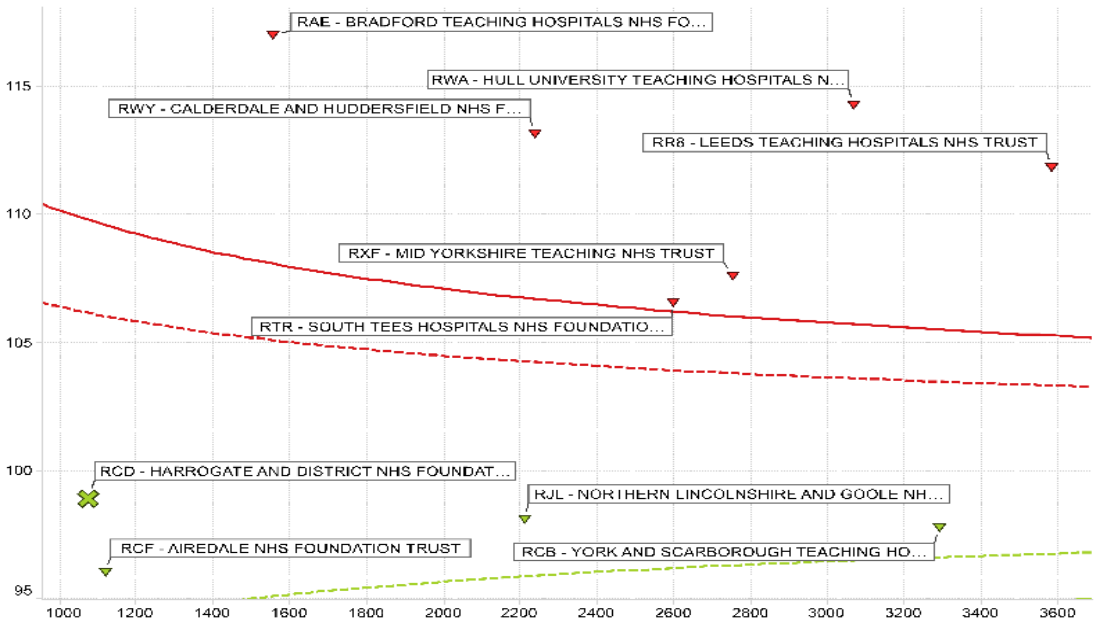


Figure 8: SHMI monthly data for regional peer organisations

3.3 Structured judgement reviews (SJR)

19 cases have been reviewed in this quarter with 13 relating to deaths in this period, 5 from the preceding Q4 and one from December 2023.

We have only received 1 “amber alert” for a diagnostic category with possible excess mortality in this quarter – deaths categorised as being due to “congestive heart failure”. This is a diagnostic area which has previously between explored with no concerns identified. We are currently finalising “business rules” as to when such intermittent alerts would trigger a more in-depth exploration of clinical cases.

In this quarter, cases chosen and reviewed by the Acute Medical team have been included. They have selected cases that they have already identified as having possible lapses in care and therefore this quarter has a higher number of episodes of poor care identified than previously (where a higher proportion of cases for review were selected at random).

2 cases were in patients with a learning disability who will receive a second external review as part of the LeDeR process. Feedback on their findings will be provided in subsequent papers when the reports are received.

All cases in this quarter were reviewed using the new Datix iCloud SJR module which uses the most up-to-date national question set. New questions include a subjective assessment of the avoidability of death – if this were deemed to be higher than 50:50 then a Patient Safety Incident Investigation (PSII) would usually be initiated. A second new field is whether there were gaps in clinical care, organisational aspects or both. In this quarter, organisational aspects noted were delays in admissions from the Emergency Department and failure to be reviewed by a consultant within 14 hours of admission.

The overall assessment of the standard of care of is shown in Table 1:

Date of admission	Care in First 24 hours	Ongoing Care	Avoidability of Death	Clinical and Organisational score (NCEPOD)	Overall Care
13/06/2024	Good care	Good care	Definitely not avoidable	Good practice	Good care
12/12/2023	Good care	Adequate care	Slight evidence of avoidability	Room for improvement in organisational care	Good care
02/07/2024	Good care	Good care	Definitely not avoidable	Good practice	Good care
06/06/2024	Adequate care	Poor care	Definitely not avoidable	Room for improvement in clinical and organisational care	Poor care
02/06/2024	Poor care	Not Applicable	Possibly avoidable but not very likely (less than 50:50)	Room for improvement in clinical care	Poor care
29/07/2024	Good care	Good care	Definitely not avoidable	Room for improvement in clinical care	Good care
19/08/2024	Good care	Good care	Definitely not avoidable	Good practice	Excellent care

02/06/2024	Poor care	Good care	Slight evidence of avoidability	Room for improvement in clinical and organisational care	Good care
23/08/2024	Good care	Good care	Definitely not avoidable	Good practice	Good care
15/07/2024	Good care	Good care	Definitely not avoidable	Room for improvement in organisational care	Good care
05/07/2024	Poor care	Poor care	Definitely not avoidable	Less than satisfactory (either area)	Poor care
27/08/2024	Good care	Good care	Definitely not avoidable	Room for improvement in clinical care	Adequate care
17/07/2024	Good care	Not Applicable	Definitely not avoidable	Good practice	Good care
31/07/2024	Adequate care	Poor care	Definitely not avoidable	Room for improvement in clinical and organisational care	Adequate care
04/09/2024	Good care	Excellent care	Definitely not avoidable	Room for improvement in clinical care	Good care
30/06/2024	Good care	Good care	Definitely not avoidable	Good practice	Good care
08/07/2024	Good care	Not Applicable	Definitely not avoidable	Good practice	Good care
05/09/2024	Good care	Not Applicable	Definitely not avoidable	Good practice	Good care
14/09/2024	Good care	Good care	Definitely not avoidable	Room for improvement in clinical care	Good care

Table 1: Cored details of the cases reviewed this quarter

Three cases had overall care described as “poor”. All have been highlighted for a second review by a different clinician. One case, as a result of 2 SJRs, has been declared an PSII. A second case was felt to be adequate care by the second reviewer. The third case is still undergoing a review.

End of Life Care		
	24/25 Q1	24/25 Q2
Good care	12	11
Adequate care	4	2
Not Applicable	2	3
Poor care	1	1
Excellent care	0	2
tal	19	19

Patient Record Quality		
	24/25 Q1	24/25 Q2
Good	14	12
Adequate	5	6
Excellent	0	1
Total	19	19

Tables 2 and 3: End of Life Care provided and Quality of Patient Records

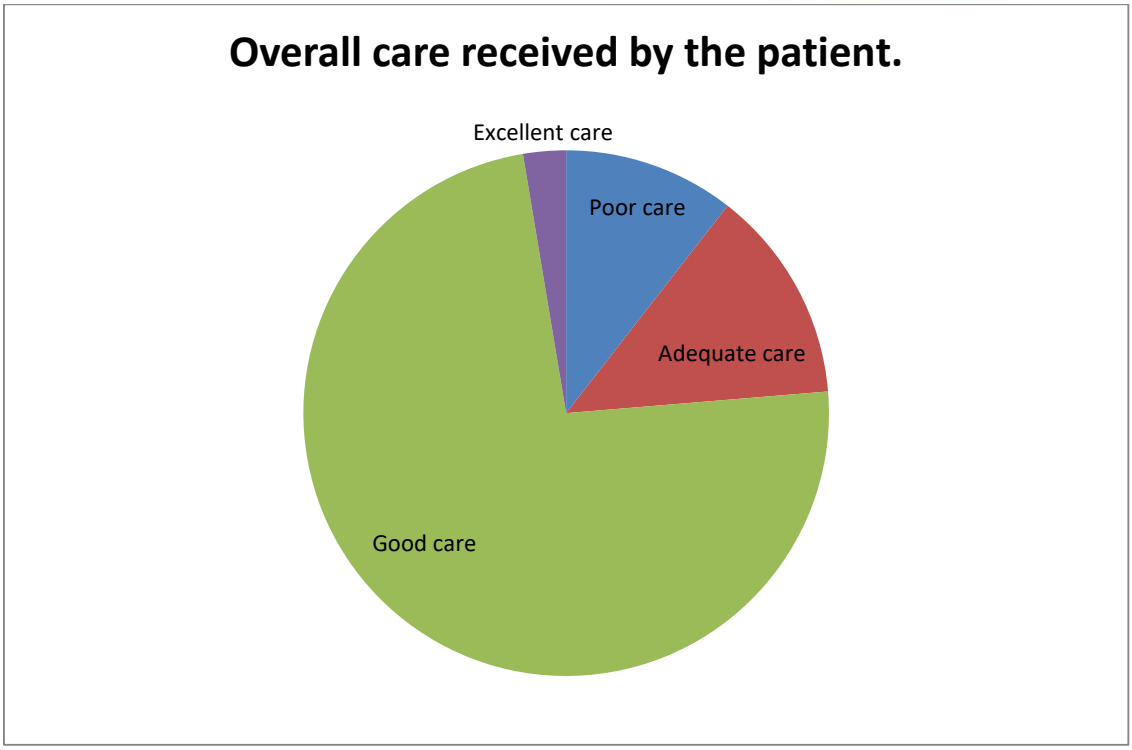


Figure 9: Overall care in all cases reviewed this financial year

Another new section of the Datix SJR is the ability for the review to identify any positive or negative learning points from the cases. These are shared with the clinicians via the regular Medical Directorate newsletter. Positive themes this quarter related to excellent use of the Critical Care Outreach team and strong communication with family members. Negative themes include early recognition of disease severity (especially in younger adults) and communications between clinical teams.

The Medical Examiner team have identified a possible theme related to early recognition and escalation of unwell patients. This will form a part of an ongoing PSII and will be the focus of some work by the Quality Team/Deputy Medical Directors.

4.0 Recommendation

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

Trust Board
Freedom to Speak Up Annual Report

27th November 2024

Title:	Freedom to Speak Up Guardian Annual Report
Responsible Director:	Emma Nunez, Executive Director of Nursing, Midwifery and AHPs / Deputy Chief Executive
Author:	Joanna Cann, Freedom to Speak Up Guardian

5

Purpose of the report and summary of key issues:	To provide details of activities relating to Freedom Speak Up within year and highlight next steps.	
Trust Strategy and Strategic Ambitions:	**The Patient and Child First** Improving the health and wellbeing of our patients, children and communities	
	Best Quality, Safest Care	X
	Person Centred, Integrated Care; Strong Partnerships	
	Great Start in Life	
	At Our Best: Making HDFT the best place to work	X
	An environment that promotes wellbeing	
	Digital transformation to integrate care and improve patient, child and staff experience	
	Healthcare innovation to improve quality	
Corporate Risks:	None	
Report History:	Quarterly report submitted to People and Culture Committee and Trust Board	
Recommendation:	The Committee is asked to review the content of this report including next steps.	

Freedom of Information:	This report will be available once published through Board reports

Freedom to Speak Up Guardian Annual Report

1.0 Executive Summary

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

2.0 Background

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

3.0 Introduction

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

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

4.0 Equality Analysis

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

5.0 Risks and Mitigating Actions

5.1 Minimal time currently allocated to Guardian role, reduced resilience when taking leave.

6.0 Consultation with Partner Organisations

6.1 This Board Report was created from internal discussions only.

7.0 Monitoring Performance

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

8.0 Recommendation

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

9.0 Supporting Information

9.1 The following paper appended makes up the detail of the report

Joanna Cann
Freedom to Speak Up Guardian

Freedom to Speak Up Guardian Annual Report

Introduction

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

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

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

"If leaders and managers create positive, supportive environments for staff, they in turn create caring, supportive environments and deliver high-quality care for patients. Such leadership cultures encourage staff engagement".
(The King's Fund: Improving NHS culture)

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

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

All Fairness Champions have been asked to complete the Speak Up and Listen Up training. Following the Mandatory Training Review Panel, all members of HIF and HDFT are required to complete "Speak Up" and all people in a Line Management or Leadership position are required to complete "Listen Up". The final module, "Follow Up" is undertaken by members of the Senior Management Team. This is to raise the profile and awareness of FTSU across the organisation and also provide staff with opportunity to reflect and consider how they can support and promote a Just Culture. As part of Speaking Up Month, October 2024, reminders were sent to any colleagues with this training outstanding. Engagement and completion continues to increase:-

The overall compliance for Trust staff to date:

Workforce	Required	Not Achieved	Compliance %
HDFT Substantive	4844	327	93%
HDFT Bank	152	33	78%

Workforce	Required	Not Achieved	Compliance %
HIF Substantive	334	38	89%
HIF Bank	55	15	73%

Workforce	Required	Not Achieved	Compliance %
Overall HDFT & HIF Substantive	5178	365	93%
Overall HDFT & HIF Bank	207	48	77%

Local work

The Freedom to Speak Up Guardian role update

The allocation for the Guardian role is currently 7.5 hours per week at Band 6. Scoping has shown this to be generally less time allocation, and lower banding, than comparable organisations across the region. Thus, reactive aspects of the role are prioritised over proactive aspects due to time constraints. FTSU capacity is being factored into future planning.

The Guardian is part of the Regional Guardian Network and, time allowing, attends network meetings and opportunities to share best practice.

Next steps / Action Plan:

- Continue regular meetings with Executive Director of Nursing to capture anonymised data from the concerns raised directly to the Director team
- Continue to raise awareness of and promoting engagement with FTSU, in particular during Speaking Up Month.
- To continue to include the FTSU Guardian and Associate role in the current work on the organisational culture, values and behaviours –
    - Presented on Team Talk
    - Attended multiple staff engagement meetings and more planned.
        - Just and learning culture
        - Speak Up, Listen Up, Follow Up training modules.
        - Supporting FTSU Champions
        - Facilitating induction training
        - Facilitating Pathway to Management training
- To continue the rebrand of FTSU at HDFT Best Place to Work through HDFT Impact to embed FTSU into the #teamHDFT values and 'At our Best' programme, current project plan.
- Further define the FTSU model within HDFT, with particular consideration towards additional Guardians and associate roles.
- The Fairness Champion Directory has been updated. Applications are being accepted to become a champion and new recruits are being trained on a rolling annual basis.

Action Required	Lead	Date for completion
Continue with the launch of the visible "Pledge Wall" and other FTSU material	Communication & Marketing Team	Ongoing
Review the NGO Gap Analysis and Just Culture Gap Analysis	FTSU Lead & HR / OD	Ongoing
Launch the e - learning package as mandatory training	Learning & Development	Completed
Update of Fairness Champions directory	FTSU Lead and Associate	Completed
Regional scoping of comparative FTSU models	FTSU Lead via Regional Network	Completed
To gain feedback from completed cases and use this to inform FTSU process moving forward.	FTSU Lead	Ongoing
Review the wider HDFT model of delivery	Associate Director of Quality and Corporate Affairs	Ongoing

The following table captures the numbers of cases received by the Freedom to Speak Up Guardian, between November 1st 2023 and October 31st 2024. These include a comparison of the previous year, however, please note that the figures from the previous year may not fully reflect the extent of FTSU activity.

Type	Group	1 Nov 2023 – 31st Oct 2024	1st Oct 2022 – 30th Sept 2023
Numbers of cases brought by professional level	Student Worker Manager Senior leader Not disclosed **TOTAL**	37 9 0 0 5 **51**	2 30 5 0 5 **42**
Numbers of cases brought by professional group	Medical Registered Nurses, Midwives & AHPS Administration, Clerical & Maintenance/Ancillary Non-registered clinical support staff Undisclosed **TOTAL**	5 21 8 12 5 0 **51**	4 23 10 0 3 2 **42**
Number of cases raised anonymously		1	2
Number of cases with an element of bullying or harassment		18	14

In Summary:-

What were we aiming to achieve?

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

What have we done?

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

1. Fairness, compassion and psychological safety: ensuring each individual knows they will be treated fairly and compassionately by the group if things go wrong or they speak up to stop problems occurring.
2. Diversity, inclusivity, trust and respect: ensuring people are treated fairly regardless of ethnicity, gender, disability or other characteristics;
3. Speaking up and listening: ensuring speaking up about concerns, events, errors or poor behaviour is welcomed, and seen not just as safe, but the right thing to do;
4. Leadership and teamwork: ensuring supportive, effective and ideally multidisciplinary teamwork alongside compassionate and collective leadership to reinforce a sense of care and belonging, a culture of honesty, authenticity and safe conflict;
5. Trust Values and behaviours: ensuring we promote and expect positive behaviours that improve patient safety and colleague experience, and that behaviour which is at odds with our values is called out and challenged;
6. Open to learning and improvement: ensuring that when things go wrong there is focus on no blame, a just culture, an understanding of human factors, supporting staff, and learning.

What are the results?

- Currently, the Freedom to Speak Up Team includes:
  - 1 x Freedom to Speak Up Guardian
  - 1 x Freedom to Speak Up Associate Guardian
  - 28 x Fairness Champions across the organization

- The next cohort of Champions awaiting training currently stands at 9 colleagues.

- Speak Up Month – Listen Up – October 2024, was marked with a presentation on Team Talk, awareness raising across the Trust and a drive to complete e-learning.

- Collaborative work and constructive signposting, within the Trust established and continuing, including with:
  - Union Representatives
  - The Wellbeng Team
  - Occupational Health
  - Human Resources
  - Equality, Diversity & Inclusion Team

- Regular facilitating within Trust Induction

- Regular facilitating within Pathway to Management training

- Attendance as a presenter on Team Talk

- Regular attendance and updates provided to the People & Culture Committee.

- Fulfilling requests to attend team meetings / huddles including within SROMC; Matrons; SDEC teams and ensuring this offer is given when in communication with managers and their teams.

- Attendance at both Harrogate & Durham Wellbeing Days

- Contributor to Equality Delivery System 2022.

- Speaker at the Professional Nurse Advocate Timeout Day

- Recognition of need for and completion of reflective resilience training and mental health training by Guardian.

- Conversation with CQC in the context of FTSU at HDFT

Summary

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

Premises Assurance Model 2023/2024 Summary Report

Produced by: Daniel Munroe, Estates Compliance Manager

Date: August 2024

Contents

1. Introduction

The NHS Premises Assurance Model (PAM) is a monitoring tool developed by the Department of Health to provide information relating to the NHS Estate. Estate costs are the third highest in the NHS after staff and drugs and nationally the estate is valued at tens of billions of pounds. It is therefore essential we provide a safe, high quality and efficient estate, supporting patients' right to be "cared for in a clean, safe, secure and suitable environment".

The intended benefits of PAM are to:

- the ability to demonstrate to patients, commissioners and regulators that robust systems are in place and to provide assurance that the premises and associated services are safe;
- helps trusts prioritise investment decisions in order to raise standards in the most advantageous way; and
- the ability to measure compliance against legislation and guidance across the whole NHS.

NHS Boards have a responsibility to hold their own organisations to account, but the specialised nature of Estates and Facilities (E&F) can make this challenging. The PAM tool is intended to offer assurance to Boards in a consistent way nationally, recognising that this is a self-assessed, high level view, rather than a detailed operational tool for each service.

The tool has developed over time, both in terms of addition, amendment and removal of questions but also with fundamental structural changes, with the current format last updated in April 2024. The NHS England E&F maintain the model with a user group comprising NHS trusts, regional colleagues, Care Quality Commission and other users overseeing the changes within the model. The PAM submission is an online submission allowing comparison of data with other Trusts, with the 23/24 return to be formally submitted in September 2024.

2. Structure of the Premises Assurance Model Tool

The current PAM tool contains 370 self-assessment questions (SAQs) categorised into main 5 domains:-

- Safety (Hard FM and Soft FM)
- Patient Experience
- Efficiency
- Effectiveness
- Organisational Governance

Within the 22/23 submission, an additional domain in the form of Helipad was introduced although this is not applicable to HDFT.

Self-assessment responses to each question can be stated as:-

- Not applicable
- Outstanding
- Good
- Requires Minimal Improvement
- Requires Moderate Improvement
- Inadequate

Appendix B details the selection of self-assessment questions present within each domain.

3. 23/24 Model Amendments

A number of additions and amendments were made to the 23/24 model resulting in an additional 8 questions based on the previous year's model, bringing the total quantity to 370.

Alterations have been made to Safety, Efficiency, Effectiveness and Helipads domains with all details located within Appendix C.

Majority of amendments fall within the Safety Hard section with the addition of SH21 focusing on Built Environment: Reducing Harm by Ligature in Practice. Although primarily aimed at Mental Health trusts, the SAQ is applicable to HDFT through the presence of the Emergency Department, with particular emphasis on the ability to report on the requirements of safer wards and never events.

SH20 – Medical Gases Framework has been removed from the submission although may return in future years dependent on the release of supplementary guidance.

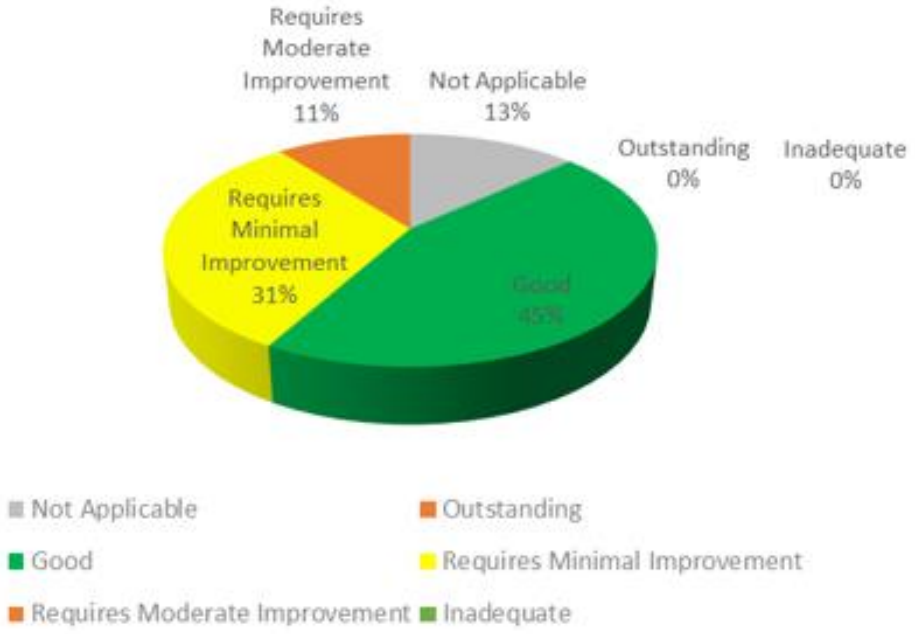
The bulk of remaining amendments constitute an update of guidance, legislation and regulations, evidence to be used within the self-assessment and further Net Zero focused requirements.

4. Summary of Results

The table below shows the number of questions in each domain across the self-assessment ratings, with a comparison shown for 22/23 and 23/24 submissions.

Domain	Submission Year	Not Applicable	Outstanding	Good	Requires Minimal Improvement	Requires Moderate Improvement	Inadequate	Total SAQs
Hard FM - Safety	23/24	16	0	61	51	22	0	150
	22/23	24	0	47	70	12	0	153
Soft FM - Safety	23/24	10	0	39	42	9	0	100
	22/23	9	0	27	52	6	0	94
Patient Experience	23/24	6	0	19	3	0	0	28
	22/23	6	0	18	3	1	0	28
Efficiency	23/24	4	0	17	7	3	0	31
	22/23	7	0	17	4	0	0	28
Effectiveness	23/24	1	0	8	12	5	0	26
	22/23	4	0	10	9	2	0	25
Governance	23/24	3	0	22	1	0	0	26
	22/23	1	0	17	8	0	0	26
Helipad	23/24	9	0	0	0	0	0	9
	22/23	8	0	0	0	0	0	8
Totals	**23/24**	**49**	**0**	**166**	**116**	**39**	**0**	**370**
	22/23	**59**	**0**	**136**	**146**	**21**	**0**	**362**

The summary of results shows the majority of answers were rated good at 44.9% with no SAQs determined as outstanding or inadequate. 31.3% were rated as requiring minimal improvement and 10.5% requiring moderate improvement. Not applicable accounted for 13.3% of the responses. This is further represented via the summary chart below.



Proposal for improvements within future PAM submissions include closer collaborative working between HIF & HDFT enabling a smoother assessment process and greater accuracy in the review and inclusion of community sites.

5. Outstanding areas

There were no areas assessed as outstanding.

6. Good areas

166 areas were defined as good which is an increase in comparison to the 22/23 submission, although this is attributed over a slightly greater quantity of questions. An increase from 37.5% to 44.9% between years showcases a positive improvement. Patient Experience, Efficiency and Effectiveness domains scored particularly well in this area.

7. Requires Minimal Improvement areas

116 areas were rated as requiring minimal improvement which provided a decrease in comparison with 22/23, although across a higher quantity of SAQs with a reduction of 8%.

Mains areas of improvement are linked to the periodic reviewing of BCPs, associated testing exercises (in particular practical assessments) and the reviewing, development and control of polices, SOPs etc.

Remedial actions were carried out over the previous annum assisting in the decline of the minimal improvement rating.

Full details of all areas requiring minimal improvement are shown in the costed action plan (Appendix A).

8. Requires Moderate Improvement areas

There were 39 areas rated as requiring moderate improvement relating primarily to the hard and soft safety domains, providing an increase in the rating of 4.74%.

These are largely pin pointed general security assurance, evidence of functional suitability demonstrated across sites and the additional inclusion of SH21 – Reducing harm by ligature in practice which highlights a number of areas of improvement within high risk areas across the trust.

Full details of all areas requiring moderate improvement are shown in the costed action plan (Appendix A).

9. Inadequate areas

There were no areas assessed as inadequate.

10. Costed action plans

Where SAQs within the PAM tool have been defined as requiring minimal improvement, moderate improvement or inadequate, a costed action plan has been devised to support in providing a minimum rating of good, with 191 actions present within the current position.

The majority of the actions fall within the Safety Domain (both Hard and Soft FM) with the quantity of actions falling broadly in line with the previous submission.

The actions quantified do not have a bearing or provide an improvement to the current trust backlog position which is circa £54m. The actions and associated costs provide a baseline for governance, productivity and efficiency within the E&F service.

Costs attributed to the action plan are budget, with additional development required to drill down the costs and provide a further accurate financial position.

The following tables provide a summary of each domains generated actions and applicable costs.

SH - Safety Hard			
Reference	**Number of Actions**	**CapEx (£)**	**OpEx (£)**
SH1	6	0	60,000
SH2	5	0	0
SH3	4	0	0
SH4	11	0	17,000
SH5	2	0	10,000
SH6	8	0	3,000
SH7	4	0	0
SH8	6	0	0
SH9	7	0	0
SH10	4	0	0
SH11	6	0	0
SH12	6	0	0
SH13	5	0	0
SH14	6	0	0
SH15	0	0	0
SH16	1	0	0
SH17	2	0	0
SH18	7	0	0
SH19	3	0	0
SH21	6	0	0
Total	**107**	0	**90,000**

SS - Safety Soft			
Reference	**Number of Actions**	**CapEx (£)**	**OpEx (£)**
SS1	11	95,000	87,698
SS2	0	0	0
SS3	7	0	
SS4	4	0	0
SS5	3	0	0
SS6	7	0	0
SS7	3	0	500
SS8	3	0	0
SS9	4	0	500
SS10	4	15,000	50,000
Total	**46**	**110,000**	**138,698**

P – Patient Experience			
Reference	**Number of Actions**	**CapEx (£)**	**OpEx (£)**
P1	0	0	0
P2	1	0	0
P3	1	0	0
P4	0	0	0
P5	0	0	0
P6	1	0	0
Total	**3**	0	0

F – Efficiency			
Reference	**Number of Actions**	**CapEx (£)**	**OpEx (£)**
F1	0	0	0
F2	2	10,000	0
F3	3	25,000	15,000
F4	0	0	0
F5	5	25,000	204,000
Total	**10**	**60,000**	**219,000**

E – Effectiveness			
Reference	**Number of Actions**	**CapEx (£)**	**OpEx (£)**
E1	3	0	0
E2	5	20,000	0
E3	1	50,000	0
E4	15	287,000	110,000
Total	**24**	**357,000**	**110,000**

G – Governance			
Reference	**Number of Actions**	**CapEx (£)**	**OpEx (£)**
G1	1	0	0
G2	0	0	0
G3	0	0	0
Total	**1**	0	0

Capital Planning department have assessed the 4 SAQs under Efficiency and 11 SAQS relating to Effectiveness. IT department completed the assessment of SS10 and the 8 associated SAQs.

These actions are predominantly trust led with HIF support in certain areas mainly in line with Sustainability and Net Zero.

Total Actions: 191

Total Projected Costs: £1,084,697.60

Highlights of typical actions found within each domain against Requires Minimal Improvement and Requires Moderate Improvement can be found below. Cost action plan in its entirety can be found within Appendix A.

Domain	Requires Minimal Improvement	Requires Moderate Improvement
SH - Safety Hard	• Training and Staff Development (additional CPs, APs) • BCP Testing (non desktop) • Policy and Procedure Review/Development (inc. SOPs)	• Asset Register Development • Operational Maintenance Digital Improvements • Ligature Risks (Development of Policy, Roles & Responsibilities, High Risk Area Assessments)
SS - Safety Soft	• Policy and Procedure Review/Development • Risk Assessment Review (Waste, Security, Catering) • Review of 24/7 Catering Offering • PSTN Migration Plan	• Training and Staff Development (Security, Laundry/Linen Services) • Development of Improved Security Asset Maintenance Programme
P – Patient Experience	• Review of Benchmarking • Review of Survey and Focus Group Strategy • Food & Drink Strategy Review	No Actions
F – Efficiency	• Development of 2025-30 Green Plan • Net Zero Digital Improvements • Sustainability Training including Departmental Leads Appointed • Heat Decarbonisation Plan Development • Finalisation of Capital Management Playbook • Space Utilisation Survey Improvements	No Actions
E – Effectiveness	• Review of E&F Strategy • Implementation of E&F Communication Plan • Further collaboration with NYCC in Relation to Town Planning and Control • Development of 20/20/60 Waste Management NHSE Target • Smart Metering Plan Development and Implementation	• Water Efficiency Review and Inclusion Within Relevant Policy
G – Governance	• Development of Corporate Governance Framework	No Actions

11. Next Steps

To enhance the accuracy of future submissions, a number of improvements would assist in the development and efficiency of the process.

The establishment of a quarterly PAM Assurance Group incorporating both HIF and HDFT would enable a ‘soft’ periodic review of the live position, tracking progress against actions, departmental development and highlighting any further risks/actions that may have arisen within the period. Domain workshops would provide the ability to conduct local reviews with relevant stakeholders prior to reporting to the main assurance group. Target action completion dates also require formalising and monitoring.

A review of domain and action owners will ensure the relevant personnel are assigned to accurately develop, resolve and escalate a formal reassessment of the model. Findings should then be inputted onto relevant risk registers if applicable.

Governance route to be formalised ensuring information is taken through all relevant groups, committees and boards for oversight, comment and approval. An appointment of a board level Senior Responsible Officer (SRO) within both HIF and HDFT will enhance the process and give high level exposure of all conclusions.

With current costed action plans attributed with budget costs only, development of costs will provide a true financial position to assist in the goal of achieving a ‘Good’ or greater rating across all domains within the model. Cost development would be tracked through the assurance group providing a live position at all times.

The community estate requires inclusion within the model, with currently HIF maintained sites providing the basis for the submission. Inclusive of the community will further develop the trust’s overall position and any potential unknown risks and actions.

12. Appendix A

HDFT PAM XLS Risk Assessed Costed Action Plan 2024-2025.xlsx

HDFT PAM XLS Risk Assessed Costed Acti

13. Appendix B

PAM Domains – Areas of Focus and Questioning

Domain – Safety Hard

Areas covered by this section include:-

- E&F operational management
- Design, layout and use of properties
- E&F document management
- Health and safety at work
- Asbestos
- Medical gas systems
- Natural gas and specialist piped systems
- Water safety systems
- Electrical systems
- Mechanical systems
- Ventilation, air conditioning and refrigeration systems
- Lifts, hoists and conveyance systems
- Pressure systems
- Fire safety
- Medical devices and equipment
- Resilience, emergency and business continuity planning
- Reporting of safety related issues and auctioning safety related alerts
- Ensuring E&F services are safe and suitable when the organisation is not directly responsible for providing these services
- Contractor management
- Built Environment – Reducing harm by ligature in practice

Typical questions in all of these areas focus on:-

- Policies and procedures
- Roles and responsibilities
- Risk assessment
- Maintenance
- Training and development
- Review process
- Costed action plans

Domain – Safety Soft

Areas covered by this section include:-

- Catering services
- Decontamination processes
- Waste and recycling management
- Cleanliness and infection control
- Laundry and linen services
- Security management
- Transport services and access arrangements
- Pest control
- Portering services
- Telephony and switchboard

Typical questions in all of these areas focus on:-

- Policies and procedures
- Roles and responsibilities
- Risk assessment
- Maintenance
- Training and development
- Review process
- Costed action plans

Domain – Patient Experience

Areas covered by this section include:-

- Ensuring engagement and involvement on E&F services from people who use the services, public and staff
- Ensuring patients, staff and visitors perceive the condition, appearance, maintenance and privacy and dignity of the estate is satisfactory
- Ensuring patients, staff and visitors perceive cleanliness of the estate and facilities to be satisfactory
- Ensuring that access and car parking arrangements meet the reasonable needs of patients, staff and visitors
- Provide high quality and supportive environments to patients, visitors and staff in relation to grounds and gardens
- Ensuring that Catering Services provide adequate nutrition and hydration through the choice of food and drink for people to meet their diverse needs

Typical questions in these areas focus on:-

- PLACE assessments
- Other assessments
- Views and experiences
- Engagement
- Prioritisation
- Value
- Costed action plans

Domain – Efficiency

Areas covered by this section include:-

- Having a well-managed approach to performance management of E&F operations
- Having a well-managed approach to improved efficiency in running E&F services
- Improved efficiencies in capital procurement, refurbishments and land management
- Having well-managed and robust financial controls, procedures and reporting relating to E&F services
- Ensuring E&F services are continuously improved and sustainability ensured

Typical questions in these areas focus on:-

- Analysing performance
- Benchmarking
- Business planning
- Commercial opportunities
- Capital procurement
- Policies and procedures
- Quality and sustainability
- Financial pressures
- Continuous improvement
- Costed action plans

Domain – Effectiveness

Areas covered by this section include:-

- Having a clear vision and a credible strategy to deliver good quality E&F services
- Having a well-managed approach to town planning
- Having a well-managed robust approach to management of land and property
- Having a suitable sustainability approach in place and being actioned.

Typical questions in these areas focus on:-

- Vision and value
- Strategy
- Development
- Progress
- Local and neighbourhood planning
- Planning control
- Enforcement
- Disposal, leases and acquisitions
- Governance
- Costed action plans

Domain – Governance

Areas covered by this section include:-

1. Ensuring the E&F governance framework has clear responsibilities and that quality, performance and risks are understood and managed
2. Ensuring the estates and facilities leadership and culture reflects the vision and values, encourages openness and transparency and promoting good quality E&F services
3. Ensuring that the organisations Board has access to professional advice on all matters relating to E&F services

Typical questions in these areas focus on:-

- Governance frameworks
- Roles
- Partners and third parties
- Performance, assurance and monitoring
- Audit
- Risk
- Leadership
- Staff feelings
- Culture
- Promoting safety, health and wellbeing
- Teamwork
- E&F professional advice
- Costed action plans

14. Appendix C

PAM Annual Amendments 23/24

Safety Hard
Legislation & guidance updated.
SH16, SH17, SH18 and G2 evidence: 'The organisation demonstrates that it undertakes process to identify lessons from events and incidents, with a robust process for implementing the learning into new or amended organisational policy, procedure or ways of working'
SH4 H&S - MH wording added - (cell E47)
Mental Health (MH) service Providers (and Trusts who may treat MH patients such as A&E) should consider:
• Ligature Reduction
• Barricade Reduction ironmongery
• Absconding Reduction
• Windows/Falls from Height
• Ceiling Height
• Air Locks
• Fence heights
• Bolt down Fixed Furniture and Equipment
• Non Pick Mastic
• Reduced breakable glass/plastic/fabric
• MH court yards and Garden/furniture
SH4 H&S - MH wording added (cell E45)
4. The ability to report on the regulatory requirements regarding safer wards (ligature).
5. Demonstrate clear ability to report on never events relating to estates and facilities items (window restrictors/non collapsible rails/surface temperature) particularly when in relation to Mental health facilities and A&E wards.
SH10 - wording updated
SH14 - Fire safety guidance added (cell F147)
18. Approved Document B
19. Equality Act 2010
20. Regulation 38 – operating within the building on Fire Safety.
SH19 - Safety Hard added - SH19.3 'contract expiry' and updated wording SH19.2
Previous SH20 - regarding medical gasses (Framework TBC) - removed - will be added next year if the guidance is available on this)
SH20 - removed
SH21– Added separate question regarding ligature

Safety Soft
Legislation and guidance updated
Cleanliness and infection control
Legislation and guidance updated
SS1.sub questions 15-21 wording updated slightly
SS4 - Cleanliness and infection control - Sub questions 9,10,11 added
SS4.8&9 wording added: (Although the mandatory requirement is to display in patient facing areas however a trust may choose to display in other areas so this is capturing evidence where trusts are improving standards for staff) also guidance note 'Consider ambulance cleaning supplement'
SS9 - Portering services - wording added within the guidance (cell f114):
To note we are working on guidance for portering which will be available for reference next year, covering:
- Service strategy (workforce)

- Technology and equipment
- Policy
- Working with clinical teams

SS10 - PSTN - added sub question SS10.7 - updated

Efficiency

Evidence updated:

F3 Improved efficiencies in capital procurement, refurbishments and land management guidance and evidence updated (Cell E30 and F25)

F3 Efficiency - added F3.2. 'Capital project Management' (also updated wording for F3.1)

F4 Efficiency - added F4.3. 'Board reporting and contracting'

'health system' updated, Procure 23 added - 10. NHS Net Zero Building Standard, 11. Estates Net Zero Carbon Delivery Plan (NZCDP), evidence wording updated to 'site level' 2. The organisation considers the NHS Net Zero Building Standard when undertaking construction and refurbishment projects

Effectiveness

Evidence updated (Cell E33-39)

Guidance legislation updated.

-New Transport question proposed in E4.5

- Updated E4.7 regarding procurement

-Recently published Net Zero Travel & Transport strategy added to 'relevant guidance & legislation'

Helipad - Question has been restructured to provide more evidence examples

(cell B7-9) wording added to sub questions

1.-The Trust should have a responsible person able to demonstrate and documented evidence/policy in relation to Downwash helipad factors and considerations within the Trust.

2. -The Trust should have a responsible person able to demonstrate and documented evidence/policy in relation to general helipad factors and considerations within the Trust.

3. - In addition - The Trust should have a responsible person able to demonstrate and documented evidence/policy in relation to Fire risk regarding